HEALTH CAMPAIGNS TOGETHER
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Furious NHS bosses see hospital bids binned

Angry and frustrated NHS managers in 123 trusts trying to deliver services in crumbling hospitals have been told that the time and effort they invested in drawing up bids to be one of just eight schemes to be funded has been wasted.

128 projects – from almost two thirds of all trusts in England – were submitted. But just **FIVE** schemes, not the promised eight, have been given the go-ahead: and all five are among the 14 hospitals built using reinforced autoclaved aerated concrete (RAAC) and in growing danger of collapse.

The five hospitals are **Airedale** in West Yorkshire, **Queen Elizabeth** King's Lynn in Norfolk, **Hinchingbrooke** in Cambridgeshire, **Mid Cheshire Leighton** in Cheshire and **Frimley Park** in Surrey.

NHS England states: "This is on top of two of the worst affected hospitals - **West Suffolk Hospital** in Bury St Edmunds and **James Paget Hospital**

Continued page 3

Thousands of metal props hold up QEH Kings Lynn until it's eventually rebuilt

INSIDE

NHS at 75: facing its greatest danger

The National Health Service will reach its 75th Birthday on July 5. It remains a precious lifeline for the population as a whole, largely thanks to the increasingly valiant efforts of its 1.26 million staff, who have defied the odds to keep services going despite government policies.

But with just a couple of weeks to go to the anniversary, the revelation of a record 7.42 million on the waiting list is a stark reminder of how far its performance has fallen.

When David Cameron's Tory-led coalition took office in 2010 the NHS was reaching a peak of performance, with record low waiting times for elective and emergency care, and record high levels of performance and public satisfaction. These are now a distant memory.

The target for 95 percent of people in A&E to wait no more than 4 hours has not been met since 2015: the 92 percent target for patients to wait no more than 18 weeks was last achieved in 2016. Cancer services have been missing targets since 2015.

All of these services were in decline well **before** the Covid pandemic: by December 2019, when Boris Johnson won a landslide majority (with empty promises of increased NHS spending and 40 new hospitals) the waiting list was **double** the 2010 level, at 4.5 million.

13 hard years of austerity and cuts in public health and prevention have undermined the health of communities, while real terms spending cuts, bed closures, soaring numbers of vacant posts and a continuing crisis in privatised social care have limited NHS capacity.

Prime Minister Rishi Sunak – focused on maximising NHS use of private hospitals

Fragmented

So-called "reforms" in England's NHS in 2012 were focused on forcing more services to be contracted out to profit-seeking private providers. Its massive and costly reorganisation fragmented services, undermined the finances of NHS trusts, boosted spending on private contractors, not least by privatising more and more mental health services, despite the often poor quality of private sector provision.

Subsequent "reforms" have carved England's NHS into just 42 "Integrated Care Systems", led by Integrated Care Boards that are answerable only **upwards** to ministers, not to local communities they are supposed to serve.

They were established last July, and have remained locked in financial crisis, seeking impossible levels of "savings" to balance their books, and are now refusing to reveal where cutbacks totalling tens of millions will fall.

The Sunak government has ignored stark warnings from emergency specialists, cancer specialists, mental health specialists and many more that services are in a dire state and in need of investment.

But instead ministers are now focused on finding ways to compel more NHS bodies to make more use of private hospitals – the so-called "independent sector" that is dependent on NHS-funded patients for their profits.

And ministers are widely predicted to make staffing shortages even worse by using the NHS birthday to announce a pathetic 'workforce plan' grudgingly funded by just £1 billion over 15 years – equivalent to just £60m per year.

If this situation is allowed to continue, more qualified staff will leave the NHS burnt out and demoralised, piling even greater pressure on those left behind trying to hold services together.

Yet again a ruthless Tory government has vandalised the NHS, leaving it in an even worse state than they did in1997. They are stuck on policies that have been proved to fail.

It's high time for a clear alternative to be spelled out well ahead of the next election, based on a firm commitment to pump in an emergency injection of £20bn and **commit to a decade of real terms spending increases** to repair the damage that has been done.

They need to stop squandering cash on outsourcing, bring private contracts back in-house and build back the capacity for the NHS to once again match and exceed the performance it delivered in 2010.

As well as recruiting and training more staff, urgent measures are needed to retain and support the existing NHS workforce by improving working conditions – and by restoring the full value of all the salary scales established back in the 2000s.

Health Campaigns Together, Keep Our NHS Public and SOS NHS stand ready to fight for these policies and support politicians bold enough to put them forward.

The greatest danger to the NHS means we need the boldest answers if we are to rescue it.

NHS plight in numbers – page 2
Private sector can't solve waiting list crisis – see inside page 6

Plight of today's NHS in numbers

Waiting lists

7.42m
April2023 total of patients waiting for elective NHS treatment in England

371,111
patients waiting more than 52 weeks,

11,477
patients waiting more than 78 weeks (18 months)

92%
of patients should be treated within 18 weeks

58.3%
ACTUAL proportion of people waiting less than 18 weeks

13.8 weeks
average waiting time, almost DOUBLE 7.2 weeks in April 2019

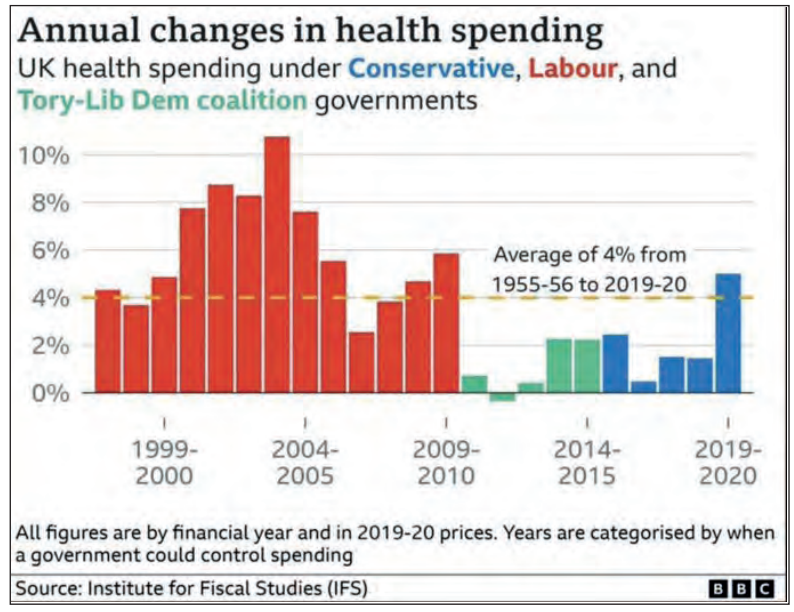
Emergencies: fewer Type 1 admissions than before pandemic, but vastly more delays

	May 2011	May 2019	May 2023
Type 1 A&E attendances	1.22 million	1.33 million	**1.4 million**
Type 1 emergency admissions	299,961	406,065	**388,202**
Total emergency admissions	427,277	547,382	**529,000**
Trolley waits over 12 hours	**3**	**416**	**31,494**

Health spending per head

Country	Spend per capita $	% UK
Germany	7383	+37
Switzerland	7179	+31
Netherlands	6753	+25
Sweden	6262	+16
France	6115	+13
UK	**5387**	

Latest comparative figures from OECD (NB 2021 or latest available, so all figures rather distorted and inflated by Covid spending)



Primary care since 2012

42%
FEWER district nurses

30%
FEWER health visitors

23%
FEWER Learning Disability nurses

25%
FEWER school nurses

2000
FEWER GPs than 2015

7%
INCREASE in population

12%
DECREASE in real terms funding for GP services

20%
INCREASE in workload

31 million
GP appointments March 2023

70%
of them face to face

SUNDERLAND & DISTRICT KONP: SAND SCULPTURE
Wednesday 5 July,
SALTBURN BEACH
10.30 am (to fit in with tides) – will take 90 minutes.
TEA PARTY
Sunderland Minster 3-4pm

A local architect and art project company Infinite Arts (https://www.infinitearts.co.uk/) designed the sand sculpture which we created for the SOSNHS day of action on Saturday, 26th February, 2022.

This time, we intend to have our stall on the promenade to collect signatures for the giant birthday card and with leaflets, banners etc. followed by short speeches.

Contact ***konpsdsec@btinternet.com***

We need a fully public NHS – because this is how we protect staff pay, conditions and it's also how we protect services for patients too. It's the only way the NHS will survive.

This isn't time to 'reform or retreat', it's time to return to founding principles.

However, it is vital we mark the 75th Anniversary and use the spotlight under which the NHS will fall this year to make our demands and organise to save our NHS. **Speakers include:**

Tony O'Sullivan – Co-chair – Keep Our NHS Public
Holly Turner – Nurse – NHS Workers Say No
Harry Eccles – Nurse – NHS Workers Say No
Ellen Clifford – DPAC activist and author
Onay Kasab – National Officer – Unite the Union
Chantelle Lunt – Merseyside BLM Alliance
Claudia Webbe MP – Independent

NO new hospitals being built . . . and there's no capital to build them

By Roger Steer
From The Lowdown
MAY 27, 2023

No one can be surprised that the Secretary of State for Health and Social Care has eventually had to recognise a bit of reality in delaying and reprioritising the New Hospitals Building Programme.

Schemes that Boris the Builder gleefully announced as 'ready to go' in 2019 are to be put back until after 2030.

Steve Barclay has 'reprioritised' his programme to direct funding to the most urgent hospitals facing the risk of falling down. However Barclay apparently took some persuading, if the account in the Guardian is to be believed.

Perhaps he noticed that all the constituencies in which the hospitals requiring "urgent" attention were in Conservative held seats.

But many of those now effectively bumped off the priority list are also in Tory areas. Like so many Jonson plans, it's an awful mess. There are several ways of looking at this fiasco:

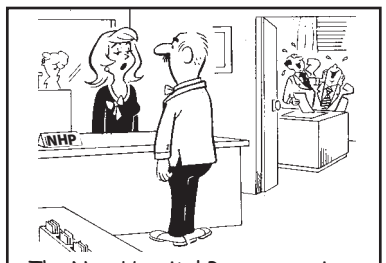
From the perspective of the 'winners' in the original struggle to push their scheme to the top of the greasy pole of political favour: they might be feeling dismayed that they have lost their "once in a lifetime" chance of a shiny new hospital. But the fine print of the announcement suggests they may be one of just 20 schemes technically "in Build" or underway by next year.

Steve Barclay's decision may be motivated by a fear of the electoral damage that might be done if less than half of the initial 40 projects have started any work, and by fear that an incoming Labour government might well prioritise projects in areas less beneficial for the Tories.

So it seems he intends to sign up to 20 long term contracts before the next election that may be impossible to rescind afterwards.

The statement pledges that, "by next year, more than 20 will be underway," even though the Chancellor has yet to commit any of the additional capital needed to fund what is now admitted to represent "over £20bn of investment in new hospital infrastructure."

From the Treasury point of view: they have reasserted their control over the capital programme. But this raises the question of what happens in the run up to the election if the Treasury say no to a "promised" new hospital. Will Jeremy Hunt step in?



The New Hospital Programme is examining your trust's bid now, sir

From NHS England's perspective it represents a recognition that problems which properly lie at ministerial level/ Treasury level are finally being addressed. But something is obviously going wrong if no one has noticed hospitals are falling down before now, and nobody thinks it is their job to do something about it.

From the point of view of those looking to build new capital projects over the next ten years, including new technology, new equipment , new productivity boosting measures (for example in pathology services, scanners etc.) it surely means further delays – and more pressure on NHS managers to privatise and subcontract services.

Already health chiefs in North West London looking to replace St Mary's hospital are crying foul as they find their plans are now postponed beyond 2030.

From the Labour Party point of view: it should be time to present their own coherent plans for a capital renewal programme. We need plans which aren't based around self-imposed fiscal limits but instead are based on meeting long term needs most economically and automatically funding self–financing business cases from an Infrastructure Bank.

For those who think its unaffordable read Marc Robinson "Bigger Government," which concluded extra spending on health and social care was inevitable, affordable and desirable in the future to meet a more elderly population's need.

Plainly councillors, trade unionists and campaigners involved in scrutiny will want to make sure that legal duties are being fulfilled. Questions about strategic plans, business cases, procurement processes and contracts will need detailed scrutiny.

This is the relevant piece of legislation. – https://www.legislation.gov.uk/uksi/2013/218/regulation/21/made

Hospital bids binned

... from front page

in Norfolk," which were included in the initial, much altered list of 40.

Chucked aside as a result are all of the outline plans drawn up, often with the use of expensive management consultants, architects and others.

Gone too are all the false hopes that were generated by naïve local press coverage of the initial promise of additional projects to increase from Boris Johnson's initial "fake forty" pledge to 48 new hospitals by 2030.

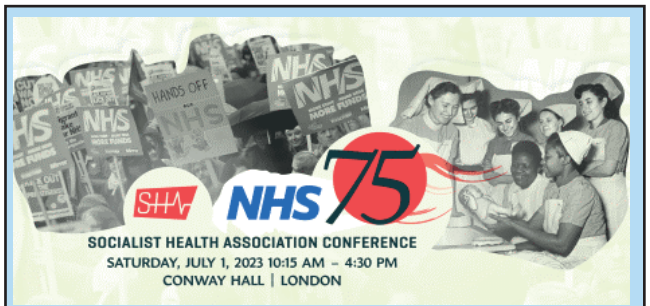
The HSJ reports that among the sidelined schemes is a plan to replace a 1960s tower block at **Wycombe Hospital**, which is now permanently covered in scaffolding to help monitor its condition, and a plan from Doncaster and Bassetlaw Teaching Hospitals to replace **Doncaster Royal Infirmary**.

Trusts in **Lincolnshire** ICS together submitted bids with a total value of £1.2bn.

London and Shropshire

In North West London, Imperial College Healthcare submitted its Strategic Outline Case for rebuilding **St Mary's Hospital in Paddington**, including 840 beds, at an estimated "£1.2-1.7 billion net, once receipts from the sale of surplus land are taken into account."

There is no word on Shropshire's much-delayed 'Future Fit' plan to centralise acute services on a rebuilt **Shrewsbury Hospital** – for which £312m in capital funding was potentially promised, but the cost of which reportedly exceeded £500m: no business case has yet been submitted.



SHA NHS 75 Conference, featuring campaigning NHS workers, union leaders, overseas workers, MPs, and we all who use the service.

The event is backed by: Doctors in Unite, Keep Our NHS Public, War on Want, SOS NHS and new endorsements are arriving daily.

Our speakers include Zarah Sultana MP, Ian Byrne MP, Rosena Allin-Khan MP, migrant champion Cllr Hosnieh Djafari-Marbini, Lester Holloway on Windrush, researchers and activists Faiza Shaheen, Liz Peretz and Benjamin Goodair, nurse campaigner Antonia Berelson, Rathi Guhadasan, Tony O'Sullivan, Coral Jones & more TBC.

BOOK NOW admin@sochealth.co.uk

COMMEMORATION

10th anniversary of saving **LEWISHAM HOSPITAL** – and **NHS 75th Birthday**

Saturday 8 JULY 1pm

LADYWELL FIELDS

(behind Lewisham Hospital)

LEWISHAM, London

Sunday 2 July 2023, TREDEGAR, Wales

The annual Bevan Festival will be a key event for those in Wales to celebrate the founder of the NHS. Starting on July 2nd with a banner parade from Charles Street to Bedwellty Park for Speeches and family fun

MORE INFO can be found at
https://www.facebook.com/Bevanfestival

Bevan's founding princip
NHS have stood the test o

John Lister

When it was launched by then Minister of Health, Aneurin Bevan, on July 5 1948, the NHS was based on three core principles:

- that it should be comprehensive – meet the needs of everyone;
- that it should be universal – free to all at the point of delivery to access GP consultations or hospital treatment;
- and that it be based on clinical need, not ability to pay.

And although Bevan did not make a further explicit principle out of public ownership, the nationalisation of the hospitals was also central to the 1946 Act which established the NHS.

Bevan was convinced it would have been impossible to ensure that that the chaotic mix of under-resourced and in many cases near-bankrupt voluntary, private and municipal hospitals would work together if they remained in separate hands.

Some Tories (not least Jeremy Hunt) have tried to argue that the NHS would have been set up whichever party had been in office. **But the 1944 White Paper from Tory minister Henry Willink would have left the responsibility for the NHS in the hands of local government, and the scattered network of voluntary hospitals largely unchanged, with fees still in place.**

Bevan insisted he had not felt any consensus behind him as he fought to get the Act passed and implemented: only Labour's landslide 1945 majority ensured repeated Tory attempts to defeat the Act (and – as late as spring 1948 – block the launch of the NHS) were beaten back.

Public ownership and control, with public funding raised by central government through general taxation, rather than dependent on local council decisions or local taxes, was essential to ensure services would be equitably funded and available to all.

So most hospitals were nationalised, brought into a single system for the first time, and administered on a regional basis, although some public health, community health and ambulance services remained initially with local government.

NHS 70th birthday in 2018 was marked by large HCT-organised demo in London, backed by TUC and major unions and supported by then shadow health secretary Jonathan Ashworth (holding banner, third from left).

Insurance model rejected

And with the call for hypothecated taxes or insurance based systems still doing the rounds in the right wing news media, it's useful to note Bevan's argument that by raising the necessary funding through taxation rather than insurance, the NHS also worked as a mechanism for redistribution of wealth and addressing inequalities:

"… **we rejected the principle of insurance** and decided that the best way to finance the scheme, the fairest and most equitable way, would be to obtain the finance from the Exchequer funds by general taxation, and those who had the most would pay the most.

"It is a very good principle. What more pleasure can a millionaire have than to know that his taxes will help the sick? … The redistributive aspect of the scheme was one which attracted me almost as much as the therapeutical."

The principles of the new NHS immediately proved so popular with voters that for almost four decades it enjoyed consensus support from both Conservative and Labour parties.

However subsequent 'reforms' imposed by governments have served to fragment, disorganise and demoralise the NHS, undermining its principles to make room for private profits in place of the focus on patient care.

Contracting out

This began in the mid-1980s with the Thatcher government contracting out hospital support services (cleaning, catering, laundry, porters, security) to profit-seeking and generally poor quality private contractors, which broke up NHS ward teams and effectively casualised vital jobs.

Then 1990 legislation implemented by John Major's Tories established an "internal market", which separated NHS 'purchasers' from providers. It set providers in competition and rivalry with each other, making collaboration and cooperation difficult or impossible.

These changes, which emerged from Margaret Thatcher's secretive "review" of the NHS in 1988 and the 1989 White Paper "Working for Patients," brought the alien notions of neoliberalism and "new public management" into the NHS, supplanting Bevan's 1948 values of public service and social solidarity.

The same 1990 Act included similar plans for what we now call social care, implementing proposals from Sainsbury boss Sir Roy Griffiths in 1988. The new policies, implemented from 1993, transferred responsibility for "community care" – most notably for long term care of older people – to local government social services.

This made these services subject for the first time to means tested charges. It deepened the divide between care for vulnerable people inside and outside hospital.

Specialist beds axed

As a result, most NHS specialist beds for older people were closed down, while government restrictions on councils' use of funding for community care forced a growing level of privatisation of domiciliary services and long-term care.

To make matters worse, tightening 'eligibility criteria' imposed by councils from the mid 1990s, driven by growing constraints on local government budgets, ended any possibility of proactive and preventive care that might keep potentially vulnerable patients out of hospital.

Despite Tony Blair's repeated empty promises up to 1997 to end the 'costly and wasteful' internal market, the fragmentation of the NHS was deepened from 2000 by even more far-reaching competitive market measures which included for the first time tendering out contracts for clinical care under New Labour's NHS Plan, as well as the use of private capital to finance new hospitals and other projects under the Private Finance Initiative. (1)

Unlike Bevan, who had been forced to compromise and permit private beds for consultants and independent contractor status for GPs in order to establish a new publicly owned system, New Labour actively pursued policies to privatise what had been core NHS services.

They signed a Concordat for NHS patients to be treated in private hospitals, and established Independent Sector Treatment Centres to treat elective cases funded by the NHS, as well as for-profit 'Diagnostic and Treatment Centres' – all at higher cost than NHS provision.

Even primary care was opened up for private corporations. Meanwhile substantial annual real terms increases in spending in the 2000s ensured that NHS performance increased and waiting times were drastically reduced.

Austerity since 2010

But in 2010 David Cameron's Tory-led coalition slammed on the financial brakes, ending a decade of NHS funding increases. Within weeks of that election Health Secretary Andrew Lansley also unveiled wide-ranging and complex proposals – none of which had been put to the electorate – to further entrench the competitive market within the NHS and create new opportunities for the private sector. (2)

Lansley's hugely controversial 2012 Health & Social Care Act brought a wholesale top-down reorganisation of the NHS and compelled commissioners to put an ever-widening range of clinical services out to tender, while encouraging foundation trusts to expand their income from private medicine to as much as 49 percent of turnover. (3)

For almost 40 years various so-called 'reforms' have served, piece by piece, to undermine the initial values of the NHS as established in 1948.

NHS managers have been diverted down costly cul-de-sacs of 'new public management', 'business-style' organisation, competition and privatisation, often urged on by unhelpful advice from expensive management consultants.

The huge historic achievement of the NHS in 1948 was always more than as simply the first universal health care system to be funded from taxation and free from charges.

It was a decisive modernisation, which made it possible to supersede the previous "mixed economy" of health care, in which voluntary, private and municipal hospitals and GP services had functioned in parallel, with no co-ordination between them, while patchy insurance cover left a majority of the population unable to afford to access a full range of services.

bles for of time

Although it began with old and inadequate building stock, with an ad-hoc and undemocratic regional management structure, and even though it inevitably took time to develop, the seeds were sown in 1948 for the development of a **qualitatively new service.**

It was as fair in raising its funding as the taxation system, and could be shaped around the needs of the population rather than the charitable whims of the wealthy or the quest for profit.

The creation of the NHS as a national organisation also meant systems for training doctors and nurses could be put in place, and more specialisms were encouraged. **Consultant numbers since 1949 have increased more than ten-fold from 5,000 to almost 55,000 in 2023. The Nurses Act 1949 established a modern framework for the role of nursing increasing and nurse numbers almost three-fold, to 333.000 in 2023.**

As a national system, the NHS created – for the first time – the possibility of planning the allocation of resources according to need.

This was especially important for establishing hospitals in post-war new towns and other previously under-served areas, and rectifying inequalities between regions and within regions. (4)

A new role for primary care

A specific arrangement was eventually agreed with General Practitioners, who had remained diehard opponents until the very eve of the launch of the NHS on July 5 1948.

They would not accept Bevan's plan to make them salaried employees, and were only eventually drawn to work with the NHS as independent contractors.

Nonetheless the rapid enrolment of so **many families in the new NHS meant almost all GPs immediately found themselves dependent on NHS contracts.**

From the mid-1960s as more, younger GPs embraced this link with the NHS, new policies increasingly focused on the development of a specific role for primary care as the first point of engagement and gatekeeper controlling referrals to specialist services and elective treatment.

The early NHS, funded almost entirely from general taxation, but launched in a period of generalised rationing and austerity, **nevertheless provided all services free of charge at point of use – including prescriptions, eye-tests and spectacles, and dental checks and treatment.**

Even overseas visitors living in Britain were covered. This removed any of the deterrents that might prevent poorer families from accessing the full range of treatment.

However this principle came under attack from the beginning, and there were soon discussions about imposing charges for prescriptions and for dental treatment, which have persisted.

This has been revived by post Brexit racism and chauvinism, with new requirements on front-line NHS staff to enforce mean-spirited charges on overseas visitors (also requiring some British residents to produce ID or face punitive costs).

Charges have only ever been marginal to the total NHS budget. Almost 9 of every 10 prescriptions are dispensed free of charge in England; and they have been abolished in Wales, Scotland and Northern Ireland.

Prescription charges in England, now £9.65 per item – are a problem for the working poor, but raise **less than 0.5% of NHS England spending.**

Charges mainly deter people from accessing the full treatment they require – regardless of their level of need for treatment. Like so many of the counter 'reforms' that have disfigured and distorted the NHS since 1980, charges have made the service less effective, less efficient and less focused on patient care.

Having superseded the limitations of the market in 1948, every reversion to competition and market-style methods has been a step backwards: even plans claiming to aim for "integration" threaten loss of accountability and potential privatisation. There is no evidence of any benefits to compensate for the extra costs, bureaucracy and complex reorganisation.

Bevan was right.

And the NHS founding principles are still valid and essential.

75 years on from its launch the task of restoring the core values of the NHS and reinstating it as a public service is a vital one for staff, patients and the wider public.

(1) Lister J. (2008) ***The NHS at 60: For Patients or Profits***, (Libri) Chapters 6 and 9
(2) Tallis, R. (ed) (2013) ***NHS SOS***, Oneworld, London
(3) Davis, J., Lister, J. and Wrigley, D. (2015) ***NHS For Sale***, Merlin, London
(4) Timmins, N. (1995) ***The Five Giants: A Biography of the Welfare State***, HarperCollins.

Alamy

Migrant workers always key to NHS survival

Gay Lee, Lambeth KONP

A discussion – or argument – with people objecting to the numbers of immigrants coming to the UK should get the response: 'But the NHS wouldn't survive without them.' Opponents fall silent – what else is there to say? According to NHS England, 25% of NHS staff today are from ethnic minorities.

On 22nd June 1948 the Empire Windrush docked at Tilbury in Essex, carrying 492 passengers from the Caribbean. It was probably no coincidence that 2 weeks later, on 5th July, the NHS was born; there were 54,000 nursing vacancies in the new service and 75 years later they remain at 43,000.

The NHS also needed immigrants to take up the other low-paid jobs, that local people didn't want, when there was better paid work available; porters, cooks, cleaners, and ancillary workers were all in short supply

In the words of Karen Bonner, the daughter of Windrush Generation parents and Chief Nurse of Buckinghamshire Healthcare NHS Trust, in 2020:

'Today, the NHS is the biggest employer of people from a BME background in Europe – 20.7% of the NHS workforce which represent over 200 nationalities. Many are doctors, nurses, allied health professionals, domestic, catering and porters. Our thanks and gratitude to all of them'.

Balancing act

The peoples' history of the NHS describes the continuing balancing act between the need for workers from abroad – both skilled and unskilled – and the desire to keep immigrants out of the UK, as illustrated by racist legislation and government actions over the past 75 years.

A very revealing blog written by Dr Habib Naqvi, on the NHSE website, written in June 2020, describes Windrush as 'still on a journey' with a crucial stage being the effect of and on ethnic minorities in terms of their contribution and their terrible sacrifices during the worse of the Covid pandemic.

Alamy

Today's NHS even more reliant on migrant workers than in 1948

There is a long road still to be travelled in terms of 'equity and inclusion' even though all governments since the birth of the NHS have had to recruit overseas to solve workforce problems.

The Royal College of Nursing at its 2023 Congress discussed the Windrush legacy, focusing on the unjust treatment of the Windrush generation and the need to recruit ethically from abroad and treat 'migrants with respect and compassion'

Dr Naqvi also makes the important point about the impact on other aspects of British life – particularly cultural – that Windrush generation and its legacy has made – from language and literature to food and sport, remembering that the 2012 Olympic Games opening celebrations.

He says '…it is also true that the only way we can work collaboratively on our shared future is by learning the reality of our origins, embracing the facts, and by sharing those narratives with others in a way that will make positive difference... yet this agenda should not be the burden for BME folk alone; white allies have an even greater role to play in upholding a positive vision of an inclusive and shared society which is welcoming, just and fair to all'.

He specifically emphasises the under-representation of BME staff in senior NHS management and the discriminatory work environments that are the Windrush legacy for those staff at all levels.

Lambeth in South London, is celebrating Windrush with a dedicated website organised by the Council. Events include a procession on Windrush Day to Windrush Square, Brixton, where many from Empire Windrush settled.

The website includes a 'teachers pack' of information, acknowledging the dependence of the newly-established NHS on the Caribbean migrants:

'Without their input, it is likely that the NHS would not have survived, failing before it really had time to be established. Before their contribution, Britain simply did not have the workforce required to run the service. By 1954, more than 3,000 Caribbean women were training in British hospitals'.

Disjointed

Despite this impressive website, and the NHSE website which has both a Windrush 75 section but separately an NHS 75 website, there are little joined-up words or actions on these two momentous and intertwined events.

The events page for example of the NHSE Windrush section has no joint events (as of 5th June). Keep Our NHS Public is working on something reciprocal for Lambeth but there seems nothing nationally.

Though written for the NHS's 70th birthday Gary Younge's Guardian piece is sadly still apt:

"The institution that we value the most has been sustained by people whom we value the least…..This is not a problem of the past.

"That fundamental inability to understand immigrants as people who stay and contribute, rather than as people who come and take, remains a central obstacle to any meaningful debate about immigration.

"Not only are we failing to have the discussion in terms of our human obligations; we are not even having it in the national interest."

Integrated Care Boards – big spenders with private sector

Greg Dropkin

NHS monies are flowing to private companies, including firms with a dismal track record in the UK and some whose US parents have faced multi-million pound penalties from state and federal authorities.

The spending spree may escalate as companies are accredited by NHS England to develop Integrated Care Systems, giving them strategic influence over NHS planning.

After the Health and Care Act sailed through Parliament last Spring, control of local NHS budgets passed to 42 Integrated Care Boards (ICBs).

NHS hospitals, community, mental health, and primary care, still account for most ICB spending. But the threats to a publicly provided and accountable NHS are real.

From July to February, nearly 2,900 private companies received over £3.9bn directly from 40 ICBs, as shown by the available monthly spending reports.

Centene

The biggest winner, Circle Health Group Ltd, received nearly £169m from 36 ICBs. Circle's name was already notorious for the failed takeover of Hinchingbrooke Hospital in 2012 and its early exit from the 10-year deal in 2015, by an earlier incarnation of the company.

Now 100% owned by Centene Corporation, a $135bn/year US firm specialising in health insurance and

Alamy

managed healthcare, Circle was more recently one of the companies to benefit from the under-utilisation of private hospital capacity block-booked for Covid in 2020.

The Violation Tracker is a searchable database of corporate offences. Centene's rap sheet has 205 penalties imposed by state and federal authorities, including:

● In September 2022 Centene agreed to pay Texas $165.6 million to settle allegations the company overcharged the Medicaid program for pharmacy benefit management services. Similar large claims were settled earlier with the US government, the state of Washington and at least 9 other states.

When Centene took its initial 40% stake in Circle back in January 2020, the CEO of Centene's UK arm Operose Health was Samantha Jones.

She was later appointed as Boris Johnson's Chief Operating Officer and has now been appointed as a non-executive director at the Department of Health and Social Care.

Optum

Another US-owned firm, Optum Health Solutions (UK) Ltd., received £4m from 17 ICBs for contracts which include Medicines Management, Prescribing, Central Drugs and IM&T. What should we know about Optum and pharmacy?

Optum is owned by UnitedHealth Inc, the largest US health corporation, and operates through OptumHealth, OptumInsight and OptumRx businesses.

● Last year, the State of Arkansas sued Pharmacy Benefit Managers (PBMs) including OptumRx, and drug manufacturers. The defendants were accused of engaging in a collective "Insulin Pricing Scheme" which caused millions of Arkansas residents to pay inflated prices for insulin.

The PBMs establish a list of drugs to be covered by health insurance. Other drugs are not covered, giving the defendants "enormous control over drug prices and drug purchasing behavior". Drugs which cost under $2 to produce, sell for $300 to $700.

Arkansas charged the firms with deceptive trade practices, unjust enrichment, and civil conspiracy.

UnitedHealth itself has paid over $667m in 354 penalties mainly concerning consumer protection and government contracting, small change for a firm with an annual revenue of $283bn.

In Britain the Competition and Markets Authority is investigating plans by an Optum subsidiary to buy EMIS Group Plc, formerly known as Egton Medical Information Systems. Egton software is widely used in primary care, community care, accident and emergency, and community and hospital pharmacies.

Fast-track procurement

The Health Systems Support Framework (HSSF) is an NHS England scheme to fast-track procurement for contracts to develop Integrated Care Systems. Over 230 firms, at least 32 of them US-owned, are accredited.

In Cheshire and Merseyside, HSSF accredited firms with ICB contracts include Circle, Optum, Egton Medical, and various consultancies:

● PricewaterhouseCoopers (PwC) advises Liverpool University Hospitals on how to comply with £75m budget cuts imposed by the ICB.

● PA Consulting, owned by US firm Jacobs Engineering, has advised the ICB on its long term financial planning.

● Deloitte supplies unspecified Programme Wide Projects to the ICB.

● The Public Consulting Group UK deals with personal health budgets for continuing healthcare.

● Carnall Farrar carried out a Liverpool Clinical Services Review which recommended "an ICB-led service change programme" for Liverpool Women's Hospital which may involve moving services out of Toxteth, despite strong public opposition.

Carnall Farrar was appointed via the HSSF as "the procurement timeline could be reduced as the Providers are in essence 'pre-approved'", the ICB stated.

Meanwhile, companies hold contracts with NHS England or the Department of Health, and individual Trusts funded by the ICBs have their own contracts.

Cheshire and Merseyside ICB spent £154m: but its 18 Trusts spent at least £568m on private companies.

The reality may shock those who thought the Health and Care Act would end NHS privatisation, or that it makes no difference who provides the service.

We call for the restoration of the NHS as a publicly provided, publicly accountable, universal, comprehensive health service, free at the point of need, with decisions on treatment taken on clinical grounds without regard for ability to pay.

■ The full version of this article with links is available at **http://labournet.net/other/2303/ICBspend.html**

First year of crisis leaves ICBs seeking huge "efficiency" savings

From The Lowdown

According to the latest NHS England overview, 16 of the 42 Integrated Care Boards (ICBs) failed to achieve their financial plan in last financial year, most of them failing by less than 1 per cent of total allocations. Of course a number of them had planned from the outset to run a deficit, or been obliged to admit during the year that they were not going to be able to balance the books.

NHSE Finance chief Julian Kelly explained away the issues, arguing:

"This variance is largely caused by operational pressures, in particular higher levels of COVID and sickness absence, and also the ongoing impact of inflation."

However he also admits that a third of the ICBs (14/42) are projecting deficits totalling £650m for this financial year, despite the immense top-down pressure on Boards to reduce the shortfall from an initial £6 billion in March, and £3bn at the end of April.

NHS bosses have known that the financial pressures are growing ever-tighter: England's NHS is expected to deliver £12 billion in "efficiency savings" over the next two years, while reducing waiting times and waiting lists.

Lowdown articles have explored the situation in 32 of the ICBs in London, East of England, and the North East, North West, South East and South West, underlining the main challenges facing the Boards as they seek to both balance the finances and expand the services. The latest information on the ten Midlands ICBs fits the same general pattern.

Underlying all of these local financial pressures are a number of common problems seen in almost all ICBs:

● overspending above the arbitrary NHS England "cap" on use of agency staff (costing £46 per hour compared with £16.85 agenda for change rate. Herefordshire & Worcestershire ICB trusts have overspent the cap by 38%, 60% and 79%, Northamptonshire system exceeded the cap by 58%; Nottingham & Nottinghamshire by 60%

● pressure on acute beds – especially given continued burden of Covid patients (703 in Midlands beds on May 17) and Medically Fit For Discharge patients who cannot be discharged for lack of community health services or social care.

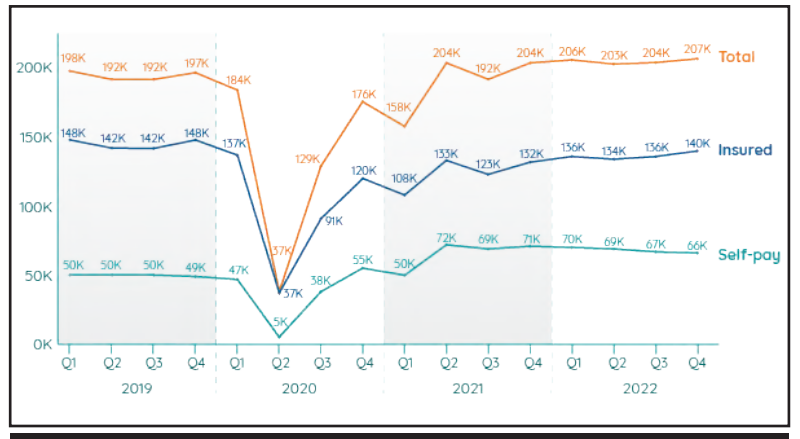
● inflation running far above the official forecasts, and showing little signs of falling as predicted, leaving providers carrying much higher than funded costs.

● under-funding of pay awards, leaving providers stuck with the extra cost.

● failure of NHS providers to meet tough targets for "efficiency savings" in 2022/23, (or sometimes imaginary assumptions or unassigned savings)

● and almost universal over-reliance on one-off "non-recurrent" measures and budgetary fiddles, which leave an underlying deficit rolling in to an even tougher 2023/24.

Private sector can't solve NHS waiting list crisis



Despite claims of a 'boom', the private sector's own figures show virtually no overall growth beyond 2019 levels despite the soaring 7.3 million on NHS waiting lists. 'Self pay' numbers that were rising are now falling again.

From The Lowdown
MAY 26, 2023

The (£ paywalled) Times has reported that one of the outcomes of Rishi Sunak's controversial taskforce on boosting NHS contracts with private hospitals will be a new push to persuade patients to use the NHS app to "book private healthcare."

Of course the right for elective patients with sufficiently minor conditions to "choose" their elective provider, including private hospitals working on the NHS tariff, is not new. It was established back in the mid 2000s by Tony Blair's government.

Even then the notion of "choice" was deceptive, since most patients needing healthcare preferred to be able to access prompt, safe treatment in their local NHS hospital, which was not the kind of choice New Labour was promoting. Recent Health Foundation polling confirms that local NHS care is still the preferred option for most people.

New Labour resorted to threats to in their efforts to push patients in to unwanted, newly-established "independent sector treatment centres" which had been established by the Department of Health over the heads of local commissioners, and which many patients preferred not to use.

Real terms investment

The Blair government's costly experiments with use of private providers took place in the context of a decade of rapid real terms increases in NHS spending, which was always the decisive factor in expanding NHS capacity and reducing waiting lists.

By contrast Sunak's latest efforts to steer more patients and funds into the private sector comes after 13 years of real terms cuts in NHS funding, and at a time when up to 20% of the reduced number of NHS front line general and acute beds are tied up with Covid patients (3,550 on May 17) and patients who are medically fit but cannot be discharged for lack of social care and community health services.

Tory ministers now seem to believe that encouraging more patients to choose private providers will somehow reduce the record 7.3 million-strong waiting list.

Labour's Keir Starmer also seems to believe the same: the policy is now cited by the right wing press and the Independent Healthcare Providers Network as a "cross party consensus".

But it won't work. The evidence from NHS experience, and from recent similar moves in Canada (see box – below) is that this approach does NOT deliver. Even the Times's Chris Smyth points out that

"The evidence that choice itself makes a difference to waiting lists is largely inconclusive. Patients have

Labour leader Keir Starmer: cross-party line or crossed wires?

been sceptical, asking why they should be expected to shop around when they just want a good local hospital."

A recent Health Foundation report has also warned that use of the private sector can only have a "limited impact" on tackling things like NHS backlog, and cannot solve other issues such as the spate of different workforce-related challenges and general underfunding.

Nor of course is the private sector any help to NHS trusts dealing with continued delays in treating the most serious emergency cases.

The Health Foundation report, focused on private sector provision of NHS-funded ophthalmic and orthopaedic care, notes that the overall number of NHS-funded treatments has only just recovered to pre-pandemic levels.

Cataract operations

'Independent Sector Providers' (ISPs) delivered 8.7% of these treatments – a 1% increase from before COVID-19. **But the private sector share of ophthalmic care procedures almost doubled to nearly four in 10 in February 2022 compared with 23% before the pandemic.** The report explains:

"This suggests the delivery of cataract procedures is both highly amenable to scaling, and attractive to ISPs – **which isn't true of other procedures ….**"

The report also notes the increased share of orthopaedic operations carried out in the private sector to almost a third of inpatient orthopaedic care in February 2022, up from around a quarter before the pandemic.

However even the Times report notes that "the private sector performs about 140,000 procedures a month paid for by the NHS out a total of 1.5 million [i.e. 9.3%]. **There are questions about how far this can be scaled up**."

This is especially true given the limited size of private hospitals (average size 40 beds) and their limited facilities, which mean they cannot take on more complex cases – all of whom wind up waiting for the limited number of available NHS beds.

Same pool

The NHS Confederation in December noted that both the NHS and private sector "are recruiting from the same pool" of qualified staff, so any growth of the private sector inevitably undermines the NHS. It went on:

"the independent sector will not have the capabilities, workforce or capital to take on the cases which are more complex in nature and acuity. The NHS will likely be left with the more complex and costly procedures to carry out because of the expertise and infrastructure needed.

"People on waiting lists, many of whom have been waiting several months, have deteriorated in their health and will need more complex care than they did when they first joined the waiting list.

"Due to this, these patients will not have the choice to use the independent sector, and this further complexity of care means health inequalities worsen."

NHS Providers also warned:

"private sector provision is not uniform across the country and therefore access to the independent sector isn't always available. […] reliance on the independent sector could further widen health inequalities as independent sector provision is more likely to be present in affluent areas. […]

Only low risk patients

"The role of the independent sector is limited … **Independent sector provision largely covers high volume, low complexity cases as most independent sector providers do not have intensive care capacity. Therefore, independent sector provision can only really accommodate low risk patients."**

Money paid to the private sector cannot be used to develop NHS resources, and flows out of the NHS, often lining pockets of shareholders here and overseas.

Only recently the *Health Service Journal* reported private sector bosses calling for an increase in the rates they are paid for treating NHS patients, and threatening to "turn away" from NHS work if they don't get a big enough increase – **which would destroy the argument that private provision costs the NHS no extra money.**

The Health Foundation warns:

"ISP activity is ultimately funded from an NHS budget already stretched by high inflation and other cost pressures.

"Against a backdrop of an imperative for ICSs to cut costs and deliver financial balance, it may be challenging for the NHS to fund a substantial increase in ISP activity even where genuinely additional capacity to treat more patients is present."

The Public Accounts Committee itself has also questioned

"the extent to which these initiatives [purchasing care from private providers] have so far generated genuinely additional activity, rather than simply displacing activity elsewhere in the NHS."

Private beds may indeed be empty, but with many NHS trusts carrying eight-figure deficits from last year, and Integrated Care Boards seek endless "savings," it's not likely that many NHS bosses will be too keen to funnel more cash into the greedy hands of the not-so-independent sector.

Harsh lessons from Alberta:
Privatisation of surgery brings reduced services

From The Lowdown
MAY 26, 2023

An important new report has exposed the sorry failure of policy in Alberta in Canada, where the right wing provincial government in 2020 announced it would spend $400 million outsourcing surgical services to for-profit facilities.

It committed to doubling the number of outsourced surgeries over three years, from 15 per cent to 30 per cent of total surgeries province-wide.

This seems to closely resemble the "cross party consensus" policy proposed in England … but goes far further than New Labour's experiments in 2005-2010.

"Three years later the report has found that Alberta has among the worst performance in reducing surgical wait times in Canada.

"The province has prioritized for-profit surgical delivery rather than system improvement, leaving nearly 30 per cent of public sector operating room capacity unused."

Far from increasing provincial surgical capacity, data suggest that the expansion of the private sector's 'chartered surgical facilities' (CSFs) has diverted resources away from public hospitals and, in turn, reduced provincial surgical volumes.

Investor-owned surgical facilities have been expanding through substantial contracts with the government.

Public sector cut

Between 2018-2019 and 2021-2022, surgical volumes in chartered surgical facilities increased by 48 per cent while surgical activity in public hospitals declined by 12 per cent.

Surgical outsourcing has come at the expense of public hospitals and undermined efforts to reduce surgical wait times over the long term, especially for patients requiring complex surgeries only performed in the public system.

The report, Failing to Deliver, also shows the disproportionate private sector focus on quick and simple cataract surgery, leading to an improved province-wide performance under the Alberta Surgical Initiative, while performance has fallen back for more complex hip and knee replacement surgery, and the province's total surgical activity declined in the first three years of the scheme.

And it highlights more generalised problems with contracting out surgical services: in a period of growing staffing shortage the private sector is able to offer incentives such as reduced workloads, less complex patients, and higher pay to attract workers from the public system.

As a result, surgical activity in public hospitals has declined while for-profit facilities focus on lower-complexity procedures, destabilizing the public hospital system.

"Over time, entrenching for-profit providers also reduces the public system's ability to negotiate prices with private providers."

And, as British researchers have pointed out, evidence shows that private, for-profit health-care delivery is generally less safe and provides lower-quality care than public sector care where the profit motive is excluded.

Mental health: still treated as the poor relation

Not one of almost 50 mental health projects for new hospitals submitted in response to the government inviting bids for an additional eight "new hospital" plans was successful, according to a recent HSJ report.

The so-called 'New Hospitals Programme' may not be delivering any new hospitals, but it is proving itself very much a reassertion of the dominant NHS England focus on acute hospitals and services that already command the lion's share of NHS revenue and capital spending.

Some time ago the Royal College of Psychiatrists called for an extra £3bn capital, and £5bn in additional recovery revenue over 3 years to equip mental health services to cope with the increased demands since the pandemic and expand services for adults and children. Their warnings like those of other medical specialists were ignored.

Emergency funding

But they have been included in the SOS NHS call for an emergency injection of £20 billion to help kick start the revival and repair of an NHS battered by a cruel decade of austerity before the pandemic.

Meanwhile there are other worrying signs that ministers are refusing to treat mental health services seriously, not least by misrepresenting statistics on the IAPT "talking therapy" services for some of the most common and least serious mental health problems such as depression and anxiety.

Therapists have pointed out via politicshome.com that although NHS figures show 1.81 million people were referred to IAPT in 2021/22, only 1.24 million entered treatment, with only 688,000 finishing a course of treatment.

Therefore only 38 per cent of those referred actually completed treatment, (which is defined as attending two or more treatment care contacts between referral and end of treatment.)

And in the aftermath of the spring budget announcement of expansion of the individual placement and support (IPS) scheme – which supports people with severe mental health difficulties into employment – there are concerns that mental health services are not equipped to cope.

Royal College of Psychiatrists president, Dr Adrian James, said: "Last year, mental health referrals reached record levels of 4.6 million [but] there are just simply not enough psychiatrists to deal with this surge in demand. If the government is serious about improving productivity, it needs to publish the workforce plan – backed by adequate investment – as a matter of urgency."

Vacant posts

Recent NHS workforce statistics show a shortage of mental health nurses, with more than 1000 fewer employed in hospitals, community and mental health services in England than there were in 2010, and almost 13,000 vacant posts in March 2023.

And that's hardly 'stop the press' news – almost a year ago Baroness Watkins of Tavistock , chair of a review by Health Education England warned that, if steps were not taken immediately, "There is a risk that this profession will be lost."

How long will it be before a government is willing to listen and act?

HEALTH CAMPAIGNS TOGETHER #OurNHS

KEEP OUR NHS PUBLIC

Our vision for the NHS

The NHS has served the people well for most of the last 75 years but it has been undermined by damaging underfunding and the private sector, within the body of the NHS.

There is an orchestrated chorus claiming that the NHS model and principles have failed. No! It is this Government that has failed the NHS over the last 13 years, taking it from best in the world into a dangerously deteriorating state.

Principles

We demand that the NHS is built back and built stronger, based on the principles that made it an unparalleled success:

Universal care – no gatekeeping through insurance or means tests – ensuring equity of access for all and to comprehensive, high-quality healthcare required throughout life, publicly provided without private interest, and publicly funded through taxation, guaranteeing a service free at the point of delivery and offered according to need, not the ability to pay.

People are dying because of political choices

* Austerity is responsible for 335,000 excess deaths 2012-2019.

* A degraded and underfunded NHS that meant the NHS could not cope during Covid and is now the cause of up to 500 deaths per week from delays in emergency care alone.

* An ideologically based support for private interests undermined the pandemic response in the UK, and over 220,000 have died with Covid

This policy continues now as £billions are poured into private hospitals at the expense of the NHS.

We call for three fundamental shifts in policy

1. A commitment to fund the NHS and care services without which we cannot have a caring, successful society and healthy economy;

2. An end to feeding the private parasite eating away at the heart of the NHS; reclaim that wasted funding and reinvest it into rebuilding public services and safe staffing;

3. A commitment and respect for public servants: to provide the staff needed, to pay staff well and to repay their loyalty and service to a fully public NHS.

These commitments, if fulfilled, will guarantee the future of the NHS.

Unions, campaigners, join us!

Health Campaigns Together is a broad campaigning coalition of trade unions and health campaigners, established in 2016.

All three major health unions (UNISON, Unite and GMB) are part of HCT, and we support them in their fight to win a fair pay deal for staff. We also have great support from non-health unions.

Last year HCT and KONP played a key role in the establishment of the broad SOS NHS coalition launched in January 2022. This coalition now has the support of 55 organisations including 18 trade unions. The immediate demands of SOS NHS are: Emergency funding to save a struggling NHS; investment in a fully publicly owned NHS; and to pay staff properly - without fair pay, staffing shortages will cost lives.

SOS NHS gathered over 345,000 signatures on a petition early last year demanding emergency funding for the NHS. It held a successful conference in November with speakers from several trade unions. And we held a national demonstration on March 11th.

We hope your branch or regional committee will wish to affiliate for 2023. Health Campaigns Together merged with Keep Our NHS Public in 2022 and continues to play a vital role within KONP in broadening the alliance and strengthening the work of KONP and HCT with trade unions. Your affiliation to HCT will also bring with it the option of a complimentary affiliation to KONP.

HCT holds affiliates meetings online: affiliates decide policies and campaigning priorities. We are only as strong as our affiliates. We value your support.

Please **affiliate** (or **reaffiliate**) for 2023 – if possible **ONLINE** at https://healthcampaignstogether.com/joinus.php, which gives details on how to pay. **Make sure to send us your contact details.**

ANNUAL SUBSCRIPTION RATES ARE AS FOLLOWS:

- £500 for a national trade union,
- £300 for a smaller national, or regional trade union organisation
- £50 regular rate for local organisations such as union branches, labour parties or local campaigns – unless your organisation is unable to afford £50, in which case please contact us at healthcampaignstogether@gmail.com .
- If you wish to pay by cheque or communicate with us by post, please contact us at: Health Campaigns Together, c/o KONP, PO Box 78440, LONDON SE14 9FA

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