@nhscampaigns

HEALTH CAMPAIGNS TOGETHER

#ourNHS

Campaigners conference

Fighting back to win!

Saturday
November 4
11am to 4pm

Hammersmith Town Hall
London W6 9LE

Open for stalls and registration from 10am
Lunch provided for pre-booked tickets
www.healthcampaignstogether.com

HEALTH CAMPAIGNS TOGETHER

#our NHS

About us

We are best known as the organisation which called for and worked, with the Peoples Assembly to build the huge March 4 demonstration through London against cuts closures privatisation and the pay cap within the NHS and for a fully funded, publicly owned National Health & Social Care Service. More than a dozen national trade unions supported the march, which was estimated by police at over 200,000.

Prior to that we organised two successful national conferences and a Northern regional conference in 2016. This year we made a major impact on the General Election, working with a non-party but highly political NHS Roadshow. Our successful AGM this year in London was attended by representatives of over 50 organisations. We worked with the TUC to help coordinate celebrations of the NHS on its 69th birthday. We now have over 75 affiliated organisations and our quarterly newspaper has a rising circulation of more than 12,000.

But Health Campaigns Together is not just another health campaign

It is a new initiative, begun in late 2015, to enable many of the campaigns that have been formed to liaise together, share experiences and lessons, and where possible work together on issues of common concern.

Our aim is not to recruit individuals, who are encouraged to join one of our supporting campaigns, or other local campaigns and get them to link up with us. So you cannot join HCT as an individual (although donations from individuals who support our objective are very welcome).

We welcome affiliation from trade union branches (NHS and non-NHS), campaigns and political parties opposed to NHS cuts and privatisation. Delegates from affiliated organisations meet every few months to decide policy and priorities and to share lessons and experiences from local campaigns and specific initiatives.

Individuals who want to help are welcome to send us donations to take forward the work, but are also encouraged join one or more of the many NHS campaigns, a growing number of which are represented on HCT.

Contact us at:
healthcampaignstogether@gmail.com

Join us

Health Campaigns Together needs funds to organise events, publicise them, tell people who we are, and publish a newspaper showcasing our supporters and the issues they are campaigning on.
So we asking supporting organisations, local and national, to work with us to build a network powerful enough to make a difference.

We now have the two largest unions, UNISON and Unite affiliated at national level, with a growing number of their local branches also affiliated and subscribing to receive bundles of our quarterly newspaper Health Campaigns Together. We work on campaigns in collaboration with the TUC.

We expect soon to welcome affiliations from more national unions, while our campaigning network will remain firmly based at local level across England.

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
- and any other organised group wanting to fight with us in defence of the NHS.

Methods of Payment

It's best for us, and you will get a more rapid response, if you can make direct payments online to our Coop Bank account: Sort Code 08-92-99, Account Number 65797921. If you are unable to make payments online, cheques are very welcome. Please send your full name and email, the name of your organisation and full postal mailing address with post code, with a cheque made out to Health Campaigns Together, and send c/o HCT, 28 Washbourne Rd, Leamington Spa CV31 2LD

If you are not part of an organisation you can still help Health Campaigns Together by sending us a donation in the post or online at https://healthcampaignstogether.com/donate.php

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 – unless this is an obstacle to supporting Health Campaigns Together

If your organisation is unable to afford £50 but would like to support Health Campaigns Together, please contact us at healthcampaignstogether@gmail.com
To join Health Campaigns Together, preferably please fill in the form at https://healthcampaignstogether.com/joinus.php

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Working with Local Government

Mike Forster
Chair of Hands Off HRI in Huddersfield
and National Vice Chair of Health Campaigns Together

I have been asked to talk about Local Authorities (LA's) and how we might influence them to oppose health cuts, closures and STP's/ACO's.

ALL councillors have a duty to oversee and scrutinise the work of Health Trusts and CCG's. Some have representatives who have sit on health boards but ALL LA's have a powerful and statutory role in overseeing any reconfiguration proposals through their Joint Scrutiny roles. They can exercise that power forcefully but must be made aware of their briefs.

HCT has produced an excellent broadsheet (Into the Red Zone) for councillors which can be found on the HCT website (https://healthcampaignstogether.com/redzone.php). It's thorough and detailed but it summarises the cuts programme we all now face and how LA's must face up to them.

As campaigners, our role is to initially educate and inform councillors about the imminent threat to the NHS and their local services. Never assume they know even if they tell you they do! Groups must find out who all their councillors are and make them aware of our existence.

Remember, they are there to represent us but also have very busy workloads so they will priorities issues. We must make them aware of the importance of health.

Identify those who sit on Health Scrutiny Committees and target them. Also identify every political group leader and make appointments to meet them, if required on a regular basis. Ultimately they can control what every councillor does. Foster good relations and pick out those who appear sympathetic.

Find out when councils meet and organise lobbies and address the full meetings. Get the press there and invite them to join the photo shoots. Councillors always have an eye on the next election! Invite councillors to any public meetings or events your group may organise (NHS Birthday is a good opportunity).

Most councillors have local surgeries, so pay them a visit and get them onside as much as possible.

The Health Scrutiny role however is key. They have statutory powers to veto local recommendations by CCG's or Trusts (although ultimately the final say rests with the Secretary of State via the IRP process). Councils can refuse to endorse STP's and are the only statutory public body which can do so.

Some councils will happily refuse to endorse STP's (they are still a minority) but the government is offering sweeteners to get them to support STP's. And councils can take out legal action via judicial reviews either on their own or jointly with campaign groups so make them they have the resources, expertise and power to do so!

Intransigent councils can of course face electoral challenges from campaign groups standing under the single issue banner (e.g. 'Save our NHS' or even NHAP). This needs careful thought and preparation but it can help to change minds very quickly! And as always keep the press informed of everything we are doing re councillors as they don't like adverse publicity. ●

What's making the NHS less accountable?

NHS Support Federation

There is huge public support for the NHS and growing community activism around its future, but the public voice within the NHS is weak. Its structure does not give the public effective influence or scrutiny powers. There are three clear reasons for this democratic deficit.

The influence of the market and competition
The introduction of the internal market split NHS organisations into purchasers and providers. This change to the structure was accompanied by a new belief in competition, allowing private companies and charities to bid for a huge range of NHS contracts. This new market place deterred cooperation. It reduced any joint planning of healthcare between the major players in each local area. This process was started by legislation in 1990 but supercharged by the Conservative's Health and Social Care Act 2012.

Lack of public involvement in decision making
Current models of patient involvement are too narrow. Few organisations offer decision making authority, share power or regard the public as active partners.

Where CCGs have patient representatives they are mostly selected, not elected. They are also heavily outnumbered and have no mandate from local residents, making it hard for them to be an effective voice.

CCGs are currently losing power to the newly formed Sustainability and Transformation Partnerships whose lack of governance is predictably leading to less scrutiny and public involvement.

"It is getting difficult to work out where accountability lies, who's in charge, and whether organisations are doing their job properly....For NHS boards, there is a potential conflict between their statutory duties as a board and an organisation, and some of these changes which require them to cede autonomy and authority to new organisational forms (like STPs) which have no formal existence."
– Kieran Walshe, Professor of health policy and management at Manchester Business School

Local authorities are increasingly involved with healthcare, having taken over responsibility for public health in 2013. Here there is direct accountability, through council elections and committees – such as the Health and Well Being Board. They are also involved with pilots for integrating care (joint health and social services), but progress varies across the country and public involvement and awareness of this process is generally low.

NHS organisations are legally required to consult over a substantial variation in service, but confidence in the process has been undermined by a series of cases, where residents' views were not properly sort or listened to. In several high profile examples (eg Lewisham 2013 and Liverpool 2010) local residents have been forced to resort to Judicial Review to enforce these duties and challenge decisions.

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What's making the NHS less accountable?

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Degrading of public scrutiny within the NHS
There is no effective and well-resourced network of local scrutiny organisations. Community health councils (CHCs) were set up by the Government in 1974 as statutory, independent organisations to represent public opinion. They were criticised for their patchy performance and abolished in 2003. However CHCs can now be seen as a high point in independent scrutiny of the NHS, as they have been followed by a string of organisations eg Links and Health Watch which appear more remote from the public and are less effective in representing the popular concerns.

What can we do about it?

First, some positives
Despite a lack of accountability in the NHS new forces in society have emerged and have helped to scrutinise decisions and apply pressure about them from the outside. 3 examples are:-

- *The Freedom of Information Act*
- *The rise of social activism*
- *The open sharing of information through social media and the internet*

Change the law
Ultimately there needs to be a structural change to the NHS to give the public more power, by making the organisations within it directly accountable. This will involve new legislation to address the weakness in accountability at all levels in our health service and would include the removal of all the market based rules and incentives which make it impossible for local organisations to meet and jointly plan care services according to local health needs.

The Reinstatement Bill addresses both these points and is a valuable example of some the steps needed in making the NHS more accountable.

Look at other systems
In Scotland pilots were carried out to test the idea of holding elections for positions on their health boards. An evaluation reported that these direct elections to NHS health boards were successful and that members of the public were prepared to stand in considerable numbers. In the pilots most of the elected board members were not strongly political and acted in ways that were similar to appointed non-executive directors.

An international literature review suggests that the Scottish experience is not unusual; New Zealand, some Canadian provinces, and English Foundation Trusts all had relatively low turnout but did not experience predicted problems with politicization and division.

Campaign for a bigger say, for greater democracy
Growing energy for activism, involving all ages, gives genuine hope to challenge the current holders of power, so that they might relinquish some of it in favour of the citizens who share the cost of the NHS. This has to be a theme of campaigning, part of the demands that we make. It helps to have a vision of what we want eg directly elected health reps but also a list of significant changes that could be made to improve local accountability.

The new models of care are already providing powerful reasons to campaign for increased accountability. The misleading use of "accountable" in the title of the new ACOs is sure to push this issue forward.

Here are two examples of how campaigners have focused on the lack of accountability within other key NHS issues and gained local and national media coverage.

The emergence of STP without legal basis
Mike Scott, who represents more than 100 members of Notts Keep Our NHS Public , told the *Post*: "We are not aware of any comparable situation, in which control of millions of pounds has been passed over to an unelected body, with no checks on how the money is being spent.
"Council Tax payers' money should be under council control. Just who is the leadership board accountable to.

The outsourcing of services to unaccountable providers
Overcharging by outsourcing giant Serco costs NHS millions (The Independent: 28 August 2014)
Outsourcing giant Serco is embroiled in a fresh misuse of public funds scandal after a company it set up overcharged NHS hospitals millions of pounds.

Internal documents leaked to Corporate Watch indicate Britain's biggest pathology services provider, which was established by Serco in partnership with Guy's and St Thomas' hospitals, overcharged the NHS for diagnostic tests. ●

The Naylor Report – Q&A

NHS Support Federation

What is the Naylor Report?
The Naylor Report, released in March 2017, is an independent report by Sir Robert Naylor for the Secretary of State for Health that looks at ways to raise funds for the NHS via its land and property.

The recommendation of the report, which is endorsed by the Government, is to raise money for the NHS via NHS property disposals, private capital investment in primary care and allocations from the Treasury.

The report concluded that £2.7 billion could be raised by selling property and land, possibly more if planning permissions were favourable.

How will the process of selling NHS land and property work?
The Naylor report recommends the setting up of the NHS Property Board to "provide a focus for the strategic development of the NHS estate and leadership across the system."

In addition, in May 2017, it was revealed that the government plans to set up six regional public/private partnerships (PPPs) to dispose of NHS land and property.

The plan, known as Project Phoenix, will see private companies working with the NHS to get the best market price for the land, with profits split between the NHS and private company. There are no details of the profit split yet.

The business plan for Project Phoenix was submitted by Community Health Partnerships to the Department of Health in April 2017, but its approval has been delayed. In September 2017, it had still not received approval, according to the answer to a written question from Jonathan Ashworth, Labour's Shadow Health Secretary.

Will the NHS sell land currently used for clinical or medical purposes?
The report states that only land "which is no longer required to deliver health and care services" will be sold off.

However, Labour commissioned research reported in The Independent in August 2017, found that the amount of land up for disposal was double a previous prediction and that much of it is currently being used for clinical or medical purposes. Also little information has been disclosed on over half of the land due to "issues of sensitivity".

Jonathan Ashworth, Labour's Shadow Health Secretary said: "It all adds to the suspicion that ministers are drawing up secret plans for a fire sale of valuable NHS assets to plug the black hole in their finances."

Are trusts being forced to sell off their land?
The report states that: "if provider plans are not embedded in STP plans, which maximise disposals, address backlog maintenance, and deliver the 5YFV, then they would not be eligible to access public capital funding."

Essentially this means that if Trusts do not "maximise" the amount of land they sell off, then they will not receive funding from the government.

Trusts are also being incentivised to sell off their land as quickly as possible through a 2 for 1 offer where "providers are given additional capital to match their disposal proceeds".

The report says this offer should be "time limited with a fixed funding pot and allocated on a "first come first served" basis." The report goes on to state that "this will encourage STPs and providers to act quickly to take advantage of this opportunity and discourage them from holding on to land."

The Great PFI Swindle

What it would cost the private sector to build the hospitals (original capture expenditure)

£12.2 BILLION

£41.4 BILLION AVAILABILITY CHARGE

£29.1 BILLION SERVICE CHARGE

What the NHS is paying the private sector for the hospitals (total cash repayment)

£23.5 BILLION 5% OVER 30 YEARS

What it might cost through a high street mortgage

£17.4 BILLION 2.5% BOND ISSUE OVER 30 YEARS

What it might cost the government to borrow the money

What will the land sold by the NHS be used for?
The report comes across as mixed on what to do with the sold NHS land.

It recommends that "land vacated by the NHS should be prioritised for the development of residential homes for NHS staff, where there is a need."

However the report also contains suggestions that the amount of money raised by the NHS could increase if "the NHS adopts a more commercial approach to obtaining planning consent, negotiating affordable housing quotas and maximising value from the highest value sites in London."

Affordable housing is desperately needed in London and the South East, where housing costs are a major issue for recruitment and retention of NHS workers. Yet it is possible that Trusts could minimise the amount of affordable housing built on high value sites (e.g. London and south east) and instead sell the land to property developers to maximise profit with luxury properties.

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The Naylor Report – Q&A

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What is "Private capital investment in primary care"?
The Naylor report recommended that GP practices could be given incentives to move into new facilities, supported by substantial private sector investment. The report itself, however, is very light on details on how these private investment deals will work.

The *Health Service Journal* reported in August 2017 that Primary Health Properties, Octopus Healthcare and Assura have together offered £3.3bn upfront in capital funding, which the private companies say could fund up to 750 new primary care centres. This offer was welcomed by Robert Naylor, author of the report. This group of companies already owns 850 healthcare facilities, mainly GP surgeries.

The companies' proposed model would mean GPs and other primary care providers move into specially built premises and pay rent to the group; the private companies would retain ownership of the premises.

The concern is that history shows that when private firms have put up capital to build NHS premises, the contracts have been long-term, inflexible and had devastating effects on NHS finances. The group of companies insists that this is not a type of Private Finance Initiative (PFI). The leases for the premises, for example, will not include an extra annual maintenance payment. The NHS will merely be a tenant and the group of companies the landlord.

However, the NHS will be paying an extra £200 million per year in rent under the group's plans. To counter this the companies have claimed that their commissioned research shows that the NHS could save more than £270 million per year as the new premises would "enable a reduction in non-urgent use of accident and emergency departments, remove pressure on walk in centres, and help increase GP care for the elderly."

Is "Private capital investment in primary care" a repeat of PFI?
Private Finance Initiative (PFI) schemes, first used in 1992, usually involve large scale infrastructure buildings such as schools and hospitals which would have previously been funded by the Treasury. Instead, the projects are put out to tender and contracts awarded to developers who then raised capital, built the premises and leased them back to the government.

The lease arrangements for PFI projects are long-term, often 25 years or longer. Annual repayments include an availability fee, which is interest and principal debt payments, and a service charge, which covers routine maintenance and upkeep of the property by a company appointed by the leaseholder.

PFI is widely acknowledged to be a very expensive way of building a hospital, with the design of the contracts resulting in cash-strapped hospital trusts paying millions each year to the lease holders, often companies based in tax havens.

The private investors involved in the new investment schemes have said that it isn't like PFI, but there is such a lack of detail on the proposed scheme that it is difficult to tell at present whether there are similarities or not. ●

Safe Staffing and the NHS - Health Campaigns Together

Dr Ben White

Safe staffing is crucial to good care and patient safety and thus, I argue, should concern all who are concerned about the NHS.

Increased demand for Registered Nurses(RNs) post-Francis Enquiry (Francis 2013) and a reduction in training places left a deficit in the RN workforce of around 15,000 (NHS Improvement 2015). Political decisions taken by the government such as imposing pay restraint and removing the nursing bursary have contributed factors to the waning nursing workforce.

In fact, recent work by the Department of Health in England estimates the nursing deficit, combined with a 'Brexit' effect, could be as high as 40,000 (Lintern 2017a). (Leary 2017).

The idea of an ideal ratio of nurses to patients is not new. The odds of care being left undone halved when nurses had 6 or less patients to care for. (Aiken et al 2016) (Leary 2017). Graduate RNs are associated with better outcomes and high RN:Pt associated with poorer outcomes (Griffiths et al 2016). It's complex (Hall 1964, Ebright et al 2003, Leary et al 2016) as the causal relationship is not fully understood.

Therefore, available evidence suggests we should support, retain and recruit nurses.

If we accept the argument that we need more RNs, we should try to influence decisions regarding:

A The cost of employing enough nurses in the NHS on appropriate pay and conditions, and
B The ability to recruit and retain nurses in the first place.

These need fundamental shifts in government policy.

The profound depth of wisdom and experience of the RN should not be underestimated and is something to be championed publicly. At the last count, almost 700,000 registered nurses and midwives were employed in the UK. Simple active discussion via word of mouth and social media may be the most powerful tools available.

We must be aware of the proposal by Health Education England's 'Shape of Caring review': to introduce a Nursing Associate (NA) role (HEE 2015), which looks at least for now to have the support of Nursing leaders. The role has been introduced with a relative lack of professional debate or consultation.

There is no evidence as yet this move will improve mortality or patient care. As I have outlined, there is some evidence to the contrary. Recent work suggests adding nursing associates and other categories of assistive nursing personnel without professional nurse qualifications may contribute to preventable deaths, and erode quality and safety of hospital care (Aiken et al 2016). (Leary 2017)

These issues could be further brought into the public domain and nurses and other healthcare professionals could be encouraged to speak out. Unions, government and other sectors and groups should be appraised of the evidence to inform policy. ●

Thank you to Professor Alison Leary whose article I quote extensively

http://onlinelibrary.wiley.com/doi/10.1111/jocn.13885/abstract

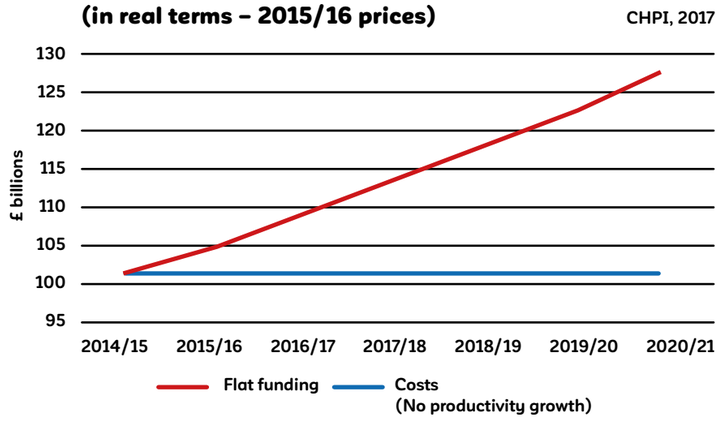
The NHS Funding Gap

Vivek Kotecha
Centre for Health and the Public Interest (CHPI)

The NHS Five Year Forward View (FYFV) estimated that between 2014-2021 the English NHS would given less funding than the amount needed to provide comprehensive healthcare to the population i.e. a **'funding gap'**.

Much attention has been given to the £30bn a year funding gap in 2020/21 but the gap between what the NHS gets and what it has needed and will need over the whole seven years from 2014 to 2021 widens year by year and adds up to a total of **£90bn**. £90bn is equivalent to losing almost 1 year's NHS funding over the 5 years to 2020/21.

The NHS funding gap



NHS England assumed that this £90bn funding gap would be closed with a combination of government funding and productivity savings by the NHS.

Extra government funding (the grey line) reduces the gap from **£90bn** to £57bn.

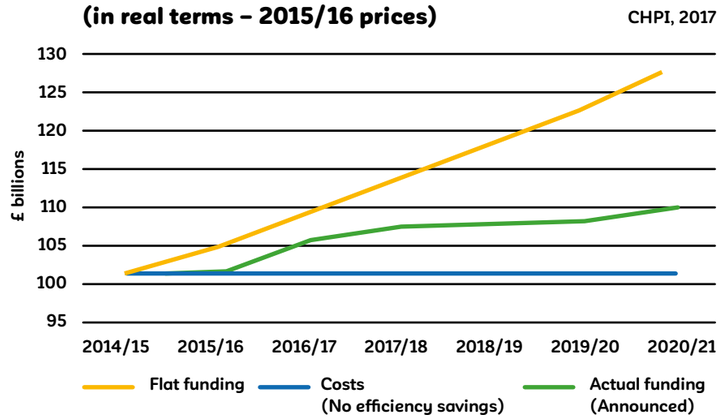
This leaves **£57bn** of productivity savings for the NHS to find. To find these savings the NHS needs to average 2-3% productivity savings a year. This is a tough ask and the NHS FYFV acknowledges this:

*"For the NHS repeatedly to achieve an extra 2% net efficiency/demand saving across its whole funding base each year for the rest of the decade would represent a strong performance – **compared with the NHS' own past, compared with the wider UK economy, and with other countries' health systems.**"*

Yet this was the challenge set. To achieve this ambitious challenge the following assumptions were made:

1. There is **sufficient capital** and recurrent funding available to transform the organisation and operation of NHS services so as to achieve the aims of the NHS Five Year Forward View (5YFV).
2. The new organisation of NHS services will lead to a **fall in the rate of growth of health care provided by acute hospitals** from 2.9% a year to 1.3% a year. This realises cost savings, as according to the 5YFV it is cheaper to treat patients in non-hospital settings.

Impact of extra funding

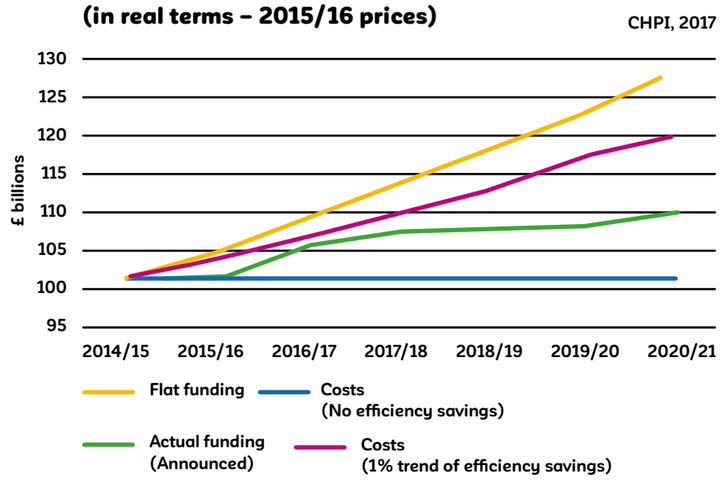


3. Hospitals will find **2% cost savings each year** and yet also be able to make additional cost savings to **clear their cumulative deficit**.
4. NHS **pay for permanent staff** will continue to grow at no more than 1% a year in line with public sector pay restraint.
5. The total cost of **agency staff** will fall by an average of 4% a year.
6. Investment in **public health** and education will improve health and enable more patients to 'self-care', reducing the costs of the NHS.
7. There will be adequate investment in **social care** to ensure that elderly patients do not need admission to hospitals or remain in hospital beds after they are ready to be moved to non-hospital forms of care.

Many of these aims are now being attempted across England by **STPs**. But given the lack of money for transformation, staffing issues, and a lack of funding for Local Authorities many of these aims appear unrealistic. This leaves the NHS with a funding gap.

Assuming that the NHS can achieve its long-run productivity of 1% a year (yellow line) over the seven years the gap reduces from £57bn to £34bn. So £34bn represents the likely amount of underfunding that the NHS will have to cope with whilst trying to meet healthcare needs of the coming years. ●

Impact of extra funding and 1% efficiency



Fighting privatisation – our successes and their failures

NHS Support Federation

Campaigning around NHS privatisation has helped to achieve a major shift in the politics surrounding the private sector's role in the NHS. A series of high-profile contract failures has also damaged the reputation of the outsourcing of NHS services.

Campaigners have been fighting privatisation using traditional tactics of raising awareness and engaging people in campaign actions. Below are two examples of specific approaches that have been used successfully to help build campaigns, followed by some case studies and some examples where outsourcing NHS services has failed.

Examples of tactics

Target the procurement procedure, for example, has sufficient public consultation taken place or has the impact of the new contract been sufficiently assessed and reported on.

Run a publicity campaign to make the public and the commissioners aware of the records of the companies that could get the contract, eg their use of tax havens or low payment of tax, failures in other contracts or legal cases that have brought against them for wrongdoing.

CASE STUDIES

1. NHS Professionals

In September 2017, the Government abandoned plans to sell-off NHS Professionals, the government-owned employment agency that supplies doctors and nurses to hospitals.

The decision to sell off 75% of NHS Professionals was announced in 2016 and immediately sparked widespread criticism from MPs, health unions and NHS staff and a campaign against the sale.

The Government blamed the u-turn on the sale on bidders not offering enough money, but it is more widely believed that the strength of the opposition to the move is the real reason for the change of policy.

2. George Eliot Hospital, Nuneaton

In March 2014, the plans to privatise the George Eliot hospital were abandoned, a victory for campaigners who had fought to prevent the hospital being privatised for over two years.

An overview of the successful campaign can be found here on the False Economy Website.

The campaign, coordinated by UNISON and involving local people, councillors and patient groups, highlighted the lack of exploration of other options for the hospital instead of privatisation, plus the lack of public engagement and transparency within the procurement process.

3. The Worthing Musculoskeletal services Contract

In January 2015, Bupa CSH, the winner of a £235 million contract for the provision of musculoskeletal (MSK) services in West Sussex pulled out of the process. The contract had been awarded in September 2014.

A campaign against the contract, included UNISON West Sussex, 'Don't Cut Us Out' and 'Sussex Defend the NHS' as well as the local hospital trust, Western Sussex Hospitals. The campaign highlighted concerns over the impact the contract would have on local services. Eventually under pressure, the local CCG agreed to conduct an impact assessment on the affect the contract would have on the local NHS hospital trust.

The impact assessment found that the cumulative impact of loss of MSK services from the local hospital trust, the Western Sussex Hospitals NHS trust, would mean the trust falling into deficit over the next five years. Western Sussex Hospitals trust had also warned that the loss of the contract could destabilise its trauma services. Bupa CSH withdrew from the contract as a result of the report.

4. Bristol Children's Community Care contract

Only a partial victory can be claimed in this case, with a campaign to prevent privatisation of children's community care succeeding in Virgin Care not winning the contract, however it was won by a non-NHS organisation, Sirona, a not-for-profit company.

In 2015, the two companies Virgin Care and Sirona were named as the two contenders to be awarded a one year £28 million contract in Bristol for the provision of children's community services. A campaign to keep the contract within the NHS was spearheaded by the campaign group Protect Our NHS.

Although the campaign was to keep the services within the NHS, a major focus of the campaign was on the tax status of Virgin Care; the company does not pay tax in the UK and its parent company is registered in a tax haven, the British Virgin Islands. The campaigners noted that under a clause in the CCG constitution, the contract could not be awarded to a company that had convoluted methods of avoiding paying tax. This type of clause in a CCG constitution has often been removed now due to fear of legal action, but public opinion is rightly against tax-avoiding companies profiting from the NHS.

2016/2017 Privatisation Failures

A few recent examples of the failures of privatisation follow, but more can be found on the www.NHSforsale.info website, produced by the NHS Support Federation.

1. Coperforma and the Sussex non-emergency transport contract

In October 2016, Coperforma finally lost a contract for non-emergency patient transport in Sussex; the contract begun in April 2016 can only really be described as a disaster from start to finish. The four year contract was awarded to Coperforma by seven CCGs, led by the High Weald Lewes Havens CCG. Coperforma replaced the NHS's South East Coast ambulance service. Coperforma acted as a prime-provider, with the company subcontracting the work to private ambulance companies around Sussex.

Problems with the service began almost immediately and by mid-April 2016 local and national press were reporting on a service in chaos, with crews not turning up to pick up patients leading to missed appointments and patients languishing for hours in hospitals awaiting transport home. The GMB union, together with other campaign groups in the area, kept up a sustained campaign highlighting the company's failures.

In mid-April the CCGs that awarded the contract produced a report criticising Coperforma for "unacceptable levels of performance". Later on there were critical reports by Brighton & Hove HealthWatch and in November 2016 it was revealed that the Care Quality Commission had served six improvement notices on the company.

As well as its poor treatment of patients, there were major problems with the company's treatment of its sub-contractors. Coperforma had major financial problems and there were problems with the payment of subcontractors; at least two subcontractors went bust, with others left in financial trouble. By the time Coperforma lost the contract, ambulance crews working for the subcontractors were owed thousands in back-pay. Despite promising to pay the crews, it was the High Weald Lewes Havens CCG that eventually had to step in and provide the money for the back pay.

2. Private Ambulance Service in Hertfordshire

In late September 2017, the private ambulance company, Private Ambulance Service (PAS) contracted to run non-emergency patient transport from hospitals in Bedfordshire and Hertfordshire went into administration, with trading ceasing 9 October 2017. The business, which had 126 vehicles and employed 300 people, only took over the contract in April 2017.

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Fighting privatisation – our successes and their failures

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Problems had been reported with the service, including reports that vulnerable patients were left stuck in their homes or in hospital for hours waiting for transport. PAS is facing a £75,000 compensation claim after a coroner ruled a patient had been the victim of a "serious failure of care" by PAS ambulance staff.

3. Central Nottinghamshire Clinical Services
In May 2016 Central Nottinghamshire Clinical Services, the private company in charge of out of hours services across the East Midlands, announced it was filing for administration. It stopped its services in Leicester, Leicestershire, Rutland and north Nottinghamshire and they were transferred to another provider.

The company also ran care home support services and these were transferred to Nottinghamshire Healthcare Trust. A report into the company by the Care Quality Commission in 2015 placed the company in special measures after it found a critically ill six-week-old child was forced to wait for over five hours to see a GP instead of the stipulated 60 minutes.

4. Primecare
In September 2017, Primecare, which was awarded one of the first integrated NHS 111 and GP out of hours services contracts in East Kent, announced that it is to hand back the contract to the NHS mid-way through the three year contract in July 2018.

The contract only began in January 2017, but after only seven months, Primecare was placed in special measures after its services in East Kent were rated inadequate by the Care Quality Commission. Failings included not assessing risks to patients' health and not having enough staff to meet patient needs.

4. GP Surgeries
In Brighton and Hove, The Practice Group announced the termination of its contract for five GP surgeries in the city in 2016, leaving 11,500 patients looking for a new GP.

The Practice Group gave several reasons for giving up the contract, however a major reason is a reduction in central funding for the surgeries.

In October 2016, Greenbrook Healthcare announced its intention to hand back an APMS contract for five GP surgeries in west London nine months before the end of the contract. This put around 27,000 patients at risk of losing their GP. Greenbrook Healthcare had been in discussions with NHS England since early 2016, but as no additional funding has been offered the company stated that due to rising demand and problems with GP retention the contracts have become "unfit for purpose".

Other earlier failures include:

- Capita and the Primary Care Support Services contract
- Hinchingbrooke Hospital and Circle
- Serco and out-of-hours care in Cornwall

Private Finance Initiative (PFI)

Vivek Kotecha
Centre for Health and the Public Interest (CHPI)

It's been 18 years since the first NHS Private Finance Initiative (PFI) hospital became operational and now there are 127 PFI-funded hospitals and social care facilities across England. Despite being called 'exorbitant' and accused of making 'ghastly' profits by MPs little has been done to tackle the burden of PFI on our NHS. What is wrong with PFI and what can be done?

What is PFI?
PFI is a scheme through which **private** companies typically fund, build, and manage large **public** sector capital projects. Once constructed the NHS or local authority pays annual repayments, known as an 'unitary charge', for an average of **31 years** to the private company.

For the NHS and social care, just under **£13bn** of new infrastructure has been built. But over the course of these contracts the unitary charges for these facilities will total **£82bn** with this nominal figure including services provided (e.g. portering, cleaning, building maintenance) as well as repaying the cost of building, and interest on loans taken out. That's over **6 times** the original cost of building.

What is wrong with PFI?
Aside from being an expensive way to build much needed hospitals PFI has other problems too.

1. Last year the NHS (and social care) spent over **£2bn** on repayments for PFI. This is rising each year and represents more than **50%** of the NHS hospital sector's £3.7bn underlying deficit for that year. As austerity worsens, **rising** PFI costs will see more NHS front-line spending diverted to PFI.
2. PFI companies made a pre-tax **profit** of **£831m** over the last 6 years from the NHS. This money would have reduced the NHS deficit by a **quarter** if it hadn't leaked out via PFI.
3. PFI costs have crippled some hospitals (such as Barts and Peterborough & Stamford) forcing them to leave vacancies unfilled and **cut** other services.
4. The **quality of services**, such as cleaning, has deteriorated in PFI run hospitals. There also concerns about building quality in particular **fire safety**.
5. PFI's private shareholders are making up to **45-60% average annual returns** on their investment when they sell out early. **Twelve offshore funds** own 74% of the UK PFI/PPP projects. The five largest paid made a **profit of £1.8bn** (2011-2015) but **paid no tax**.

What can we do?
Some suggestions.

1. Publicise the burden of PFI schemes on our local NHS. Ask our local MPs to oppose further PFI driven cuts.
2. Ask our local councils to conduct safety audits of our local PFI facilities.
3. Campaign for taxes on excess PFI profits, for the burden on our local NHS to be relieved, or the abolishment of PFI.
4. Demand accountability of the offshore funds that control and own our local PFI facilities.

Challenging STPs/CEPs/ACSs/ ACOs – what works?

NHS Support Federation

1. What are we challenging?
In 2016, the NHS England split England into 44 areas each of which was required to produce a Sustainability and Transformation Plan (STP) outlining how the local health economy would be changed to increase efficiency and reduce deficits.

Publicised as a way to improve healthcare for local communities, the STPs are in reality plans to cut services and bring in new models of care.

The STPs all contain new ways of organising care as a key aspect to saving money. According to NHS England, STPs will transform to Accountable Care Systems (ACSs) and then eventually to Accountable Care Organisations (ACOs). The terms ACS and ACO are used to describe very similar models of care:

In an **ACS** commissioners and providers, in partnership with local authorities, collaborate to integrate health and social care for a specific defined population.

An **ACO** develops from an ACS when a single provider organisation (or consortium) holds a contract with a set budget for the majority of health and care services in a defined area. A contract to run an ACO can be held by an NHS organisation or by a private company.

All STPs have projected deficits, many are very large and this is clearly is a driver behind the cuts that feature in many of plans. They also share the objective of shifting more care from hospitals into community settings. However in many areas NHS staff and the public are not engaged and onside. Detail about how the plans will be implemented is sparse. There is also no sign of the extra investment in community health services which will be needed, which the BMA estimates at £10bn if all the plans are to implemented.

The King's Fund warns that NHS proposals to slash bed numbers are "undesirable" and "unachievable" at a time when mounting pressures have left many hospitals "stretched to breaking point".

Their study shows that hospitals in England have the least beds for their population compared with any other country in the European Union, with just 2.3 per 1,000 people, compared with an EU average of 3.7.

On top of the cost cutting plans in the STPs, the 14 areas with particularly high deficits and no viable financial plans to keep within their 2017/2018 budget are now part of the '**capped-expenditure process'** or **CEP**. Under the CEP, the health leaders have been asked to take additional major actions to improve savings, including the closure of wards and reduction in staff, restricting access to services, and reducing spending on non-urgent work.

2. Campaigning
Several areas are already fighting back against the plans outlined in their local STPs, and some successes have been reported.

The boards that have produced the STPs do not have any legal status and operate with no accountability to local communities. However, the changes in the STPs and the formation of ACSs/ ACOs all rely on the cooperation of local councils.

The role of local councils
The need for council cooperation in STPs gives campaigners a significant lever of influence, which many groups are already exploiting. A growing list of councils have passed motions objecting to aspects of their local STP.

However STP boards are currently most often led and dominated by NHS managers and not their counterparts from the council. Recent reviews show that progress towards greater cooperation between the NHS and councils is slow. Many councils complained they were not involved in the writing of the STP. Some have expressed resentment that their Health and Well Being Boards, who have a remit (but no formal powers) to extend integration have been sidelined. In some areas these views will provide an opportunity to persuade the council to fully engage with the public concerns about the STP.

Given that plans for cuts and mergers in the acute sector are common in STPs, it is worth being aware of another committee in the council – the Council Health Oversight and Scrutiny Committee. Their role is to scruntinse changes in the NHS that affect local people. The committees can ultimately refer the plans to the Secretary of Health for review, where it will go before an Independent Reconfiguration Panel. This allows for another opportunity for the evidence to be considered and possibly reversed.

Case studies

A&E changes in Mid and South Essex
The STP for mid and south Essex contained plans to make significant changes to the way the three A&E departments at Broomfield, Basildon and Southend hospitals operate. The plan would have seen Broomfield and Southend A&E downgraded, with the redirection of all 'blue light' ambulances to Basildon.

The campaign began in December 2016, led by local people under the banner "Defend Our A&E Broomfield" and coordinated by Andy Abbott, the campaign included petitions, both physical and online (on the 38Degrees website), town centre stalls and demonstrations. The campaign targeted the local councillors and MPs, including the presentation of a petition to Chelmsford City Council. Hundreds of emails were sent by local people to NHS leaders.

In July 2017, the plans were shelved with the Chief Executive of Basildon, Broomfield and Southend Hospitals noted: "In the feedback from over 100 local discussion events, we have heard very clearly that some people have significant concerns about all 'blue light' ambulances going straight to Basildon."

Acute service review in Devon
In Devon, there were fears that a review of acute services, stroke, maternity, neonatal, paediatrics and A&E in the county under its STP would lead to a loss of services at the North Devon District Hospital in Barnstaple.

The local campaign group Save Our Hospitals (www.sohs.org.uk) led a county wide campaign against the loss of services at the North Devon Hospital. The campaign included a countywide 'You Can't Fool Us' day where campaigners, many dressed in red, lined up around hospitals in Devon to highlight the campaign. The campaign gathered support from local MPs and from councillors.

In June 2017, Devon CCG announced that the review of acute services had concluded that acute services should remain at all four hospitals in Devon, including North Devon District Hospital. The campaigners, however, will continue to campaign against the STP.

Closure of Huddersfield Royal Infirmary A&E
In July 2017, after a sustained campaign by local people, councillors in Calderdale and Kirklees used their powers to refer the plans to downgrade Huddersfield Royal Infirmary to the Department of Health. The plans will now go before an Independent Reconfiguration Panel, which gives another chance for evidence to be presented and the decision potentially overturned.

In addition, in September 2017, the campaign group Hands off HRI launched its legal challenge seeking a judicial review, following the decision by Calderdale and Huddersfield NHS Foundation Trust to approve the Full Business Case for the huge restructuring plan.

Continued over

Challenging STPs/CEPs/ACSs/ ACOs – what works?

Continued from page 19

Downgrading of Horton General Hospital, Banbury
Despite a local campaign that included two Conservative MPs for the area, Oxfordshire CCG agreed to many of the downgrade plans for Horton Hospital, including downgrading of maternity, bed closures and the closure of the stroke care unit.

Public opposition has resulted in a legal challenge being mounted jointly by four councils in the area – Cherwell district, South Northamptonshire, Stratford-on-Avon district and Banbury town councils, along with campaign group Keep the Horton General as an interested party.

The councils are seeking a judicial review over Oxfordshire CCG's consultation on changes to services including maternity, critical care and hospital bed use.

A campaigners guide to questioning the CCG and councillors

Ken Kirk – Defend the NHS – Sussex

On your local CCG website, there will be an officer to whom you submit public questions, in my case five working days before the meeting. For my CCG, Brighton and Hove, this is the Secretary to the Board.

Ask the Secretary by email what is the protocol for public questions, yours is possibly different, but for Brighton, having submitted the question you then attend the meeting to read it out and are allowed a supplementary question relating to the subject of your original question.

At the council the first target is the Health and Wellbeing Board (HWB), which oversees the council's public health responsibility, so you can question its policies on health protection e.g. to prevent disease, promote good health, and prolong life among the population as a whole.

Your council website should provide email address of the officer to submit your question to. The HWB may have co-opted members of the CCG, and it is may be right now considering how services are to be redesigned i.e. cut.

There is also the Health Overview and Scrutiny Committee, which can scrutinize all health decisions in your locality whether CCG or local authority. It can consider reports and policy documents of the CCG and local authority and request officers to attend its meetings to be interrogated. When it is dissatisfied the most drastic action it can take is to refer a policy to the Secretary of State.

When questioning any of these organisations be aware of the following –

You will be fobbed off with platitudinous rubbish for answers to your question. If a supplementary question is allowed prepare it in advance, it can form the punchy statement that you really want to say.

There will be protocols for the submission of questions that you need to follow e.g. submitting question in advance, limitation on question word length.

Although CCG and even local authority committees say they welcome public scrutiny, they don't! But whatever happens keep plugging away, embarrass them, get support from fellow campaigners and health workers affected by their decisions to attend meetings, don't be afraid to make impassioned ranting speeches, make a noise despite their rules, bring banners and crowds to meetings, don't be put off by their attempt to control you. ●

Mental health campaigning is a crucial area that requires our attention

Despite this government's apparent commitment to provision, there seems to be far more emphasis on reducing stigma around the illness than there is on actual funding.

A recent headline announced £15m to fund a million voluntary non-medical mental health workers; training them at only £15 each. In short mental health provision is simply not being taken seriously and consequently patients are not being given the respect they deserve.

It was an election promise in June to tear up the outdated 1983 Mental Health Act. However, this is now only to be 'amended' or 'looked at'. Similarly an election pledge to recruit 10,000 mental health staff has now been changed to 'up to' 10,000 with no quota given. It's time for the government to get serious on its commitment to mental health provision in our NHS.

According to The King's Fund, between 2015-16, 40% of mental health trusts have had their budgets cut, and in March 2017 it emerged that £800m set aside for mental health had been allocated to other struggling areas of the NHS. Without proper ring-fencing it is inevitable that struggling trusts will use money in the most critical areas.

With this background it is unsurprising our local mental health provision is under threat.

My name is Samantha Wathen and I'm founder and co-chair of Swindon KONP. Mental health provision is an area close to my heart, and one pertinent to Swindon. There are 700 Hospital admissions pa here due to self harm, much higher than the England average.

In September we were involved in a campaign to oppose the closure of our 136 place of safety facility, the alternative being a centralised hub further away in Wiltshire.

Campaigning has so far paid off. Following significant media and press involvement the local trust have delayed their decision on closure and are currently exploring other locations in the town. Until we have a firm decision, our fight continues...

Hi my name is Brendan Murphy and I'm an experienced Specialist Psychotherapist for Derbyshire NHS. I work with patients who have severe and complex mental health needs, but our service is under threat of being decommissioned by the local CCG. This is the third time in 10 years our service has been under threat.

Commissioners have failed to appreciate that cutting our service would, in addition to harming patients, be a false economy as we help service users to remain in/return to work and also reduce pressure on primary care.

We will continue to fight for our service as we have before, by engaging in the consultation process, publicising our case and ensuring our service users remain our central focus. ●

Mental health services still in crisis

Dr Youssef El-Gingihy
NHS Support Federation

Despite a recent pledge by the Prime Minister to turnaround mental health services a report from mental health trusts across the country has found that children, older people and people in crisis often receive inadequate care.

Mental health services are struggling to cope with soaring demand and patients are facing long delays. The recent survey of mental health NHS Trusts, published by NHS Providers, identified three major factors.

"The impact of rapidly rising demand, workforce shortages and the failure of funding to get through to the frontline means core mental health services are being overwhelmed,"

A separate report by the BBC confirms that services for people who are suicidal or self-harming are also facing unprecedented demand. Seventy per cent of mental health trusts have seen demand for these crisis services rise significantly, some by as much as sixty percent.

Staffing shortages

There are widespread shortages of specialist nurses and psychiatrists according to chief executives and chairs from 37 of England's specialist mental health trusts.

Between 2010, when the coalition government came to power, and July 2016, the number of mental health nurses working in the NHS in England fell by 6,610, or almost 15% of the entire workforce.

Despite the vital role of psychiatrists in treating mental illness, in the last five years numbers of psychiatry consultants increased by just 1.7 per cent.

Insufficient funding

Theresa May's pledge to tackle the "burning injustice of mental illness" is already being cast in doubt. Eighty per cent of bosses of NHS trusts fear they will have too little money this year to provide timely, high-quality care to the growing numbers of people seeking mental health support.

Many do not believe that the more than £1bn of extra funding pledged by ministers is reaching its intended destination.

The recent promise of more funding has come after an unprecedented period of cuts. Analysis by the health thinktank the King's Fund found that in 2013-14 and 2014-15, 40% of mental health trusts saw budget reductions. These cuts, coupled with soaring levels of demand, have turned the issue of mental health into a full-on public scandal.

Rising demand, falling capacity

It perhaps is no surprise given recent policy trends that the number of acute inpatient beds for adults with mental health problems fell by 15 per cent over the last three years according to a report by the Centre for Mental Health (Sep 2017).

Often this is explained away by policy makers as part of the move away from hospital to community based care, but the Centre's study contradicts this as it found that community mental health care provision has fallen too. The number of people on community team caseloads fell by 6% cent, staffing levels fell by 4% and contacts reduced by 7%.

The study also found that staffing levels decreased in mental health acute settings by 20 per cent.

As you might expect lower resourcing is leading to a rise in the proportion of people being admitted under the Mental Health Act by 10 per cent since 2012/13.

Care after hospital

The picture for patients leaving hospital is no brighter. Figures released by Mind show that one in ten people discharged from mental health hospital after being admitted in crisis are not getting follow-up within a week of leaving – which is at least 11,000 people every year.

National Institute for Health and Clinical Excellence (NICE) guidelines currently state that all patients should be followed up within seven days because people are at high risk of post-discharge suicide in the first week. In fact, more recent evidence from the National Confidential Inquiry into Suicide and Homicide shows of all patients who died in the first week after discharge, the highest number occurred on day three.

Commenting, Paul Farmer, CEO of Mind said; "If you don't get the right care after you leave, if you're left to cope alone, you can end up in a revolving door going straight back in to hospital or be at risk of taking your own life."

Stuck in hospital

Increasing numbers of children and young people are being kept in hospital despite being fit to leave because appropriate specialist or community support isn't available.

Between October 2015 and February 2017, children spent nearly 9000 "wasted days" in NHS hospitals when they could not be discharged, according to an analysis by the Education Policy Institute. The number of delayed days was 42% higher between December 2016 and February 2017 than in the same period in 2015-16, the institute said.

They also said that one in nine inpatient units in England failed to meet the minimum standard for staff to patient ratios, while a quarter (24%) did not employ enough permanent staff. Concluding that children and young people with mental health problems are still being let down by variable service provision.

"A programme of Care in the Community was launched in the 1980s accompanied by the closure of inpatient facilities and wards. The result has been chronic shortage of psychiatric beds with patients, including children, forced to travel hundreds of miles if they require inpatient care."

Overall, hospital bed numbers have dropped from 299,000 to 142,000 since 1987, at a time when the population has risen by 16 per cent, with the number of pensioners up by one third, according to a report by the King Fund.

The number of mental health beds has fallen from 67,002 to 19,000 in the last 30 years. Bed capacity has been outsourced to independent providers. The Royal College of Psychiatrists says the shortage of mental health beds in England "is a crisis".

Organisations campaigning on mental health

MIND https://www.mind.org.uk/news-campaigns/campaigns/
RETHINK https://www.rethink.org/get-involved/campaigns
TIME TO CHANGE https://www.time-to-change.org.uk/
STUDENT MINDS http://www.studentminds.org.uk/campaigns.html
UNISON https://www.unison.org.uk/our-campaigns/mental-health-matters/

Fighting privatisation – what works?

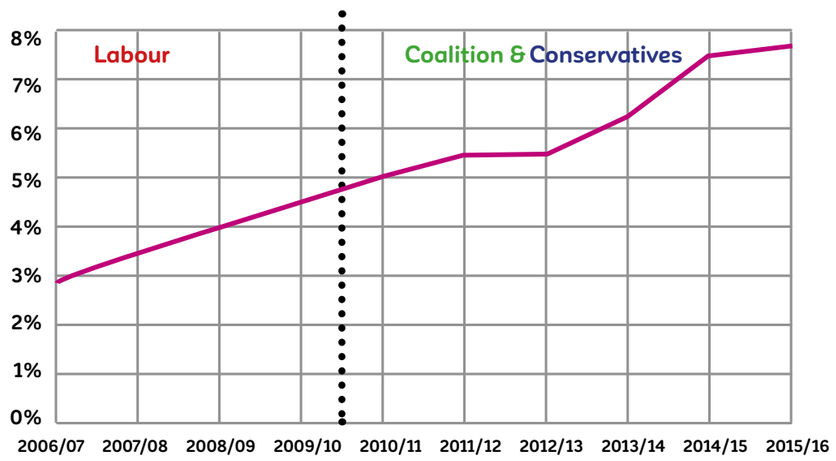
Facilitators: Caroline Molloy (OurNHS[1]) and Ellen Lees (We Own It[2])

The issue:
According to the Kings Fund[3]: "Analysis of the Department of Health's published accounts shows that the share of spending by NHS commissioners on the private sector was 7.7 per cent of the budget in 2016/17. This has increased slightly from 7.3 per cent in 2014/15, although changes in data definitions mean this is not strictly a like-for-like comparison. Total spending by NHS commissioners on non-NHS organisations (including the voluntary sector and local authorities) was 10.9 per cent, up from 10.7 per cent in 2015/16."

The trend is steadily upwards, with compulsory competitive contracting in many instances since 2013.[4] The vast majority of the NHS budget remains in public provider's hands, but a large number of contracts going to competitive tender are won by the private sector, and the sector is growing.

Private providers in the NHS

NHS spending on independent sector providers as a proportion of total NHS revenue spending



Source: Department of Health figures provided to Full Fact and parliamentary question 66091 (1 March 2017)

The response:
The general public is beginning to see this threat, through the efforts of campaigners and the more widespread examples of NHS care being in private hands. And there are examples of failed privatised contracts – the most notorious being Circle and Hinchingbrooke Hospital.

Health campaigners have fought against privatisation for years – Keep Our NHS Public was formed in 2005 with that explicit aim.

We Own It led the protest over the summer against Hunt's determination to privatise **NHS Professionals** and following a referral of this decision to the National Audit Office, the decision was reversed in September.

How do we achieve this?
The workshop will share experiences and thoughts on how to fight against privatisation.

OurNHS: Caroline Molloy is editor of *OurNHS*, itself part of **openDemocracy** "openDemocracy does fiercely independent journalism ... This includes our specialist, campaigning OurNHS project. On very low running costs, OurNHS regularly breaks the stories the mainstream media miss about the crisis faced by England's National Health Service, exposing sneaky moves towards charging for vital health services, withdrawing services, hospital sell-offs and the shocking failures of privatisation. But now it needs to your help to continue." *OurNHS* plays a crucial part in the campaign to save the NHS.

We Own It: "After 30 years of handing over our public services to private companies, it's clear that privatisation has failed. Public services – the NHS and schools, rail and Royal Mail – belong to you, me and everyone. We pay for them, we use them, we own them. Public services are vital for our families, friends and communities. But privatisation isn't working – the evidence doesn't support it and neither does the public. That's why we want to see a world where public services are run for people, not profit – whether that's water or energy, care work or council services. We Own It was launched in 2013 to be a positive, forward-looking voice for public ownership." ●

1 https://www.opendemocracy.net/ournhs
2 https://weownit.org.uk
3 https://www.kingsfund.org.uk/publications/articles/big-election-questions-nhs-privatised?gclid=Cj0KCQjwprbPBRCHARIsAF_7gDY6XPYietZEKEZ1GskXvs0rJ2eFgsIRRrQvBmFX_W6RELQgXyICoRMaAjcJEALw_wcB
4 https://fullfact.org/health/how-much-more-nhs-spending-private-providers/

Resisting the introduction of immigration checks in the NHS

From Monday 23rd October all NHS trusts in England will be forced to check the residency and immigration status of patients and demand upfront payment for care from those who can not prove their eligibility. This covers all secondary care and a large proportion of community and mental health services. It does not include GP services or A&E.

The scheme has been piloted in 20 hospitals over the last year but there has been little evaluation of the impact prior to national implementation, and the majority of doctors and nurses are not aware of it. Already there are numerous examples of patients being racially profiled and targeted with threatening letters and demands for payment.

The NHS is now the front line in the Government's attempts to create a 'hostile environment' for migrants. Recent changes requiring GP surgeries to share data with the Home Office and the expansion of health surcharges to migrant visas in 2014 sit alongside policies requiring schools and banks to check immigration status.

Docs Not Cops along with groups like Doctors of the World and Medact Refugee Solidarity Group have been leading a campaign to scrap these checks. Docs Not Cops groups are emerging across the country in Brighton, Manchester, Newcastle, Brighton, and Cambridge and starting to build local networks of resistance.

Docs Not Cops is a group of NHS staff and patients that work to combat racism in the NHS. We believe no one should be afraid to access the healthcare they need, either because they can't pay or might be punished, and that NHS workers should not be forced to police the people they treat.

DocsNotCops@gmail.com
facebook.com/DocsNotCops
@DocsNotCops
#PatientsNotPassports

1 Day Without Us is campaigning against a closed, intolerant Britain where Polish teenagers are hounded to suicide because of their nationality; where doctors and nurses are obliged to act as immigration police, where families are separated because they fail to meet arbitrary income thresholds, where migrant workers are treated as intruders or commodities rather than human beings. 1 Day Without Us will have a second national Day of Action on 17/02/18.

1daywithoutus.org
Info@1daywithoutus.org
@1daywithoutus
facebook.com/1DayWithoutUs ●

Building the pressure to bust the cap on NHS pay

Jacqui Berry

Behind the headlines of "NHS Nurses: We're Using Food Banks" lies a protracted crisis. The real value of average NHS salaries has fallen by an average of 14% since 2010, with profound implications for recruitment and retention of the largest workforce in Europe.

The Health and Social Care Act saw the government seek to absolve itself of political responsibility for the National Health Service. This has been mirrored in their approach to negotiating NHS pay, which has been devolved to a so-called independent Pay Review Body, which has made recommendations to the government, within the narrow confines of the 1% pay cap.

In 2014, for the first time in 30 years, trade unions in the health service took strike action over pay. They engaged in 2 separate 4 hour strikes in October and November that year after the government refused to implement the PRB's very modest recommendation of a 1% increase.

Health Secretary, Jeremy Hunt warned that pay increases would spark 15,000 job losses in frontline nursing. The unions' demand, that the government implement the PRB recommendations, paved the way for an eventual settlement which effectively spread the 1% award over 2 years, however changes in tax brackets, pension accrual and student loan repayment rates resulted in many graduate staff experiencing an actual cut in take home pay.

Hunt's prophecy was borne out in a way would never have intended, as nurses in particular voted with their feet. He now presides over the largest shortfall in nursing and midwifery numbers in NHS England in history.

Since 2013, the number of registered nurses and midwives leaving the profession has increased by 51%, according to the professional regulator, the Nursing and Midwifery Council, with the actual shortfall now around 43,000.

Many NHS employers have sought to bridge the skills gap by recruiting migrant nurses. However, the decision by the NMC to impose increasingly difficult English language tests, which many native speakers struggle to pass, has proved a barrier to many. In addition, the looming retirement of one third of NMC registrants by 2026 and the plummet in numbers of healthcare students following the abolition of the NHS Bursary look set to compound the crisis further.

The dual burden of dwindling salaries and compassion overdrive compels staff to pick up the slack themselves, with employers providing financial incentives to work as many additional hours as possible.

In October 2017, Jeremy Hunt proclaimed the pay cap "scrapped", but few are clear on what he actually means. The pay claim, submitted by 14 health unions demands 3.9% rise for 2018-2019 plus a flat £800 consolidated award for everyone on Agenda for Change.

- Will the PRB meet the unions' demands?
- Will any pay increase be subject to further cuts in services?
- What is an acceptable pay offer and how can we make this a reality?
- If industrial action is necessary, how can we build a strike which overcomes repressive anti-trade union legislation?

Come along to our workshop to find out! ●

How do we get legislation to reinstate the NHS – working with political parties

Facilitators: Tony O'Sullivan and Nicholas Csergö

The issue

Successive governments have undermined the NHS stepwise, privatising first ancillary services, then introducing the internal market, and PFI, and then the race towards privatisation, escalated by the 2012 Health & Social Care Act.

In a very real sense, the NHS still exists for the population, as a service people receive, with clinicians still working hard to get around competition between trusts, underfunding, vacancies, and growing waiting times. As campaigners we must give the message that the battle is on, and we are not going to lose the NHS.

In a strictly legal/statutory sense, there is no longer a truly national NHS.

Foundation Trusts can to some extent work outside NHS restrictions and raise 49% of income privately; ACSs and ACOs threaten to bring in enforced service rationing, restrictions, cuts (here and now).

Legislation would be brought in now to legitimise these steps, if the Government were not so weak and unstable; calls for integration with social care can only be progressive if personal social care is also free at the point of use, not means-tested and brought back to public control.

The NHS is undermined by defunding, devolution, fragmentation, breaching of national terms and conditions, pay caps and legislation that enforces competitive tendering.

The solution

To preserve the NHS, we need a change of government and new legislation.

Legislation must undo the dangerous steps of the 2012 Act and beyond.

- The NHS Reinstatement Bill[1] drafts out how this can be achieved.
- The #NHSTakeback pledges bring into accessible easily digested message form the steps we require, based on the NHS Bill.

To achieve this, we must persuade a majority of MPs to vote for a change in NHS legislation

- This must be an alliance of MPs because it cannot be relied on that one party will have and use a majority vote to end the market in the NHS and fully return it to a publicly funded, managed, provided and accountable service.
- We need a social media campaign locally and nationally – linked to STP proposals at local level.
- We need to lobby, persuade, cajole MPs from all parties. We need to point out to those where NHS services are at risk through STP recommendations and ACSs/ACOs that their seat may be at risk if they don't understand the dangers facing the NHS. Those of us who are members of a political party must organise to make our voices heard in favour of the NHS.
- We must renew our efforts to get MPs behind first the **#NHSTakeback pledge**[2] inspired by the NHS Bill. However in a situation where legislation can be tabled, fierce debate, compromise and amendments are inevitable to achieve an act that can restore Bevan's vision for the NHS, in place of that of Hunt and Letwin.
- We need to target all parties – to mount grassroots lobbying at surgeries, Town Hall forums and other local meetings. ●

1 Campaign for the NHS Reinstatement Bill: http://www.nhsbillnow.org/

2 The Pledge: https://weownit.org.uk/nhstakeback
Has your MP signed? https://weownit.org.uk/act-now/nhstakeback-action

The Politics of Care

In 1948 the post-war Labour government established:

- The **National Health Service** to deal with illness and provide healthcare free at the point of delivery. The long-term illnesses of old people were dealt with WITHIN the NHS.
- The **National Assistance Act** set out the responsibilities of local authorities to provide services to assist people, who by reason of age or infirmity were in need of residential accommodation and domiciliary and community services. These services were means-tested.

From 1948 to 1981, geriatric beds were cut and a critical number of NHS services were transferred to local authorities. During the 1980s local authorities cut their in-house services, opting for "best-value" contracts from private agencies who put in cheaper bids, often employing under-trained and unqualified staff.

In 1990 the Conservative government's Community Care Act (implemented in 1993) required local authorities to purchase nursing home care for people with "long-term illness" – a move which sped up the process of shunting sick elderly patients out of the NHS.

In the 1997 general election, Frank Dobson, who became Labour's Health Secretary, supporting Labour's manifesto, said that arrangements for such care were so unsatisfactory that they "cannot be allowed to continue for much longer".

The Labour government set up a Royal Commission on Long Term Care (chaired by Stewart Sutherland), which issued a critical report in 1999 and called for free personal care to be paid through general taxation. Prime Minister Tony Blair refused to accept the report, and in 2000 Labour announced the NHS Plan, which set up new Care Trusts and stated that while medical care could be given free in nursing homes, in most cases it was social care (ie, means-tested charges) that was provided.

In 2003 the Fair Access to Care Services (FACS) guidelines forced every local authority in England to use four standard criteria: critical, substantial, moderate and low to assess and deliver social care. However, local authorities could cut the criteria if they claimed they couldn't afford to provide the services and subsequently most councils only provide for substantial and critical care needs. It was this legislation that stated that dementia sufferers were not eligible for NHS care.

Also in 2003 came the Delayed Discharges Act, whereby local authorities are fined £125 a day for keeping an older person in hospital after the time he/she is deemed fit for discharge – legislation which forces older people back out into the community, often without a suitable support package.

The National Coalition on Charging report in 2008 revealed that 80% of people surveyed, who no longer used care services, said that charges contributed to their decision to stop their support.

Cuts imposed by the 2010 Coalition government and the 2015 Conservative government have forced local authorities to remove services traditionally seen as social care, such as sheltered housing wardens, day centres, luncheon clubs and meals-on-wheels services, or increase the costs.

Almost annual research papers, reviews and commissions have concluded that the social care system is still not fit for purpose. In 2011 the Equality and Human Rights Commission issued a report, 'Close to Home', saying that the abuse and neglect of elderly people in social care was a breach of human rights.

Following a number of incidents in care homes, the Commission for Social Care Inspection (CSCI) was set up but when it published a critical report in 2008 it was disbanded and the Care Quality Commission was set up instead with a budget 30% less than its predecessor.

Despite reports of abuse and neglect, the government set up the Dilnot Commission but instructed that it could only deal with how care would be paid for and that a tax-funded system like the NHS was off the agenda. In 2011, the Dilnot Report proposed that the charges should be "capped" after which government would pay. The Coalition government agreed self-funders would have their charges capped at £72,000. However, the 2015 Conservative government ditched this within two weeks of winning the election.

Anyone with assets including property, above the following thresholds will be liable for all their residential/nursing care costs: England and Northern Ireland £23,250; Scotland £26,000; Wales £24,000. With care home fees from around £800 to £1,200 a week, it is no wonder that 30,000 to 40,000 family homes are sold every year to pay for care. It is estimated that self-funders are now paying up to 40% more for their care.

In addition, almost 1.2 million people are not getting the care they need – a rise of 48% since 2010. This includes: 696,500 who do not get any help and 487,400 who get help but not enough to cover their needs.

Furthermore, a report by the Centre for Research on Socio-Cultural Change (CRESC), entitled 'Where does the money go? Financialised chains and the crisis in residential care' reveals the dubious financial engineering, tax avoidance and complex business models shifting risk from the corporate care home owners to care workers, local authorities and self-funders.

The policy of the National Pensioners Convention is:

- Greater funding for the NHS, an end to privatisation in the health service and a National Care Service funded from general taxation, free at the point of delivery and without means-testing.

Please sign this pledge for #NHSTakeback

We pledge to

1) Honour the founding vision of the National Health Service

- Give back the duty to provide high quality NHS services, open to everyone, to the Secretary of State for Health.
- Make sure the NHS is properly funded, ready to deliver the comprehensive care people need now and in the future.

2) Take private profits out of the NHS

- Get private, profit-making companies out of NHS service provision – bring contracts in house as they come up for renewal.
- Make the NHS an integrated, efficient service – scrap the costly bureaucracy of the internal market and end the 'purchaser/provider' split.

3) Create truly accountable local NHS planning

- Run the NHS as a national, democratically accountable service delivered through regional and local publicly owned NHS bodies.
- Require joint planning with local authorities, with integration of social care and public health into the NHS.
- Establish Community Health Councils to represent the interest of the public in the NHS.

4) Scrap PFI and safeguard NHS assets for the future

- Keep NHS assets and land in public ownership, for the benefit of patients, now and in years to come.
- Save money by stopping any further private financing of the NHS (PFI/PPP), manage existing debts to limit the damage to the public purse.

5) Protect our NHS from global trade

- Make sure no part of our NHS is for sale, now or in the future, as a result of international trade agreements.

#NHSTakeback

Signed by

Green MP

Caroline Lucas

33 Labour MPs

Mike Amesbury
Tonia Antoniazzi MP
Roberta Blackman-Woods
Bambos Charalambous
John Cryer
Alex Cunningham
Marsha de Cordova
David Drew
Paul Farrelly
Ruth George
Mary Glindon
Roger Godsiff
Margaret Greenwood
Mike Hill
Steward Hosie
George Howarth
Mike Kane
Chris Law
Emma Lewell-Buck
Clive Lewis
Kate Osamor
Jared O'Mara

33 Labour MPs (contd)

Laura Pidcock
Faisal Rashid
Paula Sherriff
Eleanor Smith
Alex Sobel
Thelma Walker
Catherine West
Martin Whitfield
Chris Williamson
Mohammad Yasin
Daniel Zeichner

33 Scottish Nat Party MPs

Hannah Bardell
Mhairi Black
Ian Blackford
Kirsty Blackman
Deirdre Brock
Alan Brown
Lisa Cameron
Douglas Chapman
Joanna Cherry
Ronnie Cowan
Angela Crawley
Martyn Day

33 Scottish Nat Party MPs (contd)

Martin Docherty-Hughes
Marion Fellows
Stephen Gethins
Patricia Gibson
Patrick Grady
Peter Grant
Neil Gray
Drew Hendry
David Linden
Angus MacNeil
Stewart McDonald
Stuart McDonald
John McNally
Carol Monaghan
Gavin Newlands
Brendan O'Hara
Tommy Sheppard
Chris Stephens
Alison Thewliss
Philippa Whitford
Peter Wishart

Please sign now or at: www.weownit.org.uk/act-now/nhstakeback-action

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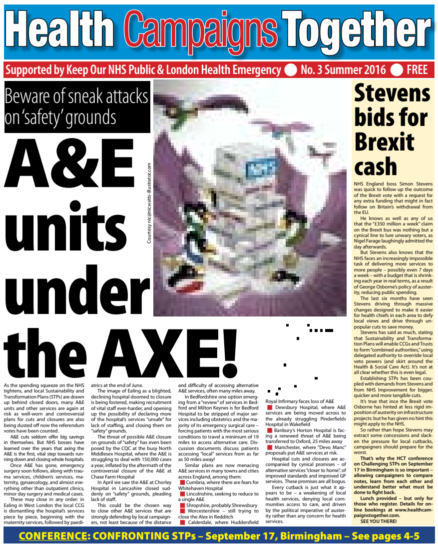

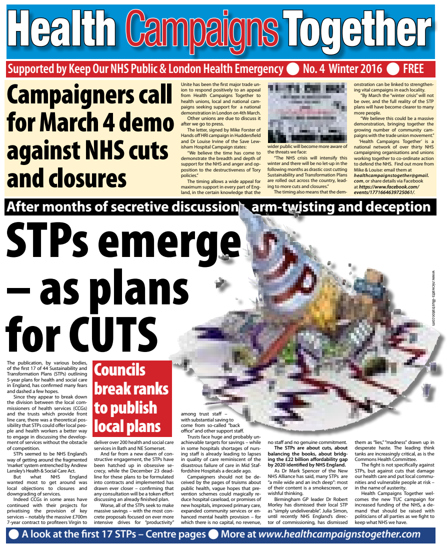

Unions, campaigners, join us!

HEALTH CAMPAIGNS TOGETHER is an **alliance** of organisations. That's why we're asking 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.

We have produced Health Campaigns Together newspaper QUARTERLY in 2017.

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)

- 10 copies £10 (£5 + £5 P&P)
- 50 copies £25 (£15 + £10 P&P)
- 100 copies £35 (£20 + £15 P&P)
- 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.

- 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 28 Washbourne Rd Leamington Spa CV31 2LD.

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