

HEALTH CAMPAIGNS TOGETHER

#OUR
NHS

MONTHLY
ONLINE NEWS
BULLETIN #8
MAY 2021

73rd Birthday protests planned for July 3

Health Campaigns Together is linking up with Keep Our NHS Public, NHS Staff Voices and NHS Workers Say No to organise events on July 3 that celebrate the NHS Birthday and protest at its under-funding. More details soon on the website.



Jess Hurst: reportdigital.co.uk

PAY UP NOW TO REBUILD OUR NHS!

73 years ago on July 5 a Labour government in the war-ravaged British economy managed to invest to create the world's first universal and comprehensive health service, free to all at time of use – the NHS, which all parties now profess to love.

But an unrelenting financial squeeze by Conservative governments since 2010 has reversed all of the improved performance achieved in previous 10 years.

The NHS was on its knees BEFORE the Covid pandemic, with 80,000 vacancies, missing targets and lacking adequate stocks of PPE, ventilators and intensive care beds.

Public health had been slashed to ribbons, and social care locked in crisis.

Now, after ministers squandered billions on private contractors and consultants, failed test and trace and dodgy PPE contracts, the NHS is at crisis point.

■ Waiting lists are at their highest ever level and rising. Waiting times that were limited to 18 weeks are now rising back above 18 months. Thousands more “hidden” cancer and heart patients who avoided visiting GPs and hospitals for fear of Covid will need urgent treatment.

■ Billions are set to flow to private hospitals to treat NHS patients – while thousands of NHS beds lie unused

■ Mental health services, disastrously limited during the lockdown, are under massive



strain: on April 24-25 there was not even one psychiatric bed available in England.

■ The broken, privatised social care system brought countless avoidable deaths in care homes

■ Hospitals are literally falling down and equipment failing as the £9 billion backlog bill for maintenance rockets upwards

■ And with staff burned out from coping with Covid while covering an extra 50,000 covid-related sickness absences, ministers have now insulted them by insisting on a maximum 1% pay rise that would leave all health workers worse off than ten years ago.

Without the recruitment and retention of more staff each year, the NHS is doomed to ever-declining performance, while private hospitals prosper.

Any serious plan for the NHS must include showing proper respect and commitment to staff who have battled to hold the line against Covid-19.

That's why we support the unions' campaign for significant increases in pay, fully funded as part of an investment programme to rebuild and reopen our NHS.

More investment is needed to repair and re-equip hospital buildings, adapting them to reopen closed NHS beds, and reduce the backlog of patients waiting for elective and mental health care.

We need action to roll back the privatisation and market system that have fragmented the NHS and drained resources, and reinstate the NHS as a public service.

Covid-19 has shown us all that this government can create money to invest, and is happy to funnel billions into contracts for its donors and cronies.

There are hints that some extra funding for the NHS may be in the Queen's Speech next week. But it has to be more than a token amount. They must now be forced to break from austerity measures and increase core NHS funding: if not they will stand exposed as the government that wrecked a priceless national asset.

- Pay up for NHS staff;
- Pay up for repairs and expansion;
- Cut out the private profiteers
- Rebuild our NHS!

Health Bill expected, but social care plans pushed back again

The February White Paper, [Integration and Innovation: working together to improve health and social care for all](#) set out plans for a Health and Care Bill, which is expected to be included in the Queen's Speech just after this issue is published.

The White Paper confirmed earlier proposals from NHS England to establish Integrated Care Systems as statutory bodies, with the possibility of including private companies on boards, and to formally merge NHS England and NHS Improvement.

It made no commitment that

the Boards would meet in public, publish their papers or be subject to the Freedom of Information Act.

It did however propose scrapping much of Andrew Lansley's 2012 legislation requiring local Clinical Commissioning Groups to carve up services into contracts and put them out to competitive tender.

While on one level this is a welcome retreat from the ideological obsession with competition and markets in health care, only a small minority of contracts are currently subject to competitive tender,

since NHS England has switched to framework contracts which allow purchasers to choose from a list of pre-approved providers.

The new ICSs will also bring new openings for private contractors.

The White Paper made other proposals that were not requested by NHS England, including increased powers for the Secretary of State to intervene on local issues, abolition of local rights for councils to refer controversial plans to the Secretary of State, and abolition of the Independent Reconfiguration Panel.

However despite the fact that no

health care reform could possibly work effectively or be properly integrated without changes to the dysfunctional privatised social care system, the White Paper was largely silent on the issue, and Boris Johnson has once again decided to [postpone any proposals](#) for change.

When Johnson came to power in the summer of 2019 he promised to ["fix the crisis in social care once and for all."](#) Last month it was "highly likely" that his plan would be in the Queen's speech on May 11, but since then he has had some decorating to do.



Jess Hurd: reportdigital.co.uk

Fighting US takeover

Keep Our NHS Public and We Own It campaigners were joined last week by Jeremy Corbyn and other MPs to protest the take over of 50 GP surgeries by private company Operose, owned by US health company Centene.

Operose now owns GP practices delivering NHS services for over 500,000 people in England.

A main protest was staged outside Centene's subsidiary offices, Operose in London on Thursday 22 April 2021. This socially distanced protest was attended by Jeremy Corbyn MP and Apsana Begum, MP for Poplar and Limehouse.

A total of **11 protests were held**, many of them outside of the surgeries affected by the take-over, to make patients aware of the change.

£102bn investment needed – but who should pay?

A major new inquiry report on the [future of the NHS and social care](#) calls for an increase of £77bn in NHS spending and £26bn in social care spending over the next ten years.

But [the report](#) also flags up the need for urgent action on serious staff shortages – and opposes the planned reorganisation of the NHS that is likely to be announced in a Health Bill in the Queen's Speech.

The Commission established by the London School of Economics and the Lancet back in 2018 to mark the 70th Birthday of the NHS, includes 33 academics and health experts, and has taken three years to come up with proposals that campaigners will find unsurprising.

Indeed many will question the wisdom or achievability of the proposal to raise the equivalent of a 4% per annum increase in health and care spending through income tax, national insurance and VAT – especially given that the Johnson government has [explicitly rejected](#) income tax increases, and NI and VAT



are both regressive taxes falling more heavily on those with lower incomes.

There are not even [Biden-style proposals](#) to get the billionaires and big business to pay their fair share, or to tackle tax-dodging multinationals or tax speculation and stock market transactions.

The Inquiry shows that while in theory the world's fifth largest

economy the UK ranks 9th on share of GDP on health spending and 13th on actual health spending per head.

Calling for more focus on the welfare of NHS staff, it implicitly supports trade union demands for increases NHS pay, noting the failure to increase NHS staffing to meet growing demand for care: "Despite increasing demand, the number of nurses per 1000 people has hardly grown across each constituent country over the past decade" Indeed "the number of mental health nurses decreased by 8% in England between 2010 and 2020."

And it makes clear its opposition to legislation to reorganise England's NHS into 42 "integrated care systems":

"This Commission ... rejects any calls for reorganisation of the NHS on a large scale. Past experiences have taught us that reorganisation on a large scale is often a disruptive process without any evidence of benefit.

"We argue instead that the

foundations of the NHS can be strengthened through further investment and integration of pre-existing operational institutions."

A more detailed analysis of the report will appear in the next [Lowdown](#).

In the meantime why not check out the simpler, bolder plan HCT published a year ago?



A Rescue Plan

2020 vision for a post-Covid NHS

A draft for discussion and action

Covid bed closures worsen waiting times

Tackling the second wave of Covid-19 infection in January and February of this year halved the numbers of patients admitted for routine treatment – [down 54% in January](#) and 47% in February compared with the previous year.

This further contributed to the lengthening waiting times for treatment, according to the most recent figures.

Year-plus waits, reduced to a rarity by investment in the 2000s, have increased 240-fold in a year, to 388,000 in February ... compared with 1,613 the previous February.

Waiting lists had grown to record numbers, soaring above 4 million, and were rising before the pandemic struck.

The target for 92 per cent of patients to begin treatment with 18 weeks of referral from their GP has

not been hit for five years.

The queue is now 4.7 million strong and likely to rise further as [up to 6 million people](#) who have delayed seeking treatment for fear of Covid infection begin to emerge once again.

Beds closed

However bed numbers, reduced to dangerously low levels before the pandemic, plunged by an unprecedented rate in 2020 as infection control measures forced thousands of closures and remaining beds to be left empty.

While front line [general and acute bed numbers](#) reduced by 6% from 2010 to 2019, from 108,023 to 101,598, they fell a further 9% to 92,559 in Quarter 1 of 2020-21.

They only partially recovered in Quarter 3 to 95,649, 6% below the



previous year.

And fewer of the reduced numbers of beds have been occupied, resulting in a large drop in numbers treated: there was a 38% reduction in numbers of [general and acute beds occupied](#) to just 58,000 in Quarter 1 of 2020-21 compared with the previous year, and a 15% reduction to 79,520 in Quarter 3.

Mental health services were also hit, with a reduction of almost 11%

in beds occupied.

Now continued under-funding, ministerial denial of the scale of the problem, mean that waiting times are set to increase further, and there will be no real reduction of the waiting list for years.

Meanwhile NHS England's decision to spend up to £10 billion on NHS patient care in private hospitals raises doubts over how many of the closed and empty NHS beds will reopen.

Top trusts focused ... on boosting private income

Waiting lists are soaring, with NHS hospitals warning it could take years to clear the backlog of elective surgery that has built up during the Covid lockdown.

But the attention of some trust bosses is on very different issues, and not on the NHS at all.

Hot on the heels of our report in the last issue on [Oxford University Hospitals](#) FT seeking private partners to expand their private patient income, another prominent Trust is opening of a [new diagnostic and treatment centre](#) in central London.

London's Royal Marsden NHS Foundation Trust has opened a new Cavendish Square centre which will "initially" treat both NHS and private patients.

But it's primarily aiming to offer a Rolls Royce service to the minority with the money to pay, including the "worried well," while thousands of NHS patients are facing long delays in accessing cancer care.

RMH Private Care is already the UK's [most lucrative NHS Private Patient Unit](#). According to LaingBuisson, on average roughly 30% of its patients are from overseas, but this is expected to increase to around 40% at the new site.

The Financial Times reports that the Trust earned £132.6m



from private patients in the year to March 2020: "income from private patients now accounts for [36% of the trust's patient revenue](#), and 29% of total revenues."

LaingBuisson analyst Ted Townsend told the FT that fees from private patients "offer a more consistent source of income compared to ... an under-pressure NHS funding regime".

The Trust of course assures us that the new centre will "contribute to the financial sustainability of The Royal Marsden", and that revenue generated from Private Care is "reinvested back into the NHS



Foundation Trust".

But even if some of the money does eventually returns to the NHS, scarce staff and valuable management time are still being devoted to private patients, while NHS patients wait longer for care.

THE Lowdown

Regular fortnightly evidence-based online news, analysis, explanation and comment on the latest developments in the NHS, for campaigners and union activists.

The Lowdown has been publishing since January 2019, and FREE to access, but not to produce. It has generated a large and growing searchable database.

Please consider a donation to enable us to guarantee publication into a third year. Contact us at nhssocres@gmail.com

● Please send your donation by BACS (54006610 / 60-83-01) or by cheque made out to NHS Support Federation, and post to us at Community Base, 113 Queens Road, Brighton, BN1 3XG.

Visit the website at: www.lowdownnhs.info

The Lowdown
NHS imaging: national privatisation threat

Imaging networks could be completely handed over to private firms

Guidance [recently issued by NHS England](#) could lead to entire networks of diagnostic imaging services being run by the private sector.

NHS trusts have until 2023 to set up separate entities to run their diagnostic imaging services as part of a reform of diagnostic services.

NHS England [notes in the guidance](#) that the networks will be “significant operating businesses in their own right”, and must have a “degree of autonomy” and “separation from the trusts”.

NHS England has given the trusts seven options for setting up a [network](#), one of which is “outsourcing” of the entire network to a commercial partner, which is marked in its [guidance](#) as one of the only two “highly feasible” options, alongside “collaboration” between two or more NHS trusts.

The document acknowledges that government funding is the cheapest way of funding new equipment, but stresses that competition for central funding may mean that the new networks have to look at more expensive options like leasing.

Clinicians discussing the document on social media fear more control for private companies will undermine the professional standards of NHS care. [One](#) consultant radiologist said:

Training

“I have major concerns about the risks to training under commercial entities which is simply forgotten or ignored because there is no money to be made from training. I have seen this first hand from existing models of privately delivered imaging.”



England’s diagnostic services have been in need of reform and investment for many years. There has been a significant increase in demand over the last decade, with more attendances at A&E and more referrals from GPs.

Lack of investment over the previous decade has led to the NHS in England [lagging far behind the OECD averages](#) for scanners (CT, MRI and PET-CT) per million population, ranking lowest among 23 countries for CT scanner provision and 19th out of 21 for MRI equipment.

Professor Sir Mike Richards was commissioned by NHS England to review diagnostic services and make recommendations for reform.

A major component of his [2020 report](#) was that major investment is needed if diagnostic services are to recover from the effects of the pandemic and the years of underfunding. But no additional funding has been made available in the recent budget, which leaves the NHS starved of capital.

The report also recommends expanding the NHS’s pool of scanners and other diagnostic equipment, buying in bulk to get good deals.

A history of outsourcing

In the [NHS Support Federation’s](#) annual review of privatisation in the NHS, diagnostics services were often in the top three for numbers of outsourced contracts.

A good example is the two phase procurement procedure for PET-CT diagnostic imaging services begun in 2014.

In late 2014, NHS England selected the Molecular Imaging Collaborative Network (MICN), led by the private company Alliance Medical, to provide PET-CT scanning services across 30 locations in England.

The phase II round of

procurement in 2018 gave a large contract to InHealth in the Thames Valley, triggering a major scandal in [Oxford](#).

Framework

Private companies are also listed on a number of framework agreements covering many aspects of diagnostic services, such as [teleradiology services](#), endoscopy, and [MRI scans](#).

The most recent is the November 2020 framework contract [NHS Increasing Capacity](#) worth in total £10 billion, which runs until November 2024.

This covers both elective surgery and diagnostics. Included on it are companies, such as InHealth, Alliance Medical, Medical Imaging Partnerships Ltd and Mediscan Diagnostic Services.

In community health, many CCGs have for several years outsourced diagnostics to private companies.

InHealth alone has 100 community diagnostic sites across the country where patients are sent for diagnostics by their GP under agreements between the company and CCG.

One such agreement was signed [in March 2019 by NHS Ealing](#) with InHealth to provide community radiology services.

In February 2021 it was widely reported that the leaked government white paper contained plans to do away with competition in the NHS.

This was interpreted by some to mean also a move away from privatisation.

This latest Guidance from NHS England, however, shows that privatisation is still an approved option that NHS trusts are being encouraged to take.

● (This article is abridged and adapted from a fuller [article in The Lowdown](#))

THE PEOPLES ASSEMBLY

NATIONAL DEMONSTRATION

AFTER COVID DEMAND A NEW NORMAL

DEMONSTRATE SATURDAY 26 JUNE

ASSEMBLE: 12PM OUTSIDE BBC, PORTLAND PL, LONDON

**RENATIONALISE KEY SERVICES • DECENT HOUSING FOR ALL
SACK THE CORRUPT POLITICIANS • PROPERLY FUNDED, FULLY
PUBLICLY OWNED NHS • END THE MARKETISATION OF EDUCATION
ACT NOW! TACKLE THE CLIMATE EMERGENCY
SAFE WORKPLACES, SAVE JOBS • END FIRE AND REHIRE
FULLY FUNDED SOCIAL CARE • END INSTITUTIONAL RACISM
KILL THE POLICE, CRIME, SENTENCING AND COURTS BILL**

THE PEOPLES ASSEMBLY **FIND OUT MORE: THEPEOPLESASSEMBLY.ORG.UK**



Monumental failure: Stevens in London's barely used Nightingale Hospital

Exit Stevens, but who will be next to take over?

NHS England chief executive Sir Simon Stevens' announcement he is to [stand down in July](#) after 7 years in charge has triggered discussion on his likely successor.

He will leave an NHS missing many of its [key performance targets](#) and mid-way through a controversial reorganisation.

Stevens' record is discussed in more detail in [The Lowdown](#), but the amount of spending on private providers has [clearly increased](#) under Stevens' watch, even if this was more to do with the operation of Andrew Lansley's 2012 Health and Social Care Act than NHS England.

In the last few years framework contracts established by NHS England have also speeded and eased contracting out by establishing pre-approved lists of providers, and the Long term Plan advocated increased use of private hospitals to deliver NHS funded care to limit waiting times.

Many of Stevens' big ideas have fallen flat. Looking back at the 2014 Five Year Forward View is like stepping into a museum of discarded priorities, not least personal health budgets.

Decline

Stevens and his team must also share the blame for constantly focusing on reorganisation rather than addressing the decline in performance of NHS services since he took the top job in 2014.

Had he performed on a similar level as manager of a Premier League football team or many private businesses he would have been out on his ear several years ago.

Now the debate is beginning over who might be able to fill

Stevens' shoes.

One of the front runners, [Mark Britnell](#), is also a one-time NHS senior manager who jumped ship – from NHS Director of Commissioning – to the private sector back in 2009.

Cameron

After 12 years in high-flying posts with management consultants KPMG, Britnell has political form as a former [kitchen cabinet advisor](#) to David Cameron, and is embarrassingly on record as arguing against the principles of the NHS.

In 2010 he gleefully told a private equity conference in New York:

"GPs will have to aggregate purchasing power and there will be a big opportunity for those companies that can facilitate this process ... In future, the NHS will be a state insurance provider, not a state deliverer."

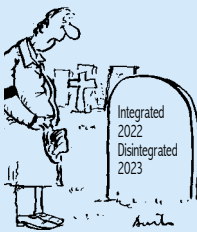
In words that will no doubt be quoted again and again if he gets the

NHS England job he added:

"The NHS will be shown no mercy and the best time to take advantage of this will be in the next couple of years."

He went on to argue for models that break from the NHS principle of care free at point of use in a [Health Service Journal article in 2011](#), insisting that "countries that have a mixed blend of public and private provision, co-payment and social insurance are possibly more capable of providing resilient healthcare systems."

If Britnell decides to go for the job we can expect him to try to distance himself from these earlier views: but could Simon Stevens' replacement have us looking back on his era as the good old days?



PEOPLE'S COVID INQUIRY

MEET THE THE PANEL



Michael Mansfield QC
Chair of panel
Internationally renowned
human rights lawyer



Professor Neema Modi
Professor of Neonatal
Medicine, Imperial College
London



Dr Tolullah Ori
Urban Epidemiologist & Public
Health physician at the
Medical Research Council
Epidemiology Unit, University
of Cambridge



Dr Jacky Davis
NHS consultant radiologist,
author and BMA council
member (PC)



Lorna Hackett, Barrister
Counsel to the Inquiry
Hackett & Dabbs LLP

Learn lessons, save lives: www.peoplescovidinquiry.com

Asking the hard questions



SESSION 6 on Inequalities and discrimination took place at 7pm on Wednesday 5 May

Podcast version [HERE](#)

The devastating differential impact of Covid and the pandemic on BAME people came as a shock but not really a surprise.

Even prior to the pandemic there was strong evidence that racism, unequal education, job and economic opportunities, housing and access to healthcare affected the health of people in BAME communities unequally.

The Covid pandemic and the

role of key workers who carried on working, who could not work at home, and who kept the transport, health, and other services going, compounded all of these issues for BAME people and were reflected in the illness and death rate.

The impact of Covid has fallen differentially on women in many important ways.

Our inquiry asked if there was any serious appraisal of risk for sections of our society who experience inequalities and discrimination?

Witnesses were

Mary-Ann Stephenson, Director, Women's Budget Group
Kamlesh Khunti, Professor of Primary Care Diabetes & Vascular Medicine, University of Leicester, member of government advisory body SAGE, Chair of SAGE Ethnicity Sub-Group and member of Independent SAGE

Dr Latifa Patel, British Medical Association (Personal Capacity), and **Aliya Yule**, Migrants Organise

Coming sessions

SESSION 7 | 19 MAY:

PROFITEERING FROM THE PEOPLE'S HEALTH?

Opening address: **MICHAEL ROSEN**

Witnesses:

Prof David McCoy, Centre for Health & the Public Interest and QMUL;

Dr David Wrigley GP in Carnforth Nth Lancs, deputy chair of BMA, co-author 'NHS for Sale', 'NHS SOS';

Caroline Molloy, editor ourNHS/openDemocracy;

Michelle Dawson, NHS consultant anaesthetist and trustee Healthcare Workers' Foundation charity

SESSION 8 | 2 JUNE:

IMPACT ON THE POPULATION #2: SCHOOLS, CHILDREN & YOUNG PEOPLE and MENTAL HEALTH

16 JUNE: CONCLUDING SESSION |

WHERE DID THE MONEY GO? WHAT MUST HAPPEN

Commission reports on 4,000 deaths – but no comment from Ontario premier

As of May 5 Ontario Premier Doug Ford had not responded even virtually, to the Long-Term Care Commission Report his government had set up.

His Minister of Long-Term Care belatedly allowed journalists, but there has been no apology or meaningful acknowledgement of the failures that allowed — even facilitated — the deaths of thousands in long-term care.

The Ford government's response has deeply offended and angered families, residents, care workers and their organizations.

"Ontarians are outraged, and so are we. It is the most visceral wave of anger that we have ever seen," reported Natalie Mehra, executive director of the [Ontario Health Coalition](#) (OHC) who has heard from hundreds of irate Ontarians watching the government's response.

"It is a total failure in leadership. Leaders in the Ford government have shown absolutely no conscience and have refused to apologize. Throughout the pandemic and now as the reports on the terrible lack of care and inadequacy of their response have come in, the Ford government has still has not committed to act



urgently to fix the terrible lack of care in long-term care."

The Ontario Health Coalition has released its summary and analysis of the Commission's report and recommendations highlighting the strongest recommendations, those that are problematic — particularly with regards to privatization — and a call for urgent action.

Almost 4,000 long-term care residents and staff have died as a result of COVID-19 so far, many in conditions that are so harrowing they have left caregivers and families traumatized.

Untold numbers have died of malnutrition, dehydration, isolation and neglect during the pandemic.

Tens of thousands of others involved in long-term care have been harmed— among those many who will not recover.

While the OHC supports many of the recommendations of the Commission, they do not support them all. Its [summary of the report](#) warns that:

"In a number of areas, the Commission has adopted wholesale recommendations without critical analysis. Many of these recommendations appear to have been made to the Commission by health provider companies themselves who have their own set of vested interests and the perspectives."

US: 8-week strike for safe staffing by Mass. nurses

800 nurses have been [on strike for 8 weeks](#) against a major hospital corporation in Saint Vincent Hospital in Worcester Massachusetts, demanding increased staffing levels.

The hospital is part of Tenet Healthcare, a major Dallas-based company.

The strike came after negotiations for a new union contract had dragged on since November of 2019 including 32 sessions between the parties. The nurses voted overwhelmingly on Feb. 10 to authorize the strike, which began at 6 a.m. on March 8.

Tenet has only met with the Massachusetts Nurses Association once since then, and their minimal



offer was rejected as insufficient.

The union is demanding a [4-1 patient-to-nurse ratio](#) on medical/surgical floors, but also wants more emergency department staffing and more nurses to help with urgent and critical situations on the medical/surgical floors.

Tenet recently reported [more than \\$97 million in profits](#) and revenues in excess of \$4.7 billion for the first quarter of the year, following the posting of \$400 million in profits for 2020.

They could well afford to implement the MNA staffing proposal that could end this strike if they simply spent the \$45 million they are believed to have already spent to prolong the strike on the proposed staffing improvements the nurses are seeking. The [union's aim](#) is to put staffing standards on a par with other hospitals in Worcester and across the state.

[Photo collage is from <https://forms.massnurses.org/we-stand-with-st-vincents-nurses/>]

Despite the fact that the Commission pressed as the top priority the need to fast-track increases in staffing to reach a minimum standard of 4-hours of care, the Minister has not announced any such plan. The policy decision of the Ford government has been to delay this increase in staffing and care until 2024-25.

"The Ford government continues to demonstrate that it is entirely captured by the priorities and interests of the for-profit corporations in long-term care with which they have very close ties," reported Ms. Mehra.

"They do everything for the for-profits and have done nothing substantive to improve care for residents and conditions for staff which remain worse than before the pandemic. It is appalling."

Homes for profit, not for care

According to the Ottawa Citizen, 360 out of 623 Long Term Care homes in Ontario are for-profit, [about 58 per cent](#), the highest proportion in Canada.

Over the past 10 years, three of the largest for-profit nursing home operators in Ontario paid out more than \$1.5 billion combined in dividends to shareholders.

Yet there is plenty of evidence that residents in for-profit homes fare more poorly than those in not-for-profit homes.

A 2015 study found that residents in for-profit homes had a 10 per cent higher risk of dying and a 25 per cent higher risk of hospitalization. For-profit homes were also twice as likely to be in the lowest-performing 20 per cent of long-term care homes.

A study published last August found that in homes that had Covid-19 outbreaks, for-profit homes had 78 per cent more deaths. About 86 per cent of COVID-19 infections occurred in only 10 per cent of Ontario's long-term care homes.

By contrast not-for-profit homes have lower excessive use of antipsychotic medications, lower restraint use and fewer hospital admissions and ER transfer. Homes run by municipalities, another part of the non-profit sector, have also performed relatively well.

Union battles IN BRIEF

Unite calls for consultation on single blood centre plan for ICS

Unite the union is calling for a proper public consultation on the merits of a new mega centre to analyse blood samples from Lancashire and South Cumbria, as the proposal will mean longer waiting times for patients to get their results.

Unite argues that the only rationale for concentrating the laboratory services from four NHS trusts in one place - currently Samlesbury in South Ribblesdale is the favoured candidate - is to sell it off to the private sector.

The Lancashire and South Cumbria Pathology Collaboration has failed to consult either the public or the region's GPs, and all dissenting voices have been shut out of the discussions. The hospital consultants are also against the plans.

Unite, which represents about 600 biomedical scientists who would be affected, claimed that already up to £3 million of taxpayers' money had been spent on staff to manage the proposed new centre, but absolutely nothing was happening, and a proper transparent review of the plans is urgently needed.

Unite said that about 1,500 staff working for the four trusts would be affected.

The trusts are:

■ Blackpool Teaching Hospitals NHS Foundation Trust;
■ East Lancashire Hospitals NHS Trust;

■ Lancashire Teaching Hospitals NHS Foundation Trust;
■ and University Hospitals of Morecambe Bay NHS Foundation Trust.



George Eliot subco plan: you couldn't make it up!

By a special correspondent

Many campaigners remember the privatisation of Hinchingsbrook Hospital. It was claimed far and wide as the answer to turning around a hospital which had posed problems for years.

But after awards were handed out the truth emerged. The whole saga was a total failure, and the many claims were bogus. The whole exercise was rigged and better NHS solutions were not properly considered.

But when the privatisation model was still being pushed, [George Eliot Hospital](#) in the West Midlands also tried to go down that route.

Despite confronting a dishonest and intransigent management at GE the trade unions and campaigners once more won the day and the whole deal fell through; other solutions were found. You would have thought someone would learn - but no.

Management at George Eliot along with partners in South Warwickshire are back on the [privatisation/outsourcing bandwagon](#).

Yet again we have management trying to transfer staff out of the NHS into some dodgy subco so the Trust can get tax advantages. Many thought we had seen the end of that saga too. Much-vaunted schemes at [Bradford](#) and [Frimley](#) were both successfully resisted by the trade unions despite massive pressures from NHS management.

Yet again we have management refusing to abide by their legal duties under the NHS Constitution. They refuse to consult over plans or to have any meaningful discussions



over what exactly the problem is that having a subco will solve. The decision is made, and staff are then 'consulted' over the details of the transfers.

Once again management refuse to provide vital information such as the options appraisal and the business case, with absurd claims that the information in these is somehow 'commercially confidential'. At trusts after trust, including Bradford and Frimley management were eventually forced to disclose the information.

Appalling management

With such an appalling approach by management it sadly looks likely that the subco plans will have to be confronted by industrial action.

Staff resent being told they will be better off outside the NHS, that they are no longer part of the team - not like doctors or nurses.

Setting up a subco or changing an existing one requires consent through a process overseen by NHSE/I. That process was tested at Bradford and Frimley and found to be utterly unfit for any purpose; it is

supposedly being revised (again).

In a sane world the politicians and the senior management at NHSE/I would stop this. The Queen's Speech will include controversial legislation which it is claimed moves away from the Lansley approach of markets/competition/outsourcing (Health & Social Care act 2012) and goes back to the days when the different bits of the NHS all worked together not against each other.

We are told there will be collaboration and solutions within Integrated Care Systems in the best interests of the population not petty squabbles, cost cutting and fragmentation. So why allow this selfish and insular proposal to even see the light of day?

Despite more than 5 years and many models the case for these subcos remains completely dishonest.

They do not improve services to patients, do not make recruitment and retention easier, do not allow efficiencies that can't be got any other way, do not generate income by selling services outside the NHS, nor do they magically improve how staff are managed.

All they do is allow cost cutting by worsening terms and conditions for staff and by tax fiddles - and the tax fiddles are likely soon to be blocked.

Just STOP!

NEXT ISSUE

Our next issue of the monthly bulletin will be in June. Please get any articles, photos, tip-offs or information to us no later than JUNE 7.

Lancs lab strike looms

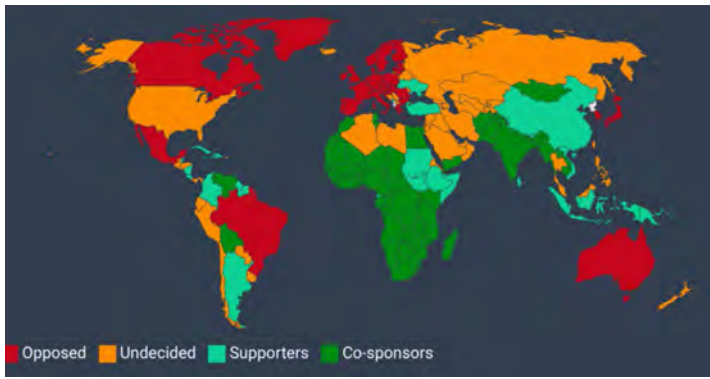
The accident and emergency department at the Royal Blackburn Hospital will close at night and weekends if biomedical scientists stop doing night, weekend and late shifts as part of a [month-long strike](#) action after 'bad faith' by bosses who reneged on an upgrading pay agreement.

The scientists have been on the frontline of Covid-19 testing at a Lancashire NHS trust,

Unite the union said its 21 members working for East Lancashire Hospitals NHS Trust

were owed back pay of up to £8,000, as managers had failed to honour an agreement to upgrade them from band 5 to band 6 on the Agenda for Change (AfC) scale. The back pay issue goes back as far as 2010 for some members.

The scientists, who analyse patient blood samples at Blackburn Hospital and Burnley General Hospital voted by a majority of 85 per cent for strike action, and will strike continuously from Friday 7 May until Friday 4 June.



Unions call on UK to follow Biden stance on vaccine

[Public Services International](#), the global alliance of public sector unions, has welcomed the announcement by the Biden administration of support for a suspension of intellectual property rights for Covid-related vaccines, and to “participate in text-based negotiations at the World Trade Organization (WTO).”

The decision from the Biden administration comes on the back of immense efforts by a range of organisations, including PSI affiliates and the trade union movement across the world.

Since October 2020, PSI has been demanding rich countries agree to the TRIPS waiver and share the vaccine, and other health products, such as diagnostics, PPE, and upcoming medicines.

More countries are likely to follow the line of the USA government. Only a few hours after the US announcement New Zealand which, decided to support the vaccine waiver, and the European Union for the first time said it was ready to discuss the “US proposal for a waiver for Covid-19 vaccines”.

It’s time to urge the British government as well as the EU, Switzerland, Australia, Japan, Brazil and Norway to follow suit.

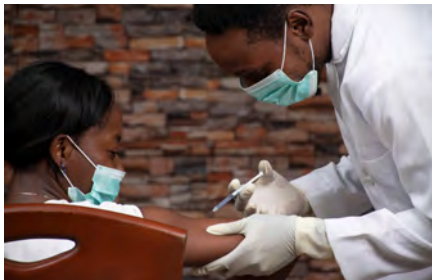
Across the world, frontline workers are making huge sacrifices

to save lives while people grow furious at vaccination delays.

Rich countries have been putting big pharma’s profits ahead of ramping up vaccine production.

PSI General Secretary Rosa Pavanelli says:

“The waiver has already been delayed too much and the actual text of the waiver will only now come under scrutiny. We need the negotiations to be speed up and we need a strong outcome.



“A strong waiver that is not only about vaccines, but also about up-coming medicines, a strong waiver that will create pathways for generic versions of existing vaccines to be produced, a strong waiver that lasts for as long as the pandemic lasts, a strong waiver that is practical to use for countries that decide to do so”.

Stop blocking wider production of a #PeoplesVaccine.

Choose people’s health over pharma profits!

Support #TRIPSWaiver

HEALTH CAMPAIGNS TOGETHER

It’s sleaziness as usual for Tories as Cameron scandal links to Covid cronyism

A growing list of NHS leaders have joined Matt Hancock, the Secretary of State for Health and Social Care, as components in the lobbying scandal that has engulfed the government over the past few weeks.

David Cameron, along with Lex Greensill and colleagues, lobbied Matt Hancock to adopt Greensill’s Earnd app, which would have allowed doctors, nurses and other personnel to be paid daily rather than monthly.



A contract was subsequently awarded without tender or an open process within the NHS.

The [Sunday Times](#) and various other media have revealed that David Cameron organised meetings between Lex Greensill and various top people in the NHS, including Mr Cameron bringing Greensill to a “private drink” with Matt Hancock in October 2019.

The Conservative peer, [David Prior, chair of NHS England](#), a former Tory MP, health minister and Tory party deputy chair, also played a role, organising a meeting between Lex Greensill, his colleague Bill Crothers (an ex-head of government procurement under Cameron), and Julian Kelly, NHS England’s chief financial officer, in July 2019.

Lord Prior also helped to facilitate a meeting at which Lex Greensill was able to lobby Dido Harding, the Tory peer previously in charge of test & trace and now chair of NHS Improvement, the health service’s financial regulator.

Following the lobbying, Greensill launched a partnership with NHS Shared Business Services which allowed up to 400,000 NHS staff to be paid daily.

However, eventually only 450 staff were reported to have used the app and both Greensill and Earnd went into administration in March 2021.

The awarding of the contract for the Earnd app to Greensill took place before the pandemic hit, when contracts still had to be put out to competitive tendering. Despite this Greensill was awarded the contract without any competitive tender process.

It is now clear that billions of pounds worth of contracts were handed to companies with links to Conservative donors, and according to [Transparency International](#) one in five of the contracts awarded between February and November last year raise red flags on possible corruption.

Legal action is now underway by [The Good Law Project](#) over what it has described as “pork barrel” politics, a term from the US to refer to the act of exchanging favours to constituents or business persons for their political support such as re-election or campaign support.

● This article has been adapted and abridged from [The Lowdown](#).

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 national NHS CAMPAIGNS opposing cuts & privatisation
- 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.
- You can sign up online, and pay by card, bank transfer or by cheque – check it out at <https://healthcampaignstogether.com/joinus.php>**