HEALTH CAMPAIGNS TOGETHER

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Plan to switch thousands of elective patients to private hospitals

NHS BOSSES TURN TO PRIVATE SECTOR

NHS England is miles off its target of ensuring the waiting list is "no higher in March 2019 than March 2018."

Instead the 9-year funding squeeze on the NHS, cuts in numbers of acute beds and a succession of winter crises have combined to force waiting lists for treatment UP – to record levels, increasing from 4.1 million to 4.3m in the six months March-September 2018.

Numbers waiting more than 52 weeks for elective treatment are also up – by almost 14% to 3,156.

Last winter NHS England made matters worse by telling trusts to halt up to 50,000 elective operations, to free up beds for emergencies.

Worryingly, however it seems that NHS Improvement has a cunning plan: they want trusts to consign thousands more NHS elective patients to the questionable care of private hospitals, even though they lack the intensive care, emergency response and multi-disciplinary teams of NHS hospitals.

NHS Improvement has even drawn up a list of 54 trusts which it feels may need to contract out operations to hold down waiting lists and cope with pressures on beds.

A third of the 54 are in London, with other major hospitals listed in Leeds, Kent, North Lincolnshire, Oxford, Derby, Leicester, Staffordshire, Plymouth, Southampton, crisis-ridden Worcestershire and many more.

However the list, which was leaked to the Health Service Journal in early December, was not intended to be sent to the trusts – many of those on the list were unaware of its existence.

Instead it was to be sent to private hospital chains such as Spire Healthcare, Care UK and Nuffield Health – effectively giving them the nod to press the target trusts for lucrative business to fill their otherwise empty beds. They have been predictably delighted.

Mass protest helped force Shrewsbury & Telford trust to halt A&E closure - p2

United campaigns needed to defend NHS

But it's a disastrous deal for NHS trusts, which would be left with inadequate capacity to get through an average British winter without triggering a crisis – while the NHS hands a bonanza of extra income to the private hospitals, many of whom will need to poach even more NHS staff to cope with any significant increase in caseload.

The reason the private sector has so many empty beds is because there is no viable market even for elective treatment; the private sector has only been able to function through hidden subsidies – cherry picking only straightforward elective work, utilising staff trained by the NHS, and depending upon NHS hospitals to deal with their emergency situations when planned operations go wrong.

Lifeline

The *HSJ* estimates cutting the waiting list back by 200,000 to its March 2018 level could cost £400m-£600m.

If this money flows out of the NHS it would throw a lifeline to a flagging private sector, which has been struggling as NHS trusts have managed to limit their use of private hospital beds.

This policy of boosting private hospital budgets might seem very clever to NHS England and NHS Improvement bureaucrats.

But it is likely to go down like a lead balloon with local politicians when they see their local NHS hospitals and their emergency services plunged into deepening crisis while extra cash flows to a parasitic and unpopular private sector.

The task of local campaigners is to make sure all MPs and councillors are aware of the mess being created in our NHS – and know if they do nothing they will be held responsible for any damage done to services.

54
Number of trusts identified by NHS Improvement as possibly needing to contract out elective work to private hospitals

Divide politicians

United campaigns can force nervous politicians of any party to intervene to stop dangerous plans, as we have seen in Shropshire, Essex and elsewhere (see inside pages).

Let's make 2019 the year we unite to divide and derail those whose policies are undermining our NHS.

Work with us to make it happen. Join Health Campaigns Together!

INSIDE

Blocking the road to cuts in Derbyshire

Keith Venables, Derby/ Derbyshire SONHS

Despite admitting that they've got their sums wrong, NHS managers in Derbyshire are still going ahead closing down Babington Hospital, axing very cost effective grants to the Voluntary Sector and threatening other community hospitals in the county.

But campaigners are not giving up the fight.

We briefly blocked then reopened, then blocked the road again outside Babington at rush hour to draw attention to the cuts and received masses of support from local car drivers.

Imaginative protest has also led to a victory - the NHS Managers have admitted defeat, and suspended the deletion of the County Psychotherapy team.

We will fight and we will win.

Next steps in fight to save HRI

Hands Off HRI has come a long way since we began our work in 2016.

The Trust has been forced back from its original intention which was to close Huddersfield Royal infirmary and A&E. Through our work, we have forced them to concede that the hospital will be staying open and we keep our A&E.

However we know that they intend to shift all emergency and acute services to Halifax and the Dept of Health has agreed to give then the money to carry out their sneaky plan. So what is the next stage of our fight?

Demand Proper Staffing Levels

Buried deep in their outline plan, they argue for a 'single expert care team'. They intend to base all essential staff at Halifax. Our plan is to argue for a 'dual expert care team'.

That argument can be won if we can put together an expert health professionals' team to argue the case for two teams, one in Huddersfield and the other in Halifax. We are now in the process of pulling together such a team who will begin their work in the New Year.

If you know of any health professionals who could help us, please let us know; we will need all the evidence we can get.

For a Peoples' Commission

The successful Lewisham campaign pulled together a very powerful Peoples' Commission which organised a public hearing to take witness statements and evidence from all sections of the community to demand full A & E Services.

500 attended the event which was conducted by Michael Mansfield QC and had a very powerful impact on their eventual victory. We cannot do this alone and have asked the council and our MPs for help.

However if you feel you could also help, please let us know.

Time for Proper Scrutiny

The Trust has now assumed it has the green light to go ahead. However they MUST go through a full and proper consultation and produce a full business plan to back up their case.

Joint Health Scrutiny must hold the Trust to account and we are pressing them to make sure the Trust goes back to the drawing board with this 'new' plan.

If the last business plan was legally flawed, then this next one is even worse, so they will do their best to avoid any public scrutiny. We WILL hold them to account.

Back to Court!

We have still not completed the Judicial Review. We are waiting for a Judge to hear our argument that the original business case should be struck out. The Trust will try to argue they have already consulted extensively and this 'new' plan has evolved from their original plan.

That is why it is important to us that it is scrapped and they are forced to consult again. If they fail to do it properly, then our legal team is standing by to pounce once again.

We are now entering our third year of struggle. This is our most important phase. To maintain momentum, we need your help with campaigning, fund raising, admin, legal work etc.

Any time you can spare is greatly appreciated. Thanks to everyone for all their hard work so far; we can finish this off. ...HANDS OFF HRI!!

More from ***https://www.facebook.com/groups/HandsOffHRI/***

Alarm over half baked plans in Leicestershire

University Hospitals of Leicester (UHL) is planning to reorganise acute hospital services nd is seeking capital investment from the Department of Health of around £370m.

The plans involve consolidating services away from Leicester General onto two sites – the Royal Infirmary and the Glenfield – and include a new maternity hospital at the LRI and a new treatment centre at the Glenfield.

There are a number of public concerns about these plans, notably:

- Virtually no detail about the plans has been put into the public domain and made available for public scrutiny. The public are being asked to trust that 'doctor knows best'.
- UHL's new plans do not include an increase in the number of beds, despite ongoing issues with capacity in local hospitals.
- Last winter thousands of operations were cancelled due to capacity constraints. Now the Clinical Commissioning Groups (CCGs) have decided to transfer 4% of UHL's elective care away from UHL to other providers in this year's contract.
- Once funding has been agreed for a local hospital plan, it will lock the people of Leicester, Leicestershire and Rutland into an inadequate facility for the next twenty years. So it is important to get it right now.

This brief article is an extract from a fuller statement. More from ***http://saveournhsleicestershire.org/***

Shropshire battle won, but war to fight

Pete Gillard

On 22 November the Shrewsbury and Telford Hospital Trust (SaTH) announced that they had cancelled their plans to close the A&E at Princess Royal Hospital in Telford overnight.

The closure had been due to start at the beginning of December. They had been trying to drive through overnight closure since 2015 but campaigners have never given up the fight to resist them.

The overnight closure would have been a disaster for patients. The nearest alternative A&E is at the Royal Shrewsbury Hospital (RSH) 18 miles away. But many patients could not have even been treated there.

All paediatric emergencies and "critically ill patients with compromised airways" would have to be transported out of county to Wolverhampton or Stoke. The centralisation of all paediatric and head and neck services at PRH in 2014 meant there are no facilities to treat these patients overnight at RSH.

55 miles for emergencies

For paediatric emergencies that could have meant an ambulance trip of up to 55 miles.

When SaTH announced their decision, they claimed it was because they had suddenly found enough locum doctors to provide safe staffing. That was not the real reason. Up until a week before they had been insisting that it was unsafe to use locums. Only permanent medical staff would do.

There was no change of heart. It was pressure from campaigners on the Government and NHS bosses at national level.

30,000 petition

In the weeks after the definitive closure plan was announced at the end of September, a petition launched by Telford & Wrekin Council gained over 30,000 local signatures in a matter of days. It specifically called for a Government-led rescue plan.

This was followed up with a demonstration near PRH on 2 November with over 3,000 people coming out, many of whom had never been on a demonstration before in their life.

Amongst the speakers at the rally were Gill George and Julia Evans, Chair and Secretary of the local Defend Our NHS campaign; Shaun Davies, the Leader of Telford and Wrekin Council; and UNISON Assistant General Secretary, Roger McKenzie.

All this put pressure on the local MPs. All five of them are Conservatives, a couple in marginal seats. They could see that they would be blamed if the Government did not come up with a rescue plan.

They made sure they had meetings with the Secretary of State.

Campaigners also destroyed the idea that an overnight closure could be clinically safe.

Simon Wright, SaTH's Chief Executive, told his Board that the closure would allow SaTH to "spread the risk around" – that's risk to the hospital bosses!

At October's Board meeting, the 50 members of the public present demanded that they should be allowed to speak during the item on A&E closure – not having to wait until the end of the meeting to ask polite questions.

Shocked

For an hour, Board members had to listen to the public, not the supposed clinical experts, tearing the proposals to shreds. The non-Exec Directors were clearly shocked but remained silent. Our demolition job had an impact.

When the West Midlands Clinical Senate came back a few weeks later with their report on the closure, they echoed the dangers that campaigners had exposed.

This was a battle won, but not the war. The planned overnight closure of the PRH A&E was merely a softening up process for their long-term plan – Future Fit – which will see the PRH A&E closed permanently and all acute services centralised at a single site, RSH in Shrewsbury.

Downgraded

PRH would be downgraded to a planned care centre with an attached Urgent Care Centre. This would make Telford that largest town in England without an A&E (population 166,000).

The plans include reducing the number of acute beds and cutting nursing staff by 20%, and were sold on the basis that care in the community would be significantly improved so people would not need to travel to Shrewsbury or Telford so frequently.

The reality, not unexpectedly, is different. The health bosses have now announced there is no money to improve services.

Rather than creating Urgent Care Centres in the market towns, existing MIUs are under threat. Rather than increasing the number of beds in community hospitals, the plan is now to remove them completely. And other services like rural maternity units are already 'temporarily' closed.

■ For the remainder of this abridged much longer article, see ***www.healthcampaignstogether.com***

Make Our NHS Safe for ALL

Consultation misses key issues

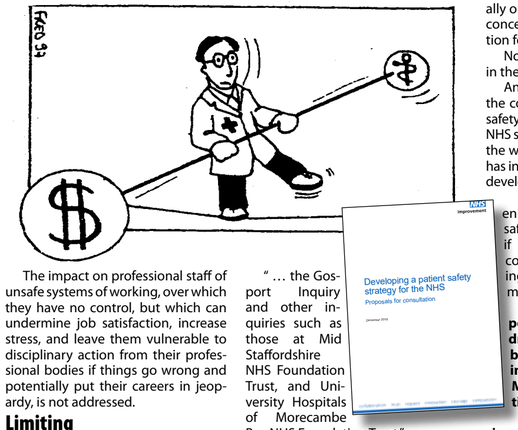
NHS Improvement's safety director Aidan Fowler, a former consultant surgeon, has hit the ground running, bringing new energy to the issue.

But he seems to be leaving little space for NHS staff to catch up with him. In November he made clear that all NHS trusts would be expected to appoint patient safety directors and work with a new national structure designed to deliver "uniformity" and help reduce patient harm.

In December he issued a 23-page consultation document ***Developing a patient safety strategy for the NHS***: however the online consultation, spanning the Christmas and New year period and during the increased pressures of winter months, closes on February 15, raising doubts over whether much is expected or wanted in the way of responses.

The document is centred, correctly on patient safety, but is focused on "Collecting information about what goes wrong in healthcare" and "Using information from incident reports and other sources to develop policy and provide advice and guidance."

It therefore makes no reference to widespread system issues such as short staffing and rota gaps, inadequate skill mix, failures of supervision, and other issues which impact on staff.



The impact on professional staff of unsafe systems of working, over which they have no control, but which can undermine job satisfaction, increase stress, and leave them vulnerable to disciplinary action from their professional bodies if things go wrong and potentially put their careers in jeopardy, is not addressed.

Limiting

This is unfortunate, and must limit the effectiveness of the initiative. The omission of staffing levels is more remarkable because the consultation document claims that the proposals draw lessons from:

" … the Gosport Inquiry and other inquiries such as those at Mid Staffordshire NHS Foundation Trust, and University Hospitals of Morecambe Bay NHS Foundation Trust."

But both the Mid Staffs and Morecambe Bay inquiries repeatedly raised the issue of staffing levels and skill mix.

The response by Health Secretary Matt Hancock to the Gosport Inquiry was to require trusts to report annually on how they have dealt with staff concerns, and to seek more protection for whistleblowers.

None of these issues is addressed in the consultation document.

Another obvious weakness is that the consultation proposal "for patient safety education and training for all NHS staff" appears to take little heed of the ways in which a cash-starved NHS has increasingly restricted training and development opportunities for staff.

It's clear that there is a strengthening commitment to address safety concerns in the NHS, even if part of that is a government concern to address the increasing costs of litigation, is a positive move.

But the initiatives so far proposed by the NHS do not address all of the concerns raised by Health Campaigns Together in launching our campaign to Make the NHS Safe For All – patients and staff.

We will continue our discussions and work with the health unions and any other organisations that wish to work with us, aiming to identify and ensure trust managers act upon potential threats to patient safety to avert any harm to patients or to staff.

CQC warns of too many "never" events

The NHS recorded 468 "never" events – serious and wholly preventable errors or actions – in the 12 months to March 2017, according to the Care Quality Commission.

But ensuring that such events really don't ever happen is a complex issue, and the CQC seems as reluctant as NHS Improvement to recognise the role of staffing levels, skill mix and excessive stress on front line staff.

A new CQC report *Opening the door to change: NHS safety culture and the need for transformation*, at least admits that with both money and staff in short supply, safety is increasingly at risk:

"Staff are struggling to cope with large volumes of safety guidance, they have little time and space to implement guidance effectively, and the systems and processes around them are not always supportive."

It concludes that "Patient safety systems are more likely to be effective if patients are actively involved," but fails to draw the obvious conclusion that staff organisations need to be involved as well.

Doctor in distress

The safety risk from under-funded and under-staffed health care is not just for patients -- but can also have brutal impact on staff.

A report last autumn from the Society of Occupational Medicine makes worrying reading as the NHS heads into another predicted and predictable winter crisis, piling added pressure onto already stressed doctors and professionals.

It notes that a substantial proportion of UK doctors experience mental health problems, manifested as burnout, work-related stress and symptoms of psychiatric morbidity. The risk appears to be higher than that of the general population, and doctors working in particular specialisations, such as GPs and junior doctors, appear to be at greater risk of burnout, work-related stress and general mental health problems.

The risk of suicide among doctors, especially GPs, psychiatrists and trainees, and among women, is high compared to the general population.

There is concern that of both sickness absence and "presenteeism" (working through while sick) are particularly high among doctors: "Doctors work while sick for several reasons such as short-staffing, feelings of responsibility to their patients, fear of letting colleagues down, the need to present a 'healthy' image at work and concerns for their future career prospects."

The most common causes of mental health problems are "high perceived workload, the growing intensity and complexity of the work, rapid change within healthcare, low control and support and personal experiences of bullying and harassment."

Conflict between pressure of work and personal life is another key risk factor for mental health problems in doctors, especially among GPs.

The report notes that "A poor work-life balance will also reduce the opportunity for doctors to spend time with family and friends and engage in other activities that replenish their resources."

■ *What could make a difference to the mental health of UK doctors? A review of the research evidence, available* ***https://www.som.org.uk/sites/som.org.uk/files/What_could_make_a_difference_to_the_mental_health_of_UK_doctors_LTF_SOM.pdf***

Nurses and other staff under stress

There have been many warnings about the potentially damaging impact of stress on front line NHS staff.

Staff working under stress are more likely to make errors, and require time off to address their own health issues, leaving services short-staffed.

In the 2017 NHS staff survey 38% of staff reported feeling unwell due to work related stress, but only 68% said their immediate manager took any interest in their health and wellbeing.

58% of staff said they worked additional unpaid hours – not surprising since the numbers of nursing vacancies now stand at 36,000, while the patient caseload has increased.

The problem is most severe in emergency departments, where the lack of sufficient beds in many hospitals and delays in seeing seriously ill patients will inevitably subject frustrated staff to high levels of stress.

The problem can be compounded by hospital management, themselves under stress, resorting to bullying and closing their eyes and ears to problems faced by inadequate numbers of frontline staff.

All of these problems have been worsened by cash squeeze on the NHS, the prolonged pay freeze in the NHS which has left real terms salaries for qualified nurses well below the 2010 level, by the short-sighted decision to scrap bursaries for nursing students that has brought a sharp drop in applications.

This has meant that most applicants are now from the younger age groups with high drop-out rates.

In addition the Brexit referendum has triggered an exodus of EU staff and a massive plunge in numbers of trained nurses from EU countries applying to work in the NHS.

Short-term answers

Since it takes at least 3 years to train a nurse, trusts need to press ministers for short run answers to staff shortages to combat rising levels of stress.

Useful ideas include:

- lifting or scrapping the cap on spending on agency staff to ensure trusts are allowed to fill vacant posts in frontline services;
- a full-scale campaign to win back some of the many thousands of nurses who have been burnt out or demoralised and left the profession for other jobs;
- dropping all the current and planned immigration restrictions (such as the £30,000 minimum income which would exclude most qualified health professionals);
- and offering those who do come the chance to stay here permanently if they wish.

Safety Watch

Our Safety Watch campaign as begun to catalogue and explore the various growing risks to safe patient care developing across the NHS as austerity cuts bite home.

This includes unsafe reconfiguration plans with inadequate bed numbers and lengthy journeys to access care, unsafe staffing levels, ramming extra beds into already full wards, and any other concerns that come to light.

We invite health workers and campaigners to submit matters of concern, as links, as full text or as notes. If you wish to be identified as the source of information, please make this clear. Email to us at ***hct-safetylog@gmail.com***.

PLEASE NOTE: If you are a health worker with internal information about your employer that might be regarded as whistleblowing, you should NOT come to us, but **GO DIRECTLY TO YOUR TRADE UNION** or professional body, to ensure your case is handled correctly and you are protected.

Council scrutiny powers in action

Bishop Auckland

Members of a Durham County Council scrutiny committee intervened in November to halt County Durham and Darlington NHS Trust's proposals to close ward six at Bishop Auckland Hospital.

Bishop Auckland councillor Joy Allen, a member of the authority's cabinet, told the Northern Echo: "It's an ill conceived plan, poorly implemented and operationally flawed.

"Scrutiny has paused the process and we hope we can get it stopped and keep the staff and keep the resources at Bishop Auckland Hospital."

The next day the Northern Echo reported on the victory that was achieved:

"After a grilling by County Durham councillors, not only did County Durham and Darlington NHS Foundation Trust apologise, it also promised the 24-bed service would remain open while its future is considered."

North Yorkshire

After seriously ill people had been unjustly refused transport to a hospital clinic under a new system of determining who was eligible, North Yorkshire council's health and scrutiny committee stepped in to put sharp questions to the local CCG.

John Darley, the Head of Urgent & Emergency Care for Hambleton, Richmondshire and Whitby, denied patients had faced a "Spanish Inquisition-style" interrogation as they attempted to get transport across the vast area to access treatment.

The committee was clearly less than convinced: after discussion a motion from Cllr John Blackie, the chair said the committee would call on the council to press CCGs to implement a series of changes to the patient transport process.

'Essential reading in the battle to save the NHS before private companies bleed it dry.' – Ken Loach

All proceeds to Keep Our NHS Public. Order online at *https://keepournhspublic.com/shop/books/*

First elements of the NHS Long Term Plan appear . . .

Another top-down plan to make our NHS even less accountable

John Lister

The postponed NHS Long Term Plan is due to be published the week after we go to press. Meanwhile, just before Christmas, NHS England appears to have revived the failed Sustainability and Transformation Plans.

These were the 44 deeply flawed and inadequate "plans" published after a secretive process at the very end of 2016 – to be largely forgotten in 2017 and 2018.

NHS bosses have apparently embarked once again on a process of launching an impossible project in an unrealistic timescale with some of the key information still unavailable.

The timing is very similar to STPs. On December 21 2018, just after announcements that a twice-delayed 10-year plan would not be published until January 2019, NHS England published a 21 page document Preparing for 2019/20 Operational Planning and Contracting, which appears to pre-empt the plan – and give a warning of its likely content and direction.

This time NHS England is imposing even tighter top-down control over the process. NHS staff and the local communities have again been left very firmly on the outside, neither consulted nor involved.

January 14 deadline

The first deadline is for "STPs/ICSs" to have convened meetings of "local provider and commissioner leaders" to collectively agree "planning assumptions on demand and capacity" in time to complete submissions to "joint regional teams" of NHS England and NHS Improvement bureaucrats – on January 14.

This is theoretically just 24 days after the publication of the document, but given the intervening Christmas and New Year holidays and 4 weekends it only leaves 13 working days (some of these almost certainly disrupted by staff holidays) to reach stage one. This ensures genuine consultation or engagement is impossible, and the 'plan' is already doomed to miss its deadlines – or be cobbled together on the most superficial basis.

The role of the "joint regional teams" is much more intrusive and emphatic than before. Unlike the old Strategic Health Authorities scrapped by the 2012 Act, the 41 regional 'teams' are not public bodies. They will not meet in public or publish any of their papers. Nor do they completely coincide with the 44 STPs.

They have no accountability to the public in the wide areas they cover, and are accountable only upwards to NHS England, embodying the new drive for centralised control – yet ironically these same unaccountable regional teams will have a key role in "ensuring local accountability," fixing "control totals" (targets for limiting the deficits or requiring surpluses for trusts, CCGs and each STP "system") and vetting plans.

NHS England is persevering with control totals, despite the fact that in February 2018 just half of all trusts told an NHS Providers survey that they would sign up to their control total, and only 35% were confident of meeting it. For many the incentive payments were too small to justify the cuts required.

None of the decisions by these new, remote regional bodies will be subject to any consultation with local communities. Everything about us will be decided without us.

Tighter targets

And all the targets these bureaucrats will be enforcing are tighter than before, despite the fact that the extra investment necessary to balance the financial books, wipe out long-held debts and improve services is still not available.

The £20.5bn 'extra' spending to 2024 is equivalent to just 3% in real terms per year, while NHS England's own forecast is for activity to increase by 3.1% per year, so nothing is left over.

Trusts have accumulated a massive £11 billion in loans and bail-out funding since 2010, in addition to underlying and actual deficits. In quarter 2 of 2018/19 89% of acute providers were in the red.

Backlog maintenance costs built up in recent years add up to a massive £6 billion, with long term implications and short term risk.

Nor is there enough capital to finance new or expanded facilities: recent announcements of capital funding of just under £1 billion fell way short of the capital requirements of the STP plans – which added up to £14 billion.

The new plan also requires CCGs to cut their own running costs by 20%, but increase the share of the budget going to mental health, community health and primary care – implying a reduction in spending on acute services, despite increasing demand.

After years of indifference and empty promises central control is being imposed on mental health spending to ensure CCGs match "minimum percentage uplift" as shown in the "financial planning template," and more of the money must be spent with frontline mental health provision.

This is backed up by a threat that "NHS England will consider appropriate regulatory action, including in exceptional circumstances imposing directions on the CCG" if they refuse to comply.

There are more tough orders on primary care: "STPs/ICSs must have a Primary Care Strategy in place by 1 April 2019 which sets out how they will ensure the sustainability and transformation of primary care and general practice."

NHS England's main objective seems to be "primary care networks" that effectively centralise more GP services, regardless of local communities' needs and wishes.

Heavy emphasis on cutting demand for emergency services is not coupled with evidence of much success so far.

NHS Providers reports "continued and unprecedented levels of demand." At quarter 2 2018/19 A&E attendances were up 3.9% on the same period last year, with emergency admissions up by 7%. The latest sit rep figures as this paper goes to press, for December 30, which are described as showing the NHS coping well, reveal 2/3 hospitals running above 93% occupancy and 11% running with 99% or more beds occupied.

Waiting lists

Waiting lists for elective treatment have grown rapidly, up 200,000 to 4.3 million in the six months to September 2018, compared with 4.1 million in March 2018.

For CCGs and providers alike, those with the toughest problems, and often with the most inadequate resources, face the hardest targets and the harshest treatment. CCGs with "longer standing and/or larger cumulative deficits will be set a more accelerated recovery trajectory."

NHS trusts are being pressured into an ongoing fire sale of "surplus" land and buildings to help reduce deficits (with NHS Improvement offering a controversial incentive of £2 from Sustainability Funds for every £1 reduction to trusts' control totals).

But trusts are now also urged to "grow their external (non-NHS) income" and "work towards securing the benchmarked potential for commercial income growth." Worse still, they must aim to increase money raised from charging patients for treatment – "overseas visitor cost recovery" – a policy opposed by medical Royal Colleges.

Even before the Long Term Plan has appeared we can tell that the new regime will be a meaner-spirited, heavier-handed, tougher, tighter attempted re-run of the STP project

So even before the Long Term Plan has appeared we can tell that the new regime will be a meaner-spirited, heavier-handed, tougher, tighter attempted re-run of the STP project, in which even the minimal level of accountability and tokenistic local consultation and staff engagement provided under the 2012 Act has been effectively stripped away, and centralised control imposed.

Despite talk of "integration", the competitive market and contracting remain intact. Patients and staff will have even fewer rights, and no voice at all – other than through political protest.

Demand for emergency and elective health care is still increasing despite efforts to contain it.

Staffing crisis

But with a chronic staffing crisis worsened by immigration controls and a continued Brexodus of EU staff, and without the revenue or the capital required to improve services, we can expect NHS performance to remain below target, stress to increase on the remaining front line staff, creaking buildings and aging equipment to threaten safety problems, and NHS England and ministers to continue to dodge any responsibility for the problems they are creating.

The challenge for campaigners and health unions is more demanding than ever: 2019 must be a year in which we step up the pressure for safe staffing and safe systems of care, full funding and against any further privatisation or erosion of the NHS.

It's a tough task – and one which needs the power of a united body of campaigners: Health Campaigns Together still has a vital role to play.

Join us now!

Looking back on the "Five Year Forward View"

John Lister

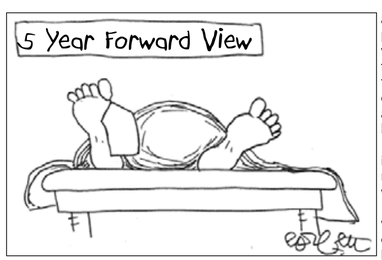
2019 will mark the fifth anniversary of the Five Year Forward View (FYFV), effectively Simon Stevens' manifesto as the incoming chief executive of NHS England.

It was uncritically embraced at the time by all main political parties as a visionary effort to modernise the NHS and to bridge the rapidly growing gap between the pressures and demands on the NHS and the post-2010 NHS budget.

On the other extreme a handful of conspiracy theorists laboured gamely through the largely abstract and waffle-strewn document to prove it was all coded messages pointing to the privatisation of the whole NHS, led by Stevens' former bosses in the US health corporations.

Both these views hold up badly now. Looking back at the 44-page FYFV is like stepping into a museum: most of the key commitments have long ago been sidelined or reduced to token gestures, not least the insistence that:

"The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health."



Public health

While the concept of improving public health to reduce demand on the NHS is a good one to which nobody could object, it was hardly new at the time.

But since 2014 we have seen year after year of cuts to public health budgets which are supposed to fund schemes to help tackle obesity and reduce consumption of alcohol, drugs, and tobacco.

Many more FYFV ideas have also remained little more than words.

For instance patients were to be given control over shared budgets for health and social care: Stevens in a July speech in 2014 even suggested "north of 5 million" such personal budgets might be operational by 2018, sharing £5 billion between them.

This apparently bold proposal would have meant average payments of just £1,000 per year, £20 per week – well short of the amount required to secure any meaningful care package for any but the most minor health needs, even if the services required were available and the patient/client was confident enough and able to sort out their own care.

However the latest figures show that the vision was unrealistic on almost every level: the number of personal health budgets has apparently been rising each year since they launched in 2014, but there were fewer than 23,000 people receiving one in the first nine months of 2017/18 – a long way short of 5 million.

Carers, too, were promised new support by the FYFV (not for the first time, and no doubt not for the last).

Yet the plight of carers remains desperate, with increased misery for many of them hit by the succession of welfare cuts and the nightmare of universal credit.

Barriers to be broken

According to the FYFV, barriers between GPs and hospitals, physical and mental health and health and social care were going to be broken down.

There was going to be a "Forward View" for GPs, and a shift of investment from secondary care into primary care (how many times have governments proposed that since the 1980s?).

There were bold promises to invest in more staff and improved services for mental health.

Predictably none of these things have happened.

Barriers are still intact. Overworked, under-staffed GPs face ever-increasing demands, with no sign of the promised increase in numbers or resources.

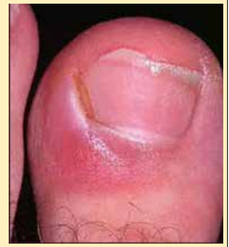
In mental health there are thousands fewer mental health nursing staff than there were in 2010, and the performance on almost every measure is as bad or worse than 2014.

After such a comprehensive failure to deliver almost any significant element of the FYFV, the likelihood of making a TEN year plan any more than a wish list or a pious declaration seems to be vanishingly small.

DRIP FEED

A round-up of news

Babylon safety fears – from doctors who designed it



The AI chatbbot app developed by Babylon, the company behind the 'GP At Hand' app favoured by Health Secretary Matt Hancock has recently failed to correctly diagnose even an ingrowing toenail (above).

Instead Babylon suggested that it was "Likely" to be "gout of the big toe" requiring an urgent visit to a GP, or "less likely" to be sciatica.

This is just one of many complaints that the diagnostic app is less accurate than its company and its founder Ali Parsa are keen to claim.

Now an article in *Forbes* magazine has revealed that some of the doctors employed by Babylon to develop the app expressed concerns to Parsa back in December 2017, and persuaded him to delay the roll-out of the app: but only for a few months.

The doctors had tested the app for a day, and, according to Forbes, "found that around 10-15% of the chatbot's 100 most frequently suggested outcomes such as chest infection either missed warning signs of a more serious condition or were just flat-out wrong."

Its clear that there is unease among its designers that the app is being rushed out, and its effectiveness exaggerated.

This follows the revelation that when Parsa claimed last summer that Babylon had scored higher than human doctors in a medical exam, it had only answered 15 out of 50 questions, and been allowed to give three answers to each, while the doctors were only allowed one!

It's not what the doctor ordered.

Royal not so Free Hospital

The Royal Free Hospital Trust board has installed a new private GP service on the premises, charging no less than £80 per visit.

This decision, which has angered patient groups, staff and campaigners in North London, demonstrates shows scant respect for the once proud history of the Royal Free Hospital itself, which was established in 1828 by a doctor, William Marsden, as a place in London where the poor could access treatment free of charge.

By contrast the £80 fee to see a private GP is almost two thirds of the basic state pension, and will only appeal to the most prosperous of Hampstead's worried wealthy residents.

Despite its name the Royal Free has for many years focused on a large private patient unit, which takes up a whole floor of the building.

However the financial performance of this enterprise is far from clear. Income figures are published – but no account is given of outgoings. The most recent trust board papers show that the PPU is consistently falling well below its target level of income – and could even be losing money.

Has Dalton got a secret plan?

Tucked away in the papers for the Royal Surrey County Hospital Trust is a fascinating report of a meeting of NHS Providers chairs and CEOs in December. According to the Trust's outgoing RSCH Chair John Denning:

"There is real nervousness about lack of capacity in the system. NHS Providers expects some consolidation of STPs and believe that [NHS Improvement boss] Ian Dalton thinks there should be 50 to 100 providers rather than 211.

"NHS Providers is nervous that ID thinks it's NHS I's role to determine who should merge with whom."

There are obvious questions from this: is this a revised plan to halve or even further cut the numbers of "providers" (hospitals and mental health trusts)? Is it a plan for massive mergers to leave giant trusts straddling large areas? Or did he really mean CCGs rather than providers?

And why aren't we being told?

Former NHS vanguards boss jumps ship

A former NHS England Director leading 'vanguard' projects, and one-time trust chief executive has stepped into the private sector by taking a job as chief executive of the UK division of US health insurance multinational Centene.

Samantha Jones, who stepped down from her NHS England role in 2017, had been in charge of the development of 50 vanguard projects which from 2015 were supposed to lead the way in implementing the vague ideas in NHS England's Five Year Forward View.

Few vanguards have delivered any significant results, despite preferential funding and management support, and even fewer have published any detailed findings. Many have subsequently fizzled out as funding was withdrawn: but one that seems to have survived was the Rushcliffe new care model vanguard, linked in with the Nottinghamshire Integrated Care System which brought in Centene on a one-year £2.7m consultancy contract in 2017.

Much was made at the time of Centene's half ownership of Ribera Salud, the Spanish public-private partnership that developed the controversial Alzira model of integrated care for the right wing regional government in Valencia, until a change of regional government.

The new regime in Valencia is committed to bringing the hospitals back into public ownership and control, and has not renewed the contract with Ribera Salud, despite heavy lobbying on the company's behalf by a former defence minister and the US embassy.

However Centene has just purchased an 89% stake in Madrid's University Hospital of Torrejón. In England it has bought up a majority stake in The Practice, which runs a number of GP surgeries and mental health provider Beacon UK, now rebranded as Simplify Health.

The company has also secured a role in nine of the ten contracts for consultancy work on integrating services in England.

Private hospitals are cashing in on worried wealthy

A US company, HCA, which runs a number of exclusive private hospitals in London, has branched out into urgent care, establishing the Casualty First clinic in north London, which has been misleadingly promoted as a "private A&E".

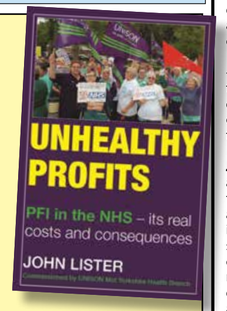
While it's definitely private (charging £100 per visit to the worried wealthy) it is clearly NOT an A&E, and anyone arriving with any serious health problems would need to be rushed to an NHS hospital for treatment.

Its attraction for people with fat wallets and minor health niggles is that the waiting times average just 10 minutes, partly because so few people are using it. HCA's five urgent care centres have experienced a "huge increase in demand" – to just 1,600 per month.

Meanwhile increasing delays in accessing NHS elective care seem to have helped to fill the coffers of the private hospitals with a growth in the "self-pay" market for operations to people without health insurance. According to private sector analysts LaingBuisson this market more than doubled from £493m in 2013 to £1.1 billion in 2017.

New!

The story of PFI … up to date



New ebook available via Amazon: paperback version to follow soon.

Unhealthy Profits by **John Lister** charts the story of PFI in the NHS from its beginnings in 1992 through to Philip Hammond's announcement that no more PFI contracts will be signed.

It also follows the story of PFI in one hospital trust - Mid Yorkshire Hospitals – and the battles that have been fought there by the UNISON branch, which has fought PFI from the outset and commissioned the book.

A chapter discusses what to do about PFI: and a postscript looks at the growth -- and costs -- of PFI world-wide.

For single copies order via Amazon. For discount on orders of 10 and above contact *midyorksunison@aol.co.uk*

Conor McGurran of NW Region UNISON

Jan Shortt, NPC General Secretary

Simon Duffy (behind him Prof Peter Beresford and chair Ann Bannister)

Gill Ogilvie, GMB regional organiser

Part of the conference, at Carrs Lane conference centre in Birmingham

Our 'Reclaim Social Care' conference in Birmingham on November 17 attracted 110 participants.

Agreeing a platform to campaign on social care

Opening the conference, John Lister, editor of Health Campaigns Together argued social care is a complex issue covering a wide range of interest groups, with distinct viewpoints.

"Given these problems, why has Health Campaigns Together called a conference on social care?

"Because we can all agree it is an important issue, which is related in many ways with public health and health care. Indeed some key elements of what is now called social care, most notably long term care of older people, were in the NHS until the mid 1990s.

"It's also an area where the approach of Health Campaigns Together – as a coalition that builds on points of agreement while leaving scope for differences of opinion on details – can perhaps help establish a campaign where so far no campaign has been established.

"Some Labour MPs, councillors and some campaigners, pointing to the lack of democracy in the NHS, now argue local government has to be in charge of social care.

"But the track record in the 25 years since long term care of older people was transferred to local government as a result of Thatcher's so-called "community care" reforms, has been disastrous.

Services that were free are now subjected to means tested charges along with wholesale privatisation, bringing fragmentation of domiciliary care as well as privately run nursing homes.

"This has been the biggest privatisation of care services so far.

"Since 1993 thousands of people each year have found they have to liquidate their savings or sell their houses to pay for poor quality nursing homes or domiciliary care.

"Home care has been largely privatised, and in many areas desperately exploited staff on minimum wage and zero hours contracts are allocated as little as 15 minutes a time to visit clients.

"What can you do for anyone in 15 minutes? Boil them an egg? Who in their right mind would ever have imagined there is any value in 15 minute appointments?

"The Tories are not the only ones to blame. The rot continued under New Labour. Some still argue that it is 'fair' for people with larger savings and higher pensions to pay for their care.

"Just imagine if we applied thisame principle to the NHS. It would smash up our universal health care system.

"The fairness has to be based in the tax system: if people have inherited wealth, or high levels of earned or unearned income, they should be taxed on that.

"Nobody chooses to rely on home care or be looked after in a nursing home. Those services should be paid for collectively through general taxation, and provided to those who need them free of charge – on the same principle as the NHS.

"We also want to see staff on permanent contracts, with decent pay and conditions, training where required, and services subject to scrutiny to ensure standards are adequate.

"So we need to hammer out a platform for the unions, Labour and other opposition parties, campaigners and the various user groups to unite in the fight to Reclaim Social Care as a public service and ensure it has the resources and the policies that can make it fit for purpose."

People - not profits - need to be central to new model for social care

Eleanor Smith (MP Wolverhampton South West) recalled the loss of long term beds from the NHS in the early 1990s:

"We used to have hospitals and services that looked after elderly people. We remember. It has been eroded."

There is now a debate to be had on where social care should lie – local government or NHS. Eleanor stressed the dangers of local government powers and budgets being further eroded by central government.

Eleanor went on to offer support – perhaps through booking rooms in the House of Commons where further debate could take place, and assisting campaigners to reach out to other MPs to draw them into the discussion.

Judy Downey, CEO of the Relatives and Residents Association, explained the origins and basis of the campaign, and the fact that anyone fighting to improve social care will find themselves up against the large private companies that dominate much of the nursing home provision, and which despite continued claims that they are under-funded are generating very high profits.

Connor McGurran from UNISON's North West Region 'Dignity in Care Campaign' made clear that none of the surpluses benefit low paid, highly exploited staff often working long, but unpredictable hours, while companies are raking in profits of 13%.

"Social care is being bled dry by hedge funds and aggressive anti-union companies, while care workers are overworked, underpaid and exploited,"

Connor gave the example of one worker's punishing rota - including 48 visits, shifts as long as 17 and even 21 hours, with virtually no pause between them, and visits to clients of even less than 15 minutes with a number of FIVE MINUTE care visits, and more than one scheduled at just ONE minute!

Explaining UNISON's campaign to recruit and organise care workers, fight for recognition and improve conditions, stressed that care workers also need proper training in meeting the needs of so many people with serious and often multiple health conditions.

A speech was read out to the conference on behalf of **Bob Williams-Findlay**, a founder member of Birmingham Disability Rights Group and "Being the Boss" / Reclaim our Futures, who was unwell and unable to attend in person.

He argued strongly that social support must be on an equal basis of esteem, and Language is also important; In the case of many disabled people the word "care" is simply inappropriate, and perceived as a way of keeping people in a subordinate position.

Attitudes and behaviour found within society present major barriers for a variety of people with significant impairments.

What is needed is assistance in basic tasks, but also in many cases helping to assist with hostile social environments, thus enabling people to determine their own lifestyles and levels of independence.

"Social inclusion is the key to developing the support and assistance people need, and involvement of Users' voices must be there in future planning and delivery of care."

Jan Shortt, General Secretary of the National Pensioners Convention reported that the NPC had been having substantial debate about the type of social care system we need, and eager to work with others to widen that debate and develop a campaign.

There were issues about integration with health care, with some good models and some bad ones.

Noting that 50% of people in care homes are self-funding their care, Jan argued:

"Care must be free at point of use, publicly funded and publicly accountable. We have to stop money going to Cayman Islands to funds that helped pay for this Government

"We need dignity and respect and a better quality of life, and a system of funding that is fair for all."

Gill Ogilvie, a GMB regional organiser who had been actively campaigning around cuts in children's services and day care nurseries pointed to the impact of the failure by many local authorities to meet their statutory duty to provide transport to get children to school.

Gill also spoke about the issues being highlighted by Children's Grief Awareness Week.

Simon Duffy, Founder & Director of the Centre for Welfare Reform, discussed why the cuts to social care are so deep (50% and counting) and why civil society has failed to offer any effective resistance.

Social care is NOT just a cheap way to reduce 'bed blocking'. We need to ask deeper questions: in particular how to achieve the underlying constitutional changes necessary to sustain social justice and a welfare state that works for everyone.

He gave the example of Australia, where a rights-based approach had led to the formation of 'Every Australian Counts,' a disability activist movement which has achieved social care reform – national fully funded, non means-tested, self-directed, social care system for children and working age adults, paid for through a 'hypothecated' (specific, dedicated) tax.

He argued it was important to examine the long-term policy failures that have led to the current crisis in social care, and not to fall into the trap of believing 'integrated care' will solve the problems.

"Social care charges are basically taxing people for their social care needs. Social justice has flown out the window. People - not profit - need to be at the centre of a new national model for social care."

More reports, contributions and pictures from the conference, and links to much more information on social care available on our website at https://healthcampaignstogether.com/socialcare.php

Social care: the biggest domestic policy disaster we face

Peter Beresford (Co-Chair of Shaping Our Lives, the national disabled people's and service user organisation and network)

Social care is the worst and most dishonest social policy we have. You can at least successfully appeal hostile decisions on benefit cuts to an independent tribunal system. You get nowhere generally doing that with social care.

Social care is the absolute opposite of all that people love about the NHS.

The NHS is still largely true to its founding principles. It is still mostly paid for out of general taxation so that most things are free at the point of delivery. Mostly getting its help is based on clinical decisions, not money ones.

When you go to hospital with a broken leg they don't say 'no it's not really broken, you don't qualify'. They get on with it, in a way that private systems like the US can't hope to do. And they do this with great expertise, commitment and kindness generally.

But social care, is a very different kettle of fish. It is the worst kind of what people call a residual or safety net system. It's only there for you if you qualify as the absolute worst case scenario.

It's no safety net at all in fact. Age UK estimated that last year more than a million older people who had social care needs got no support.

The system is means and needs tested. That is exactly the same as the Victorian poor law. What this all means is that you don't qualify to get free social care unless you are on really low income.

You also don't qualify unless you are seen as eligible for it; that is to say that your needs because you are frail, or have an impairment or long term condition as seen as qualifying you for its help.

But here it is based on a really nasty little conjuring trick. Because your needs only qualify if there is enough money to pay. And of course we know that for the last eight years of austerity the budget from central government has been cut and cut.

So it isn't like the NHS where an emergency is an emergency; a broken leg is a broken leg. If there is less money, then suddenly your needs don't qualify and you and your family and loved ones are left out in the cold.

That's because the legal requirement for local authorities to stay within budget will always trump them meeting people's genuine needs, and needs are instead more and more redefined down to keep within budget.

There's a load of talk about integrating health and social care. But it will never happen properly so long as they are based on different principles and values. This government wants to drag the NHS down to the level of social care by privatising it to make money for itself and its friends.

Instead we must have an integrated social care system accessible and equal for all, in all our diversity, based on social models, which is paid for like the NHS out of general taxation and is free at the point of delivery.

And it needs to be based on a different approach to support.

Not the failing policy of so-called personalization this government is still desperately pursuing and all its other workarounds which promise better for less – and don't deliver. But a policy of person-centred support, based on social models of disability and distress that challenge the barriers and discrimination social care service users face.

This must be a truly participatory and co-productive policy, creating new forms of support suppliers, organisations and collective enterprise and co-production – advancing empowerment, involvement and progressive change.

25 people from a wide range of organisations, including the SHA, NPC, disability groups, trade union retired members organisations and KONP groups attended our follow-up meeting in Birmingham on December 13, and held a further useful discussion to agree basic principles around which a broad campaign can be built.

It was agreed that the developing campaign wishes to be a part of the Health Campaigns Together network, and supporting organisations were urged to affiliate to HCT.

A leaflet is being produced and a further follow up meeting will be held on February 28.

If you want to get involved in future meetings, email the group at *reclaimsocialcare@gmail.com.*

Social care crisis

News in brief

90 per day die waiting for care

NHS Digital statistics show more than 32,000 people who had requested a care package died without receiving it in 2017/18.

The analysis by the Labour Party also revealed a drop of 104,000 people receiving social care since 2015, while there was an even bigger drop – almost 107,000 – in numbers of people aged over 65.

Low pay and rotten conditions for care staff

Two thirds of Britain's 1.3 million social care workers are only paid for contact time with clients and not for the travel time to get from one client to the next, according to an IPPR report, *Fair Care.*

A quarter of care workers are on insecure zero hours contracts, and half are earning less than the real living wage of £9 per hour.

A survey revealed almost 90% complaining they had so little time with clients there was no chance to have a chat with them. 30% of care staff said there was not enough time to help with washing or bathing and more than a third said they did not have time to prepare a meal.

Conditions and pay are so poor that IPPR is projecting that without a significant improvement the sector could face a shortfall of 400,000 staff by 2028.

Unequal treatment

The 30 councils with the highest levels of deprivation made cuts to adult social care of 17% per person between 2009 and 2018, compared with 3% per person in the 30 least deprived areas, according to an Institute for Fiscal Studies Briefing Note.

Powerful TUC report on mental health crisis

The TUC has revealed the devastating effects of government austerity policies on mental health over the last nine years, which has seen three quarters of people suffering mental health issues going without treatment. This must be a launch pad for a nationwide campaign.

Mental health is a major issue for the NHS. This new TUC report sets out the ways in which cuts to the NHS specifically and society-wide austerity has had an overwhelmingly negative impact on the mental health of the nation and has led to shocking failure to provide the desperately needed services to help.

The report highlights that as well as systematic underfunding of the NHS, other factors must be taken into account including low staffing levels, access to services for younger people, poor provision of perinatal health services, failing drug, alcohol detoxification services and a lack of beds for mental health (and much of what there is costing a fortune to private sector).

Government condemned

The document opens with a strong condemnation of this Government's ongoing policies which are at the heart of the crisis. Frances O'Grady, General Secretary Trades Union Congress (TUC), says:

"In the decade since the financial crash, day to day spending on running our public services as a share of GDP has been slashed to its lowest level since the late 1930s.

"Successive Conservative-led governments have pursued a self-defeating policy of austerity that has hampered our economic recovery and left large parts of our essential public services at breaking point."

This sort of context is too often missing from the mainstream narrative around the NHS and must be central to our demands about the mental health crisis.

The TUC report adds:

"To fully understand the crisis in mental health, we need to acknowledge the impact that austerity has had across our public services and the challenges that this poses for developing a systemic, cross-public sector approach to address the mental health needs of our communities."

With support in the form of advice and research from many of our own campaigners and activists, including allies in Health Campaigns Together and the NHS Support Federation, this report then goes on to outline the reasons for the crisis in the NHS on this issue and what must be done to meet it.

For all of us campaigning for the NHS, this must now become a key front of activity in safeguarding the wellbeing of staff and patients – and in the process, highlighting the reasons why the NHS is not safe in this Government's hands.

Mental health in the UK is a very real and growing problem. The Government's policies have done a great deal to aggravate the issue and, as we've already covered in detail on this site, its response has been woeful and hollow.

Increased referrals

The crisis in mental health is particularly bad for children and women. The number of referrals to specialist children's mental health services has increased by 26 per cent over the last five years, while the number of under-18s admitted to A&E for self-harm has increased by 50 per cent in five years.

Less than 25% of young people in need of care get it. And what is the new Government target? That two-thirds continue to be denied treatment: the target is for just 33% of children in need of mental health treatment to be receiving it by 2020!

And there is more: cuts to perinatal services have also had a damaging effect, as the reports explains, proving that NHS campaigning is not only for an end to health inequalities but is clearly a feminist issue too.

Alcohol and drugs misuse support services are also desperately underfunded as has been highlighted recently by Labour's Shadow Secretary for Health Jonathan Ashworth.

All this and more has aggravated a crisis situation which this timely report evidences powerfully.

Testimony

One of its key strengths is the inclusion of testimonials of health care workers themselves. For example, a cognitive behavioural therapy (CBT) Nurse Psychotherapist from Yorkshire says in the report:

"Staff teams are stretched to breaking point in mental health and referral rates are increasing whilst NHS and third sector resources are dwindling dramatically.

"Patients' needs are more complex now than ever before and more time and space is needed to meet these safely and effectively.

"Buildings are being sold off to private buyers leaving fewer and fewer community bases and services are being re-designated to suit the estate provision not the needs of the population.

"I have feelings of despair and fear for the future."

The roots of the problem are wide-reaching, coming from poor support for mental health in schools and from local authorities, more stress at work and so on.

But it is the deliberate cuts to these services and to the NHS by this Government which are always at the heart of the problem.

Ammunition

The following are some key findings which should become a vital piece of ammunition in any health campaigner's toolkit;

- In 2013 there was 1 mental health doctor for every 186 patients accessing services. In 2018 this has fallen to 1 for every 253 patients.
- In 2013 there was 1 mental health nurse for every 29 of patients accessing services. In 2018 that has fallen to 1 for every 39 patients.
- There has been a 30% reduction in the number of beds available in mental health trusts since 2009.
- The number of beds for mental health patients in England has slumped by nearly 3,000 (-13%) since 2013.
- One in six (17 per cent) of the English population aged between 16 and 64 met the criteria for common mental health disorders in 2014.
- People with severe and prolonged mental illness die on average 15 to 20 years earlier than other people but only around a quarter of those with a common mental health condition are in treatment.
- While the total amount of income received by mental health trusts in England has risen since 2016–17, once inflation is taken into account it becomes clear that they actually received £105 million less than in 2011–12.
- Between June 2017 and May 2018, 23,686 mental health staff left the NHS, equivalent to an eighth of the total workforce in mental health.
- By the end of June 2018, one in ten mental health positions were unfilled, and net recruitment of mental health nurses is getting worse.

A recent survey of staff working in mental health services shows that more than two in five staff (42 per cent) said they had been on the receiving end of violent attacks in the last year.

33%
The new Government target for the proportion of of children in need of mental health treatment to be receiving it by 2020

Another Victory for Health Campaigners in Essex

by Mike Fieldhouse. Secretary, Save Southend NHS campaign

Save Southend NHS are jubilant after their two years' of solid work raising public awareness and putting consistent pressure on politicians has resulted in the Conservative controlled Southend Borough Council referring the Mid & South Essex STP plan back to the Secretary of State for Health, Matt Hancock MP.

Having previously forced a reversal of proposals to downgrade Southend's A&E department in 2017, this latest victory is about as much as our campaign could have hoped for at this stage, short of a complete scrapping of the plans.

The 14 page letter accompanying the referral is a damning indictment of the ill-conceived project to drastically alter the NHS in Mid & South Essex.

Hardly any area of the STP's proposals escape unscathed and the letter reads like a blow-by-blow account of every criticism the people's Save Southend NHS campaign has ever levelled at this service-slashing, and purely money-driven scheme.

Omissions and assertions

How anyone could ever read through this vast catalogue of unanswered questions, gaping omissions and unevidenced assertions of the STP, that the Council has so clinically listed, and still believe there is a shred of coherence in the plans, is totally unfathomable.

Conservative-led Thurrock Council quickly followed suit at the beginning of December and also referred the plan back over concerns about the closure of their local hospital at Orsett.

This leaves Essex County Council as the 'odd-one-out' of the tripartite group, having yet to make a decision to refer the plans back.

It is surely time that the Councillors there took a long hard look at the evidence staring them in the face and, for the sake of the health and well being of the populations they represent, throw these plans out too.

Hopefully Councillors' concerns for, and duty towards their residents will again outweigh party loyalty.

Where we go from here won't be known until after the objections have been dealt with. In the meantime we continue to keep vigilant, challenging the propaganda that is spewed out on an almost daily basis by Mid & South Essex STP in its bid to hoodwink the local population, and our heroic protestors maintain their twice-weekly presence outside Southend Hospital- come rain, shine or snow – in order to keep this vitally important issue at the forefront of the public's mind.

Locked wards have no place in psychiatric rehabilitation, says Royal College

The Royal College of Psychiatrists has issued a statement expressing its increasing concern over the use of locked rehabilitation wards for people with serious mental health problems. The issue is expecially serious in the private sector.

1,025 patients are funded by CCGs in private sector establishments, mostly on 'locked' wards.

This type of treatment costs double the tariff for NHS psychiatric beds: but the costs are further inflated by the fact that admissions average almost twice as long as NHS.

The private sector, with poor liaison with community mental health teams and social care, has no incentive to discharge early, since the longer patients are locked in the more money they make.

New minister no answer to suicides driven by austerity

Theresa May announcing a Suicide Prevention Minister to tackle the growing mental health problems that are a product of austerity is empty rhetoric says consultant psychiatrist Dr MONA KAMAL.

It would not be World Mental Health day without an announcement to great fanfare by the Conservative government of new funding for mental health services – one which offers no meaningful or practical solutions.

This cynical exploitation was evident again with Theresa May's appointment of a suicide prevention minister, lauded as a world first. But what we've seen again and again by this government is the announcement of new mental health initiatives which in reality are merely exercises in PR.

Theresa May pledged to end the "burning injustice" of the mental health crisis. At the NHS's 70th anniversary in June, Jeremy Hunt promised "significant budget increases". From the coalition government we had promises to "break the stigma" of mental health and legislation to offer "parity of esteem" between physical and mental health.

The reality beneath this sloganeering however, is a disgraceful record on mental health by a government who have not only continued to withdraw funds from psychiatric services but have been responsible for a social agenda which has wrecked mental health and wellbeing.

Despite announcements of new injections of funding, the fact is that mental health trusts in England have suffered real-term budget cuts of 8.25% year-on-year since 2011 (equating to cuts of just over £100 million each year).

Back in 2015, the government pledged an extra £1.4 billion over 5 years to transform Child and Adolescent Mental Health Services – the reality was 6% funding cuts to these services in each year that followed.

This deliberate underfunding is happening on a background of an undeniable mental health crisis amongst young people: almost 19,000 teenagers were admitted to hospital for self-harm in 2015-16 which was an increase of 68% over the last decade.

Such demand for under-resourced services (at least for those who haven't the means to pay for private care) has had tragic consequences.

It means that at least 150 children each day, according to the NSPCC, are being turned away by mental health services who simply do not have the resources to provide this care.

It has meant young people having to be ferried hundreds of miles away from their homes and families to access inpatient beds and has resulted in unacceptable practices where young people who have been detained on section are held in police station cells whilst awaiting a bed.

Quite apart from their deliberate under-resourcing of services which has made this crisis inevitable, the government's real hypocrisy lies in the fact that they are knowingly implementing policies which have damaged mental health and well-being and have cultivated an environment in which the rates of illnesses such as depression and anxiety have surged.

Record levels of in-work poverty, precarious employment and zero hours contracts, unsafe temporary housing and the dismantling of the welfare state (which has arguably affected disabled people and those with chronic mental illness more than any other group) are the direct result of 8 years of failed Tory austerity.

The causes of mental illness are complex and multi-factorial but it is frankly impossible to take seriously this government's proclamations around improving children's mental health when you examine their record.

It's a record which has left a third of all children in this country living in relative poverty whilst seeing the vital services they rely on withdrawn.

It is on this record that they need to be judged and not the patronising opportunistically timed policy announcements.

150
Number of children each day, according to the NSPCC, who are being turned away by mental health services who simply do not have the resources to provide this care

£1.4 billion
Amount promised to transform Child and Adolescent Mental Health Services over 5 years

6%
Actual level of funding cuts to these services in each year that followed.

Mental health problems also affect NHS staff

The current crisis is also having a detrimental effect on the mental health of NHS staff, the TUC report says.

Underfunding in mental health services, together with fewer available staff to deal with an increasing number of users, has put huge pressure on the workforce and left mental health trusts struggling to staff services safely. This is having a negative effect on patients who use these services and on the health and safety of the staff who provide them.

This means that we need to link up our campaigns with patients and workers, campaigners and trade unionists (in other services areas such as the education sector, as well as health) and to reach deep into people's communities on this vital issue. Keep Our NHS Public therefore wholeheartedly agrees with Frances O'Grady when she goes on to say:

We need a whole system approach to the mental health crisis. And this can only come with meaningful and sustainable investment in the NHS, adult social care, local authorities and public health and in our schools and colleges.

The report makes some key demands:

- That NHS England upholds its commitment to mental health parity by 2020.
- Real terms funding increases across the public sector to address the significant cuts to resources since 2010.
- A 5% funding increase across the NHS.
- Proper investment in schools that will reverse the 8 per cent cuts to pupil funding seen since 2010.
- A fair and sustainable funding settlement for local government that addresses the £5.8bn funding gap identified by the Local Government Association, including a £3.5bn funding gap in social care by 2025.

More should be done to encourage employer support for effective workplace interventions around workplace stress and improvements made to working conditions.

Read the full report online at: ***https://www.tuc.org.uk/sites/default/files/Mentalhealthfundingreport2_0.pdf***

Poole council rejects A&E downgrade plan

Poole Council's health and scrutiny committee voted unanimously in December to refer controversial plans to downgrade their local hospital and "centralise" emergency and maternity services in Bournemouth, to the Secretary of State and the Independent Reconfiguration Panel.

This followed shock findings that as many as 396 patients a year could be at risk of death or disability if the plans are allowed to go ahead.

A South West Ambulance Trust report has provided clear evidence that plans to downgrade Poole Trauma A&E and close Poole Maternity will put at least 396 emergency ambulance patients per year 'at risk of potential harm'.

The report looked at what would have happened to emergency ambulance patients treated at Poole, January-April 2017, had the plans to end emergency care at Poole been in place.

Real patient cases examined made it clear that many may lose their lives: a child post cardiac arrest, an unresponsive child facing a 9 minute longer journey, a mum-to-be with ectopic pregnancy, in extreme pain, with internal bleeding and life-threatening low blood pressure, facing a 19 minute longer journey.

Dorset Keep Our NHS Public asked a local A&E doctor to review the cases in the Ambulance Trust Report.

They assessed that just under half were in imminent danger of dying, so that any longer journey increased the risk of fatality.

CCG's own figures

Dorset CCG themselves calculated for the High Court, based on the Ambulance Trust report, that 132 ambulance patients over the 4 months investigated – or 396 per year – would be "at potential risk of harm".

Dorset County Council has been unable to agree these plans are safe, and has referred the plans to the Secretary of State because "the evidence needs further investigation to the current claim that these travel times will not cause loss of life."

But despite ongoing written opposition from tens of thousands of residents, from eight local authorities from Parish to District and Borough Councils, and despite facing ongoing legal process, the Dorset Clinical Commissioning Group continues to push forward with these dangerous plans, despite being unable to give any assurance about the evident risk to multiple lives.

Dr Tony O'Sullivan, retired consultant paediatrician and co-chair of Keep Our NHS Public says:

"The concerns raised by the ambulance report - reinforced by emergency clinician opinion that the CCG itself should have sought - must not be ignored. Matt Hancock has a duty to ensure these avoidable, life-threatening risks are examined. That is the job of the Independent Review Panel and not Hancock's office.

"The plans mean that Maternity care for deliveries under 32 weeks, and intensive and high dependency new-born care, will only be available at Bournemouth Hospital, in the far east of Dorset, for the whole County, out of safe reach. "

It took repeated strikes to defeat the WoC at Wrightington, Wigan and Leigh

Creating Subsidiaries - reasons to be fearful

Richard Bourne

After an amazingly fast analysis of responses to its consultation NHS Improvement have decided on some changes to the way NHS Trusts and NHS Foundation Trusts can set up subsidiary companies or WoCs – Wholly Owned Companies.

They offered some dubious justifications about why they might be needed but did not mention that these claims have been disputed.

It appears that NHS improvement did not carry out this laughably inadequate consultation because of all the concerns about the 35 or so WoCs recently created for tax avoidance and to undermine national terms and conditions. Some of these led to disputes and even industrial action and a great deal of criticism.

But what has now been published is actually about clearing the way for more WoCs, expanding the scope into new areas. More fragmentation and more attacks on terms and conditions. A big step backwards. Get ready for the next round.

Little or no effort was made to reflect the criticisms levelled at the recent WoC formations which were carried out in secret, without consultation, gave dishonest justifications and had the clear aim of gaining tax advantages and the bonus of allowing staff to be employed on worse terms and conditions.

These were just nodded through by NHS Improvement who also with their performance role were actively encouraging WoC formations to try to deal with the huge deficits.

There is no positive side to explore as there should be no circumstances where creation of a WoC is better than in house provision. But it appears that some of the worst excesses of the last 18 months may be tightened up.

Some Foundation Trusts appear to be very conscious of their "autonomy" and argued that they have the power to set up a WoC whether NHS Improvement like it or not. The claimed autonomy and independence is undermined when they have to rely on public funding to bail out their deficits or subsidise their terrible PFI deal – autonomy goes only so far.

In future all proposals to form a WoC will have to be subject to some kind of scrutiny. There must be some evidence of engagement with the workforce which was has been notoriously absent in most WoC set ups so far.

Trusts must now actually provide Business Cases, set out what alternatives have been evaluated and look at risks in a structured manner. The benefits cannot depend on tax changes, although in theory that was already supposed to be the case!

And there is a need to show how the WoC can attract and retain staff in the longer term – which may bring the divisive two-tier workforce approach into question.

A few "Business Cases" for previous WoCs have made it into the public domain despite strenuous efforts to keep them confidential. They are very poor and do not actually qualify as any kind of case for change – they argue for business as usual with tax advantages.

Around 90% of the benefits they identify are from tax changes. None of this attracted any attention in the review by NHS Improvement.

Despite some caution there is to be no requirement for any independent expert scrutiny or cases and no publication of any assessment that does get carried out.

And the major disappointment is that there is not going to be any effort to go back and examine previous WoCs and the extent to which they would have met any reasonable criteria for approval.

If anyone hears the sound of one hand clapping …

Union campaigns for safer pharmacies

PDA Union

The PDA Union affiliated to health Campaigns Together towards the end of 2018.

PDAU ws established by members of the not-for-profit Pharmacists Defence Association just over ten years ago and is now one of the 25 largest independent Trade Unions in the country with over 28,000 pharmacists, pharmacy students and trainees as members.

Pharmacists are located in hospitals, primary care, academia, manufacturing and the majority permanently employed or working as locums in community pharmacy. PDA Union members are spread across the entire sector throughout the UK.

Medicines are the second biggest line of NHS expenditure and Community pharmacists are delivering NHS services in almost 15,000 locations across the UK, yet this part of the health system was not nationalised when the NHS was created and the chemist shops on our high streets remain almost entirely private businesses.

This means these health professionals find themselves trying to deliver patient care while employed and managed by retailers whose priority is profit. It is a challenging environment.

The largest dozen employers own more than half of the sector, and the largest multiple, Boots has around 2,500 pharmacies, and the union have a recognition campaign at Boots.

In June 2018, Boots Pharmacists became the only workers to ever remove a sweetheart union deal, when they voted in a derecognition ballot.

Now they must vote again to secure PDAU recognition.

■ The Boots campaign can be followed at ***https://www.the-pda.org/boots-recognition/***

■ The PDA Safer Pharmacies Charter is at ***https://www.the-pda.org/safer-pharmacies-charter/***

One of the PDA Unions' long standing campaigns is to prevent what is known as "remote supervision" where pharmacists would not be present in the pharmacy and yet medicines would still be dispensed.

The union says that treating dispensing as a commercial transaction between customer and retailer, rather than between patient and qualified health professional would end in patient harm.

Last year, leaked papers from a government appointed board revealed that this had been discussed, though denials followed and no such formal proposal has yet been announced.

The union have recently given their backing to a petition to oppose such steps: https://petition.parliament.uk/petitions/230192

Another significant PDA Union initiative is the development of a Safer Pharmacies Charter, which has already been endorsed by the UK Labour Party, USDAW and others.

The charter defines basic standards to ensure safe practice wherever pharmacists work, yet there has been some resistance to the charter from the owners of community pharmacies.

The PDA Union would welcome support for their campaigns and involvement in any issues that impact on pharmacy.

You can register your support for the charter here: ***https://www.the-pda.org/safer-pharmacies-charter/***

Push private profiteers out of NHS

JACKIE WILLIAMS, National Officer Health, Unite the Union

The NHS has been put under extreme financial pressures under the Conservative Government with additional finance being promised against an ongoing shortage of care.

It was reported in the *Financial Times* back in August 2017 that private companies had at that time made profits of £831m from NHS contracts over the previous six years, and in 2018 we heard the news that hospital staff had to fork out over £70 m in car parking charges.

What I ask, do we need to brace ourselves for in 2019?

Will it be more taxpayer's money being siphoned off from patient care in order that outsourced company contractors can increase their profits?

Perhaps we will see a repeat of the shambles of NHS outsourcing to Capita where its failures proved to be so disruptive to thousands of GPs, dentists, opticians and pharmacists that it had the potential of putting patients at serious risk of harm?

We demand an end to outsourcing of the NHS in 2019.

Taxpayer's ill-health should not be seen as a means to increase company profits. NHS staff, patients and visitors should not be targeted by those seeking to increase profits when applying car parking charges.

The NHS should be renationalised in order that profit is disassociated from patient care.

Privatisation of pathology in Kent could 'endanger patient safety'

A campaign has been launched by Unite to stop pathology services in Kent being outsourced to a private company.

Unite is concerned that such a move could mean an erosion of pathology services (which analyses blood and human tissue samples) with an adverse impact on patient safety.

Alarm bells started ringing before Christmas when Maidstone and Tunbridge Wells Trust published the range of options which include the possible takeover of the pathology services by a commercial company.

All pathology services across England are to be consolidated into just 29 networks: the whole of Kent will have one pathology services provider.

Unite regional officer Kathy Walters said: "We will not sit idly by while yet another blatant privatisation moves to the next stage in 2019."

Jonathan Ashworth (front, grey shirt) at the head of the NHS 70th Birthday demo last June.

In 2019 the fight for our NHS must gather pace

Jonathan Ashworth MP, Shadow Health Secretary

2019 is set to be a tumultuous and uncertain year for the NHS and campaigner must be ready to defend our nation's most cherished institution at every turn.

Despite the Tory spin, health services are set to suffer £1 billion worth of cuts, with swingeing reductions hitting budgets including public health and training.

With advances in life expectancy stalling and health inequalities widening it's an absolute disgrace that vital health prevention interventions to keep people well and live longer are being slashed to the bone.

Deaths from alcohol abuse are at their highest for years, drug misuse problems persist, too many women smoke in pregnancy, we face a childhood obesity crisis and STIs like gonorrhea are on the increase.

Nonetheless crucial services such as sexual health services, smoking cessation and substance misuse services will be slashed again.

The scale of the cuts facing these services is equivalent to 1634 fewer Health Visitors or 1700 fewer school nurses or 634,000 fewer sexual health episodes.

These cuts to public health must be reversed.

The next Labour government has committed to an over arching strategy to tackle these widening health inequalities.

Our task is all the more urgent as recent research revealed that the unequal provision summed up in Julian Tudor Hart's Inverse Care Law is becoming even more ingrained in our austerity dominated society.

There are fewer GPs per head in poorer areas of England than richer areas, despite the greater burden of ill health. Confronting these disparities like these has to be the mission of socialists.

Overall our NHS remains chronically understaffed with vacancies of around 100,000 including for 40,000 plus nurses and midwives. Labour would bring back the training bursary and protect the NHS through Brexit.

Staffing shortages are so acute that fifty per cent of maternity units had to close their doors on at least one occasion in the last year and staff shortages was a contributing factor in hospitals cancelling almost 70,000 operations.

Austerity has meant growing waiting lists which in turn has seen NHS bosses telling hospitals to farm our elective operations to the private sector. Meanwhile hospitals looking for financial advantage because of underfunding have tried to shift staff into wholly owned subsidiaries – an effective backdoor privatisation.

NHS underfunding and privatisation go hand in hand and both must be exposed and attacked by those who champion a universal, public NHS.

Finally NHS ministers are pushing ahead with accountable care organisations. They are neither accountable not deliver the care needs of the population.

Labour will fight vociferously against the breaking and dismantling of a public NHS. Our commitment remains a publicly provided, fully funded, reinstated universal National Health Service.

Shropshire Defend Our NHS
Spit & Sawdust Music Hall
The Regal Theatre, Tenbury Wells
Sunday 27 January
6.30pm. Adm £14
All proceeds to the campaign

Yorkshire Health Campaigns Together
Demonstration
Saturday March 30
11.30 -2pm
Starts and finishes at Leeds Art Gallery!

David Perris

Sussex Defend the NHS demonstration in Brighton last October

Fight to stop Brighton hospital sale

Pat Kehoe, Sussex Defend Our NHS

Brighton General Hospital is being sold off. Sussex Community NHS Foundation Trust Board have agreed (October 2018 meeting, in secret) plans to sell most of the site for housing, claiming that they need the funds to build a new Community Health Hub, for out-patients only.

But Brighton is desperately short of rehabilitation beds, which could have made good use of the site. We acknowledge the need of the city for genuine affordable housing, but we are dismayed that this public asset, in public ownership since 1862, should be sold into the private sector.

We say NO to fire-sale of NHS sites - ***https://keepournhspublic.com/need-to-know/naylor_sell-off/***

International campaigning

PSI demands Quality Public Health for All

In 2017 the UN General Assembly officially established December 12 as International Universal Health Coverage (UHC) Day. But 'health coverage' could mean all kinds of things, including insurance cover that turns out not to be universal.

While the UN sees UHC as a project incorporating 'stakeholders' including the private sector, Public Service International (PSI), an alliance of trade unions with 700 affiliates with 8 million members in 163 countries, is pressing hard for this to be a campaign for **universal public health care**.

In a statement on December 12 it argued:

"The enjoyment of the highest attainable standard of health is a fundamental human right. But half of the world's people have no access to basic health services and about 100 million people globally are pushed below the poverty line as a result of health care expenditure every year.

"Over the last decade of global economic crisis, millions of poor people in high-income countries have also not been able to enjoy quality health services as a result of austerity measures, liberalisation of health services and commodification of health.

"Health for all is not only desirable, it is possible. But this requires categorical political decisions by governments which challenge the dominant neoliberal model of development. Over the last four decades, private for-profit interests have expanded in healthcare delivery. They include multinational corporations and national conglomerates in the pharmaceutical industry, health insurance, hospital services and social care.

"For them, health and social care is nothing but another economic sector; and a growing, lucrative one at that, estimated at US$5.8trillion per year.

"The primacy of public healthcare delivery as the bedrock of universal health care cannot overemphasized. This is often missing or at best accorded passing attention in the universal health coverage discourse.

"Two years ago, PSI kicked-off its global campaign for the Right to Health, convinced that this will be achieved as **universal public health care**. PSI, its affiliates and allies will continue to campaign for universal health care, **built on strong public health systems that unambiguously put people over profit, and thus actually ensure that no one is left behind**."

8,000 brave the weather to rally in Toronto against privatisation and cuts

An estimated 8,000 people defied pouring rain and encircled the Ontario Legislature on October 22 in a rally organised by the Ontario Health Coalition and trade unions.

Natalie Mehra, executive director of the OHC told the crowd that in the short time since the provincial election, Doug Ford's neoliberal government had cut drug coverage for children and young people and mental health funding.

"He has also released a major report calling for means testing, user fees and privatization of health care and other services. This is intolerable."

Doug Ford was the only political leader to not address the rally, which heard from John Fraser, Interim Liberal Leader and Mike Schreiner, Leader of the Green Party who both demanded the government expand care not deepen cuts.

Andrea Horwath, Leader of the Official Opposition New Democratic Party said: "Families want to know that when a loved one needs to visit the hospital, they won't be stuck in a hallway. They need to know that a long-term-care bed will be there for an aging parent."

Michael Hurley, President, Ontario Council of Health Unions said, "The Ford government cut $377 million in funding from mental health and addictions.

"We expect the closure of 3,000 hospital beds by the time the dust settles unless we push back hard. That is what we are firmly committed to do. These cuts shame us."

John Lister, Editor of Health Campaigns Together, gave greetings to the rally and explained the common fight in England and Ontario against right wing government cutbacks and privatisation.

Royal Colleges challenge impact of charges on overseas visitors

The Royal College of Physicians has joined other royal colleges in calling for the suspension of NHS overseas visitor charges, pending review.

The other colleges taking a stand on this are the Royal College of Paediatrics and Child Health (RCPCH), Royal College of Obstetricians and Gynaecologists (RCOG) and the Faculty of Public Health (FPH).

They make clear that the rejection is one based not only on principle but also on the impact of these charges on health services and public health. In a joint statement they declare:

"We disagree with the ministerial statement that 'there is no significant evidence that the 2017 amendment regulations have led to overseas visitors being deterred from treatment or that the changes have had an impact on public health'.

"Recent research from Doctors of the World highlights how one in five of their service users were affected by healthcare charging, and one in three of those were deterred from seeking timely healthcare.

Detrimental impact

"A recent report by Maternity Action demonstrated the detrimental effects of charging on mothers and children during and after pregnancy. We are also aware of cases of children having been denied treatment for various life-threatening conditions."

The government's regulations are part of the "hostile environment" for migrants introduced by Theresa May as Home Secretary and now continued by her government.

The Royal Colleges argue that they are now having a direct impact on individual health, and have potential implications for wider public health:

"Early diagnosis and treatment are vital to improve patient outcomes and – in the case of infectious diseases such as tuberculosis and HIV – to protect public health.

East London campaigners challenging the charges at Bart's Health last year

"Concerns have also been raised about people who have been wrongly charged because they are unable to prove eligibility."

The Colleges add that

"The role of doctors in this process has the potential to damage the vital trust between us and our patients, and is likely to lead to poorer patient outcomes and contribute to already low morale in our profession."

One year on from the 2017 regulations, the regulations themselves remain "a concerning barrier to care."

The Colleges therefore

"strongly encourage the DHSC to work with the Home Office and suspend the charging regulations, subject to a full review of their impact on individual and public health."

Waive immigration surcharge for nursing staff

Christian Beaumont, International Adviser in the RCN's Policy & Public Affairs Department.

Late last year, the Royal College of Nursing launched a campaign calling on the UK Government to waive the Immigration Health Surcharge for nursing staff.

Nursing staff from outside the UK make a huge contribution to our health and care services. Put simply, without their input, there wouldn't be enough staff to provide the safe care patients expect.

The vacancy rate of registered nurses in the NHS in England is already alarmingly high – almost 41,000 at the last count – so news that MPs had voted in November to increase the Immigration Health Surcharge from £200 to up to £400 for thousands of migrant health care workers dealt another depressing blow to anyone monitoring the nursing workforce crisis.

The charge – applicable to nursing staff outside the European Economic Area (or EEA) – is intended to offset the cost of foreign workers using NHS services in the UK.

Paid by dependents

Not only is this paid by the person working as, say, a nurse, but by all of their dependents too, meaning, for a typical four person family, it could be in excess of £1,600 per year.

The Government expects this change to rake in an additional £220 million, to be spent, it says, on the NHS. However, the irony of charging a new, higher amount to the very people we've recruited to help prop up our ailing health service is not lost on me, or any of our 435,000 members.

The message from the nursing community is loud and clear: the Immigration Health Surcharge is a short-sighted measure and one that will drive away talented nursing staff at the time we need them most.

It's for this reason that we're calling on the Government, and in particular Home Secretary Sajid Javid MP and Caroline Noakes MP, to waive the fee – in its entirety – for nursing staff entering the UK and their dependents.

We must not let the Immigration Health Surcharge be the straw that breaks the camel's back. It's time to waive the fee for nursing staff and their dependents.

Find out more: **www.rcn.org.uk/immigration-health-surcharge**

Austerity kills – it's official

England's Chief Medical Officer Prof Dame Sally Davies attempts to pain an optimistic picture in her latest annual report, but is constrained by the evidence. This shows that:

"The UK has fallen down the rankings significantly ... for life expectancy at birth. **In the most recent two years ONS has reported statistically significant increases in infant mortality across England for all infants"**

She reports that life expectancy "increased steadily in England for decades" – until 2010, when the rate of increase decelerated.

We note this coincides exactly with the change of government and the austerity drive which continues, and sharp increase in inequality.

From 2001 to 2016 life expectancy increased at every level, but the gains were smaller in deprived than in affluent ones.

The report notes that the gaps in life expectancy between the most affluent and most deprived 10% of men and women are now about the same as the difference between UK as a whole and Azerbaijan.

A child born in the most deprived areas in 2014-16 can expect 18 fewer years in good health than one born in the most affluent areas.

Only people living in the least deprived 40% of areas could expect to reach retirement age in good health.

Working poverty has emerged as a prominent issue: benefit cuts have hit lowest paid families with children – and especially lone parents – hardest of all.

Meanwhile figures show one in six pensioners now living in poverty.

Austerity is killing us off – and creating massive avoidable demand for health care.

Unions, campaigners, join us!

HEALTH CAMPAIGNS TOGETHER is an **alliance** of organisations.
We ask organisations that want to support us to make a financial contribution to facilitate the future development of joint campaigning.
WE WELCOME SUPPORT FROM:

- **TRADE UNION** organisations – whether they representing workers in or outside the NHS – at national, regional or local level
- local and national NHS CAMPAIGNS opposing cuts, privatisation and PFI
- pressure groups defending specific services and the NHS,
- pensioners' organisations
- political parties – national, regional or local

The guideline scale of annual contributions we are seeking is:

- **£500** for a national trade union,
- **£300** for a smaller national, or regional trade union organisation
- **£50** minimum from other supporting organisations.

NB If any of these amounts is an obstacle to supporting Health Campaigns Together, please contact us to discuss.

Pay us direct **ONLINE** – or with PayPal if you have a credit card or PayPal account at ***http://www.healthcampaignstogether.com/joinus.php***

For organisations unable to make payments online, cheques should be made out to **Health Campaigns Together**, and sent c/o 102 Corve Street Ludlow SY8 1EB.

We have produced Health Campaigns Together newspaper QUARTERLY since January 2016.
It is still FREE ONLINE, but to sustain print publication we need to charge for bundles of the printed newspaper:
Cost **PER ISSUE** (inc post & packing)

- 50 copies £25 (£15 + £10 P&P)
- 100 copies £35 (£20 + £15 P&P)
- 200 copies £40
- 500 copies £70 (£40 + £30 P&P)

For intermediate quantities – see ***http://www.healthcampaignstogether.com/newspaper.php.***

Bundles of papers will only be sent on receipt of payment, and a full postal address preferably online.

Contact us at healthcampaignstogether@gmail.com. ***www.healthcampaignstogether.com***