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KEEP OUR NHS PUBLIC

News for union activists & campaigners ● Spring 2024 ● FREE

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Experts and public all agree

More funding is key to saving NHS

Joao Daniel Pereira / Alamy

Nobody wants the rest of the NHS to go the way of dentistry

The recent findings of the **British Social Attitudes (BSA) Survey** showed **less than a quarter** (24%) of people were satisfied overall with the NHS, the lowest level of satisfaction recorded since the survey began in 1983. 52% were dissatisfied.

Since 2020, satisfaction has fallen by 29 percentage points, "an unprecedented collapse". Responses to other questions indicate why.

The main reason people gave for being **dissatisfied with the NHS** was waiting times for GP and hospital appointments (71%), followed by staff shortages (54%). Satisfaction levels for hospital services, GP and dental services were also at record lows

But support for the NHS itself remains strong: 91% said the NHS should be free of charge when you need to use it, while 82% said the NHS should remain primarily funded through taxes, and that it should be available to everyone.

So how is it going wrong?

84% said they thought the NHS had a major or severe funding problem. When asked about government choices on tax and spending on the NHS, 48% chose 'increase taxes and spend more on the NHS', while just 6% chose 'reduce taxes and spend less on the NHS'. Significantly those in the highest monthly household income quartile were more likely to choose 'increase taxes and spend more on the NHS'.

The high-powered **Commission on the future of the NHS** set up by the British Medical Journal investigated other models of health systems and concluded that the NHS model is as good as any: **"The NHS founding principles are still appropriate today and provide a strong foundation for the future"**.

Spending gap

The Commission's second report, **NHS funding for a secure future**, found that even allowing Covid-19: "if spending had increased at the long term average from 2010-11 to 2022-23, UK NHS spending by 2022-23 would have been **around £32bn (15%) higher than actual spend."**

It argues that this gap needs to be closed in order to restore the performance of the NHS. This will take time, "But a start could be made with a real increase of 4% for 2024/25, **equivalent to around £8.5bn at 2022-23 prices**. Similar increases over the subsequent four years would make up the shortfall."

But while the view of the public and experts seems clear, what has happened to NHS spending? According to the **Health Foundation's REAL centre** "Between 2022/23 and 2024/25, when adjusted for population size and ageing, the planned NHS England budget **will have decreased by an average of 1.6% per year in real terms**."

After the Spring Budget **Matthew Taylor, chief executive of the NHS Confederation** warned that: "with a revenue settlement which is at best flat in real terms … 24/25 is going to be another incredibly tough year for the health service and for patients."

What does that mean on the ground? A huge and growing backlog of maintenance resulting, **according to the Times**, in crumbling hospitals, with "Caving ceilings and plummeting lifts." Now trust bosses have been ordered to keep beds open but **cut thousands of jobs** to close a "**£4.5bn funding blackhole**".

So without more funding no rescue is possible, and the NHS is doomed to slump from bad to worse – making it even more difficult to recruit and retain staff.

The state of the NHS in 2024 is far worse than the situation New Labour inherited in 1997. There is no scope this time for 3 more years of Tory spending limits.

Grasp the nettle

After the election the new government will have to grasp this nettle as soon as it takes office, increasing revenue funding to sustain services and capital to begin long overdue maintenance and rebuilding.

Of course more cash on its own is not enough.

Big changes of policy are also needed, not least

- more investment in primary care, mental health and community health services,
- winding down and eliminating wasteful spending on management consultants,
- expanding NHS services to enable improved emergency services and a rapid reduction of the waiting list,
- and rolling back privatisation and bringing outsourced services back in-house.

Social care, too, must be addressed. **Only 13% were satisfied with it according to the BSA survey.** Labour has **promised a national care service**, and delivering it will require more funding as well as political courage.

So any of the "reforms" set out by Labour's Wes Streeting will also cost money to implement, whether it's for training more staff, including District Nurses or **doubling the number of scanners** (which will need staff to operate them).

Streeting has so far insisted **no more money is needed.**

But all the evidence shows that on present funding levels services are set to get worse and less safe.

The BMJ Commission has a plan to get around unwise promises:

"The next government should be … bold and declare **a national health and care emergency**" and "… relaunch the NHS with the active participation of all sectors."

That would give scope for Labour leaders to reconsider their rash commitments not even to increase taxes on the very wealthiest, and devise a serious plan to rescue our most popular public service.

£300 billion cost of mental ill-health

New research commissioned by the **NHS Confederation's Mental Health Network** shows the cost of mental ill health for England was a staggering £300 billion in 2022.

The study, conducted by the **Centre for Mental Health**, shows that the £300bn figure breaks down into:

£110bn – economic costs such as sickness absence, 'presenteeism', staff turnover and unemployment

£130bn – human costs such as reduced quality of life and premature mortality

£60bn – health and care costs such as support from public services and informal care delivered by family and friends

This is **almost double** the health service's £155bn budget for England in the same year.

However the failure of the government to heed this massive problem can be seen from the breakdown on where the heaviest burdens fall.

The report **The economic and social costs of mental ill health** explains that the largest share of the costs stemming from mental ill health is borne by people living with mental health difficulties and their families: a total of £175bn.

Businesses carry a total cost of £101bn, while the government share is a comparatively small £25bn annually.

The report suggests that the majority of costs deriving from mental ill health do not fall on health care systems, and are instead reflected in decreases in wellbeing and productivity losses.

The Centre for Mental Health and the NHS Confederation's Mental Health Network are stepping up their call for a comprehensive 10-year mental health plan, which was set out last autumn as part of **A mentally healthier nation**.

Sadly there is little indication that ministers are paying any attention.

UNISON vice president Julia Mwaluke on the picket line with Barnet UNISON members (credit: Barnet UNISON)


THE lowdown
Health news, analysis and campaigns.
Informing, alerting and empowering NHS staff and campaigners
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Many of the news and analytical articles in this newspaper are drawn from or shortened versions of articles in The Lowdown.

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

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Accessing the online version enables you to access the links to the source information – including the full *Lowdown* articles from which some of these reports have been drawn.

Deadly toll of mental health neglect

The contempt with which ministers view NHS mental health services has been summed up recently by Work and Pensions Secretary **Mel Stride arguing** that concern for mental health has "gone too far", insisting that "we seem to have forgotten that work is good for mental health", and arguing that people were being signed off too easily.

Meanwhile all the symptoms of the government's continuing neglect and underfunding of mental health services keep surfacing in news headlines.

In Nottinghamshire Hospital Foundation Trust, the Care Quality Commission has found that patients at the hospital that treated killer Valdo Calocane were **discharged too soon** – and released in a worse state into the community,.

The CQC also found that more than 1,200 patients are waiting to be seen by community services, and several hundred who are receiving treatment **did not have a clinician** overseeing their care.

Calocane was under the **care of the trust's community service** team at the time he killed 19-year-old students Barnaby Webber and Grace O'Malley-Kumar before killing school caretaker Ian Coates, 65, last June. He had been discharged from Highbury Hospital.

In February, **The Independent revealed** more than 30 staff at Highbury Hospital had been suspended by Nottinghamshire Healthcare over allegations of poor care and the falsification of patient records. According to the CQC's report, 22 of the staff at the trust were suspended following inquests into the deaths of two patients.

In its review, which also covered inpatient services, the CQC noted high demand for services was leading to long waiting times for care and a lack of oversight of those waiting,

and that the trust does not have enough staff to keep patients safe in the community and within some hospital services.

It also warned of reports from staff that its services have a "toxic" and "bullying" culture.

Sadly Nottinghamshire is by no means unique in its poor services.

Deaths

Chronic failures of care have also led to an astonishing level of unexpected deaths among patients at Norfolk and Suffolk Foundation Trust.

Recent publicised examples including the deaths of Christopher Sidle a **51-year old** former government climate change advisor two days after being refused a crisis admission, and a Ellie Woolnough, a **27-year old Ipswich woman** who had been contacted by the trust's crisis team the day before, but was downgraded from 'emergency' to urgent after a 4-minute triage call with a mental health nurse.

The **Campaign to Save Mental Health Services in Norfolk and Suffolk** says the trust continues to be in a crisis sparked by austerity driven cuts in 2013.

Its calls for a public inquiry into the trust's service failures were stepped up last year after a review **found 8,440 "unexpected" deaths among its patients** or those it recently cared for.

Meanwhile despite being given increased powers, enabling it to compel witnesses to attend, the public inquiry into the **deaths of mental health patients** in the care of Essex Partnership University Trust, first set up in 2021 cannot start because of government delays.

Its chair, Baroness Lampard, has complained that its terms of reference have still not yet been agreed by the health secretary.

The inquiry is to investigate the deaths of 2,000 people who died either while they were patients on an Essex mental health ward or within three months of being discharged, between 2000 and 2020.

Barnet UNISON calls nine weeks of action

On 19 March (World Social Work Day) UNISON wrote to Barnet Council Chief Executive to inform him that UNISON intends to call its Mental Health social worker members to take part in industrial action.

A further nine weeks of strike action are planned after mediated talks with their employer failed to resolve the long running dispute.

UNISON and Barnet council held talks – mediated by employment relations body ACAS – over the pay dispute that had seen practitioners take **27 days' strike action since September 2023**.

The intended dates for members to take part in discontinuous strike action are:

- 15 April 2024 to 26 April 2024 (two weeks)
- 13 May 2024 to 1 June 2024 (three weeks)
- 17 June 2024 to 12 July 2024 (four weeks)

This is unprecedented strike action: Barnet UNISON Mental Health social workers and assessment and enablement officers will be taking **nine weeks of strike action over a 13-week period**.

The dispute is over the much **lower rates for pay** for social workers covering adults in Barnet: children's social workers are paid 15%-25% more. The discrimination is such that a lead practitioner with extensive social work experience and line responsibility in an adult mental health team is paid only £1,000 more than a newly qualified social worker in a children and family team.

Many Mental Health social workers are also Advanced Mental Health Practitioners (AMHP), following an intensive course to trains them to assess whether an adult in mental health crisis should be detained under the Mental Health Act 1983.

The union is calling for the practitioners from the north and south mental health teams, and the approved mental health professional (AMHP) service, to receive similar retention payments to those received by their children's social worker counterparts in the borough – (up to 25% of salary).

NHS England bullying can't hide A&E performance failures

NHS England has resorted to desperate tactics and impossible demands in their efforts to force an apparent improvement in A&E performance.

On the last day of February trust CEOs and chief operating officers were instructed to sign declarations that their hospitals would meet the target of seeing and treating 76% of A&E patients within 4 hours during March.

It was already nigh on impossible for this to happen, given that only 13 trusts in England had met this target in January, and almost all major targets have been missed for the whole of 2023/24.

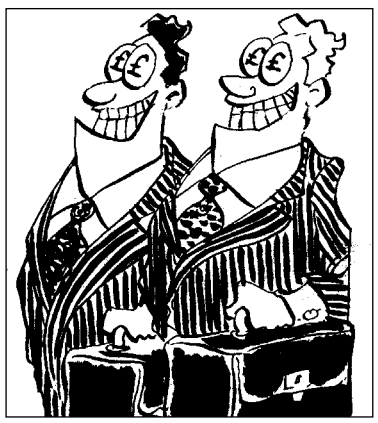
Definitions of bullying include setting unreasonable or impossible deadlines and setting unmanageable workloads. NHS England is a serial offender: and bullying from the very top is transmitted throughout the NHS.

Indeed to add further pressure trust bosses were required to give the direct phone numbers and emails of the senior officers responsible for performance. This would facilitate even more NHS England bullying.

This latest brazen effort to bludgeon trust bosses into line despite resource constraints follows on NHSE instructions earlier in February to focus on speeding the treatment of the **least serious 'Type 3' A&E patients** – to boost the overall figures on A&E performance.

Ever since the onset of the austerity regime in NHS funding in 2010 the much easier and rapid handling of the most minor Type 3 cases has helped to hold up the overall figures, while the delays have grown in handling the most serious Type 1 patients (many of whom need beds).

In **February 2011 for example** (with residual benefit from the previous decade of investment) the average for all A&E attendances was **97.1% treated and admitted or discharged within 4 hours.** This included 95.6% of Type 1 and 99.9% of Type 3.



By February 2024, after almost 14 years of real terms cuts, the latest figures show an overall average of just **70.9% within 4 hours,** within which 95.2% of Type 3 cases were treated within 4 hours, but **only 56.5% of the most serious Type 1 cases.**

That's why the number of 12-hour plus trolley waits for beds has rocketed from just 3 in February 2011 to 44,417 in February 2024.

To focus on Type 3 cases when the situation is so bad for Type 1s indicates that NHS England is not only seeking effectively to falsify the picture by devoting more resources to the patients with the least serious needs, but they are mathematically illiterate: in most cases the existing performance on Type 3 patients is already so good there is little room for significant improvement, and not enough to change the overall figures.

Trusts have also been instructed not to close beds in March as part of their cash-saving plans.

NHS England has also attempted to buy one-off improvements, offering financial incentives that would **hand extra cash from a £150m 'incentive fund'** to the best-resourced trusts that achieve the highest 4-hour performance and/or the biggest percentage improvement between January and March.

The winners could gain handouts of up to £4m – while those up against the greatest pressure and most lacking in resources would get nothing.

This follows on the promise of extra cash handouts to the **tiny minority of trusts** that can exceed "stretching" targets of 80% performance on the 4-hour target and complete at least 90% of ambulance handovers within 30 minutes during the final half of the financial year.

Only five acute trusts recorded performance above 80 per cent in the three months to June

The NHS England approach has been criticised by NHS bosses as **brazenly political**, seeking to curry favour with ministers for delivering the superficial illusion of progress at the end of a year of **failures** and **broken government promises**, and skewing the priorities of emergency services to accelerate the care of patients with least needs while neglecting the more challenging needs of the most seriously ill.

What happened to those "40 new hospitals"?

Extracted from recent Lowdown articles

Well, no new hospitals have yet been begun since the pledge was made in 2019. Nor has any got a completed business case. The project appears to be hitting yet more problems, with the **chaos in the New Hospitals Programme** set to continue.

By July 2021, Natalie Forrest, leader of the NHP, admitted to a conference that the 'brakes had come on' for some of the 'Pathfinder' projects, most notably Princess Alexandra (Harlow in Essex) – the very hospital where the ceiling recently collapsed.

Later that same month the NHP team effectively tore up initial proposals, writing to all eight of the initial "pathfinder" schemes calling for their plans to be resubmitted, each also including a proposal with **costs cut back to £400m**.

The cash squeeze threatened the viability of the schemes, all of which were already projected to above this new limit.

Nonetheless ministers kept insisting that the government was 'on track' to build 40 hospitals, and NHS England even invited trusts to submit bids to become one of eight additional projects, **to make 48 "new hospitals"**.

Image: QEHKL NHS FT

Somewhat premature: management celebrate Queen Elizabeth Hospital Kings Lynn (crumbling with RAAC concrete) being added to the government's New Hospital Programme – which has yet to lay a single brick

A massive **128 bids were received** – many of them way above the suggested £400m limit.

But in the event the need to prioritise rebuilding hospitals built with defective RAAC concrete beams and ceilings (at a cost of **£500m – £1,550m per hospital**) has meant that the chances of any of the new additional schemes being carried through was vanishingly small.

Last May then health and social care secretary Steve Barclay admitted that **eight major projects** initially on the list of 40 would be pushed back into the 2030s (St Mary's/Charing Cross/Hammersmith Hospitals (Imperial); Queen's Medical Centre/Nottingham City Hospital; Royal Preston Hospital; Royal Lancaster Infirmary/Furness General; East Sussex Hospitals; Hampshire Hospitals; Royal Berkshire; and North Devon District Hospital).

According **to HSJ's sources**, the government's new hospitals programme (NHP) now requires an extra £4bn more than the £22bn theoretically promised by ministers to complete the schemes by the end of the decade.

Changes – and delays – to the hospital plans alongside soaring inflation have meant costs have increased. Now the NHP is proposing to maintain existing bed numbers rather than reduce them, and abandoned their hopelessly unrealistic assumption that beds could routinely be run at 95% occupancy.

Almost five years after the initial promise of 40 hospitals the NHP is now reportedly drawing up its full business case, containing a more detailed plan and costing for the programme.

Top bosses leaving

However both **Natalie Forrest** and **Saurabh Bhandari**, the programme director, have both announced they are leaving the NHP.

Forrest, who was only seconded to NHP, chose not to apply for the permanent position of senior responsible officer for the NHP at the Department of Health and Social Care, which **went out to recruitment** in late December.

So the government's focus on IT and AI and 'getting the waiting lists down' (including increasing use of the private sector) is proving very short-sighted.

Without safe infrastructure, health care cannot take place, with the knock-on effect on waiting lists. No AI in the world can replace a physical structure that is safe to work in.

Money to hire **PAs** in primary care – but not for **doctors**

NHS England guidance specifies that Physician Associates (PAs) must have completed a 2-year post graduate course, achieving either an MSc or the lesser qualification of a Post Graduate Diploma. Having then passed an additional exam they should work as clinical staff **"under supervision of a doctor as part of the medical team."**

But where PAs are recruited to work in primary care with funding from the Additional Roles Reimbursement Scheme (ARRS), NHS England insists each PA has to **"provide first point of contact care for patients presenting with undifferentiated, undiagnosed problems**." (**page 91**)

NHS England guidance has only recently dropped the requirement for PAs to "participate in duty rotas" – after **hostile coverage from the Daily Telegraph**.

The BMA is **demanding an inquiry** into the extent to which including PAs on rotas is leading to them replacing doctors.

But there are other worrying proposals. For example NHS England insists PAs must "undertake face to face, telephone and online consultations for emergency or routine problems" – as determined NOT by the GPs in the practice, but "by the PCN [Primary Care Network]."

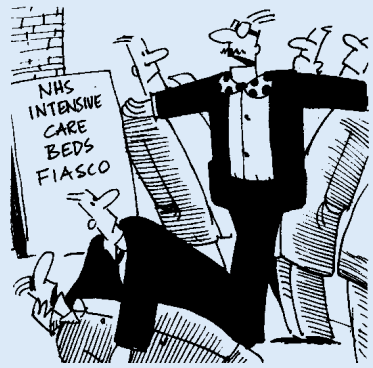
The BMA's recently published **'Scope of Practice' guidelines** have attempted to set out the proper roles for PAs and Associate Anaesthetists.

But a **growing list of Universities** that train PAs (whose 2-year courses cost upwards of £12,000 per year) seem to be encouraging PAs to believe they will cover increasing areas of work that patients expect to get from doctors.

Manchester University even promises to give students "a detailed knowledge of pharmacology and prescribing safety (in anticipation of changes to legislation to allow physician associates to prescribe)."

Another medical school website even went so far as to describe one of the Senior Lecturers leading the PA course as a doctor, despite their lack of appropriate medical or academic qualifications – and only hastily deleted the offending section after being challenged by The Lowdown.

Graduating PAs who pass the Physician Associate National Certifying Examination are classed alongside **nursing and other professional staff,** and are not included in the doctors' pay scales.



'Let me through, I'm a Physician Associate'

They jump straight in at **Agenda for Change** Band 7 – £43,742 per year / £22.37 per hour (plus additional London Weighting for NHS staff working in London). This band is for senior qualified nurses and professionals.

Newly qualified PAs in hospitals therefore begin with higher pay than many of the fully qualified nurses, health professionals – and junior doctors who have more years of appropriate training, and who **have the added responsibility of supervising the PAs' work**. To rub salt into the wound this is taking place as junior doctors have been waging a bitter and protracted fight to restore their pay to 2010 levels.

In general practice PAs are cheaper than qualified GPs, leading to growing concern that they and other "alternative roles" could begin to outnumber GPs.

Primary Care Networks (PCNs) can access extra cash (Additional Roles Reimbursement Scheme' (ARRS) funds) to cover the full cost of hiring PAs (at total costs of up to £53k per PA per year).

ARRS funding (which according to NHS England was in excess of £1billion in 2023/24) also covers **eleven other new roles**: but none of this funding can be used to hire qualified GPs or nurses that so many patients are eager to see.

As a result we have the spectacle of **locum GPs unable to find work** as Primary Care Networks are encouraged (and funded) instead to recruit a range of staff who are not doctors.

Row over exclusion of GPs from 'improved' GP services in NW London

John Lister

Leaked plans by North West London Integrated Care Board's primary care team to force through a wholesale reorganisation that would exclude GPs from almost all provision of 'same day' GP care for over 2 million people have triggered a strong response from campaigners, councillors and angry GPs.

The Integrated Care Board (ICB) has been forced into a limited retreat, with a letter to GPs from 'NW London Primary Care' dated February 19 seeking to "explain and reframe some of the language that we have been using."

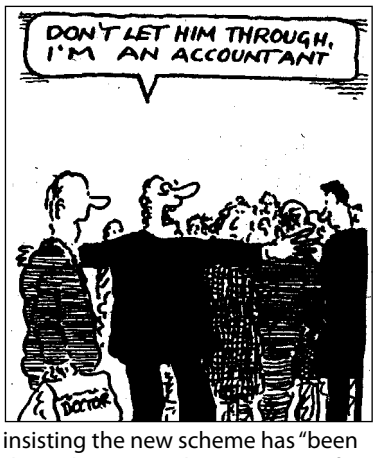
It admits: "We now appreciate that we have not explained clearly enough what our intention is around our aspiration to support same day care for patients in NW London. As a result we acknowledge that many myths have arisen…"

The ICB letter adds another half-apology: "We may have, by using some phrases such as 'target operating model' given the impression that this is an inflexible top-down delivery of a plan. This was not our aim and we apologise."

But NW London Primary Care goes on to make clear they are going to roll out exactly that same controversial plan anyway – just more cautiously and slowly.

The breakneck 13-week schedule to impose the new system by April 1 has been abandoned, in favour of "phasing of implementation during 2024/25."

Indeed the sting is in the tail of the ICB letter which concludes by



insisting the new scheme has "been through a comprehensive sign off process relating to all of the funding … in our internal ICB processes. … We cannot now unpick the access aspects from the rest of the programme without calling into question the whole piece of work."

In other words it's a fait accompli, and the only question is how long it will take to push it through. And a letter sent on the same day to the North West London Local Medical Committees (representing GPs) is far less accommodating in tone. It begins by reiterating the ICB's earlier claim that the main outline of the proposals were "agreed three years ago."

It's obvious that NW London GPs have not been engaged with the ICB body trying to reorganise GP services. It's no surprise that, with no initiative seeking to bring them on board, busy GPs have not read through every ICB Board Paper, or noted the detail of minutes of obscure committee meetings.

(Nor of course have many patients or campaigners, who have no access to many of the meetings where these proposals seem to have been hatched up.)

But widespread ignorance of the plans should not be taken for agreement.

For the ICB now to insist that proposals that have not been properly discussed or agreed have already been "signed off" and can't be changed is to admit how poor their communications have been, and no doubt still are.

As if this was not bad enough, the February 19 ICB letter to the LMCs offers just two pages and 13 vague, evasive and unsatisfactory responses in answer to the LMCs' five pages spelling out 15 detailed concerns about the plan and its potential implications.

The row began when patient participation groups, GPs and London-wide LMCs, the body representing GPs across London reacted angrily to belated news that the new system was to be bulldozed through, with no prior consultation, in less than 13 weeks.

According to a Briefing Pack sent to the 45 NW London Primary Care Networks (PCNs) at the end of January, the new system would establish "Same Day Access Hubs," each covering one or more PCNs.

Patients who select 'same day' as an option when ringing their own GP would have their call diverted through to the local hub, each of which would be staffed by a non-clinical care coordinator who would assign the patients for treatment to a team consisting of three "prescribing Advanced Nursing Practitioners or Physician Associates" (or suitable alternative staff) plus a "prescribing pharmacist" and a "social prescriber" – all overseen by a senior supervising GP.

Only the most complex cases would get appointments with a GP.

In the illustrative example, the GP in the hub team would personally deliver **only 7 per cent (ten out of 146) daily appointments**, and get less time (10 minutes with each patient) than the 93% of appointments that would be given 15-minute appointments with the other staff.

NW London ICB has made no attempt at patient involvement. The October **Board paper explaining activity so far** made no reference to any form of consultation or engagement with patients, and the slides sent out in January make only a vague mention of "stakeholder engagement."

A "system wide access workshop" to involve "stakeholders" has not yet been announced.

On February 12 the GP magazine Pulse highlighted the growing row in NW London, headlining **"GPs raise 'immense concern' around ICB plan for 'same day access hubs'"**.

It quotes one local GP describing the ICB plan in scathing terms: "Non-evidenced and no mandate – who on earth is driving this? Continuity of care saves lives."

The fight goes on.

New Cambridge University research, based on analysing data from over 10 million appointments in 381 GP practices over an 11-year period has concluded that – as the NW London GPs have been arguing – continuity of care increases productivity in general practice by reducing demand for GP consultations.

It therefore advises against models of care (such as the NWL Primary Care plan) which prioritise fast access, and instead urges GP practices to focus on continuity of care.

The study's co-author Professor Stefan Scholtes from the Cambridge Judge Business School told Pulse it does not advocate separating same-day care from longer-term term care, and he said it 'would be a mistake' to do so 'organisationally', for example with ICBs running all urgent care from treatment centres.

This and the above article combine information from two Lowdown articles (on February 15 and February 27).

Change of policies vital to rescue our NHS

In the countdown to this year's General Election, the NHS will be one of the most important election issues. It's an important opportunity for us to demand the kind of NHS we all deserve: a 'People's NHS,' says Keep Our NHS Public's Head of Campaigns, TOM GRIFFITHS.

The stakes are high.14 years of Conservative Party rule have wrought unprecedented devastation on the NHS. For the future of the NHS, just as for the rest of life in Britain, positive change is crucial.

The country desperately needs a change of government, but also needs a radical change of policies, not least on the NHS and social care.

But the solutions on offer from the Labour Party **have also disappointed**. Labour's message is that the NHS needs 'reform', and that the call for urgent funding is the simplistic demand of '**some on the Left**'. It argues that the NHS is wasteful and inefficient, that staff are reluctant to put patients first and 'modernise'.

Labour's promise to offer an open door to the private sector is especially troubling.

They are mirroring arguments made by the Conservative Government that the NHS model is irreparably flawed. They are wrong.

What is sorely needed is the political will to re-establish a national health service that is publicly funded and delivered, and universally accessible again.

The NHS must be funded to extend its capacity, to be there to meet patients' needs, and to be more open and accountable.

The crisis grows

Up to 250 people each week are dying avoidably from delayed urgent care. Tens of thousands have died from delays to over 7 million tests

and treatments **affecting over 6 million people**.

The austerity years of underfunding, coupled with the decades-long drive to privatisation, have resulted in what is now the worst performance in the NHS's history. Demoralised, underpaid staff are leaving in their thousands and **public satisfaction with the NHS** is dangerously low. It does not have to be this way.

But let's be clear, the NHS model has not failed – the Government has failed the NHS.

The NHS, when funded for need, and not defunded for ideological reasons, was and will again be **one of the best health systems in the world**.

During most of the last 75 years, the NHS has consistently delivered some of the best healthcare outcomes in the world and was 'best in class' up to 2015 (**reported 2017**).

Keep Our NHS Public is therefore calling for a restoration of the 'People's NHS'.

It's a call to act, before it's too late.

We have produced a set of demands, with the evidence to support them, to enable campaigners to argue positively for a restored NHS.

We demand: Restore the People's NHS

- A publicly provided NHS with a commitment to end private healthcare involvement
- An NHS funded to succeed, not defunded to fail.
- An NHS workforce that is respected, with restored morale and its value recognised through decent pay & conditions.
- A Public Health service rebuilt to lead the protection and restoration of the nation's health and the tackling of health inequalities.
- A rebuilt NHS, restored and expanded; enabled to tackle health inequalities and help deliver a healthy population.

The political choice at the general election is stark: the government of the last 14 years simply has to be removed.

But the parties hoping to form a new government must adopt radically different policies to earn the electorate's vote.

Nowhere is that more clear than in the NHS.

But there is an opportunity in the run up to and during the election, to help the electorate to see behind the misinformation from those in government, on opposition front benches and the right-wing media.

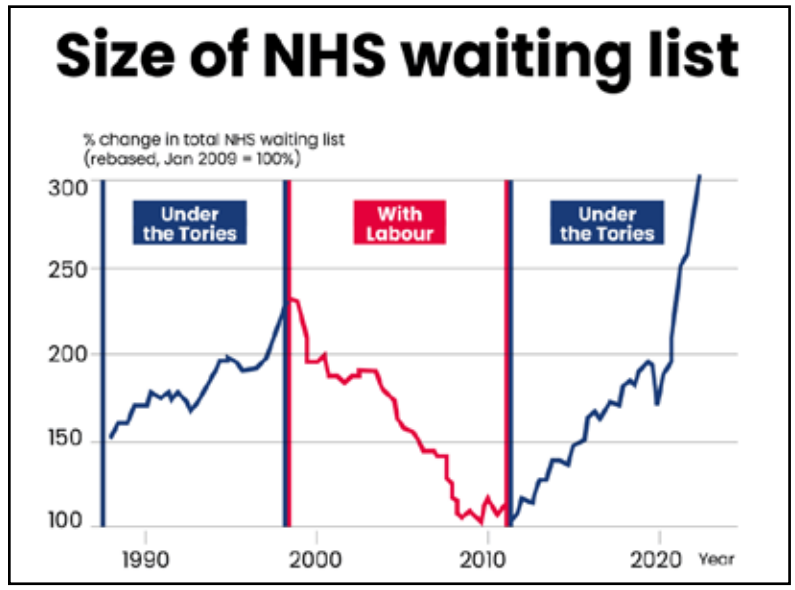
It's a chance for us to challenge all politicians who are asking for our vote.

Providing the tools to win the debate

We hope the call to **Restore the People's NHS** will become a rallying point for campaigners, those politicians who do agree with us, and the unions - and will enable and empower us all to win the debate.

We have produced a range of materials – all available for free:

- Free **leaflets and postcards**.



- A full-colour 44 page **Restore the People's NHS booklet** which includes a detailed breakdown of our demands, powerful myth busting information, tips and advice for campaigners and much more.
- A growing list of **People's NHS Factsheets** which provide the fact-checked arguments to win debates.
- **Campaigning tools**, including messaging guides, suggestions for campaigning online and in your local communities, as well resources for working with the press, social media graphics, and more.

Giving the NHS what it needs to succeed

We know the NHS model is **second to none**.

But it requires urgent funding, an end to private interests exploiting and undermining the NHS, and a restoration of a national service, comprehensive and available to all, promoting health and health equity, and delivering high quality, safe clinical care for physical and mental health.

The country cannot afford not to have a well-functioning NHS – the funding can and must be found.

The NHS was built successfully at the most difficult of times, in the aftermath of World War II.

With the right political will a restoration of the People's NHS can and must be achieved.

Read about our Vision for a People's NHS at *https://keepournhspublic.com/peoplesnhs/*

Gloomy news behind the hype for private hospitals

John Lister, from longer Lowdown article, March 28

Analysis by independent consultancy Broadstone claims private hospital admissions funded by medical insurance increased to 458,000 for the first three quarters of 2023, an 11 per cent rise on the equivalent 2022 figures.

The official figures and commentary produced for the private sector by the **Private Healthcare Information Network** (PHIN) confirm the 11% increase – which sounds more exciting than the **actual number** of extra privately insured patients, just 46,000.

Broadstone argues that total numbers could exceed 610,000 in 2023/24, "which will be a record annual level."

However this "record" would be **just 30,000** (5%) above the 580,000 privately insured patients treated in 2019 – **despite the fact that the NHS waiting list has risen by over THREE MILLION since then.**

Projections by City am also imply a continuing reduction in numbers of 'self-pay' patients, who borrow or raid savings to pay up front for health care to skip past waiting lists.

Since a dramatic 30% leap – from around 50,000 per quarter – in the second quarter of 2021 self-pay numbers have been **more or less level at around 70,000 per quarter**, and have fallen back during 2023.

The City am projections would suggest an even bigger (9%) fall – to 256,000 a year – in 2024.

Self-pay has been seen by many as the way the private sector could really cash in on the lack of NHS capacity, since NHS waiting list patients are by definition unable to take out private insurance to enable them to jump the queue – because they have a pre-existing diagnosed health issue.

However that growth has stalled as the cost of living crisis and the soaring costs of private ops have made private treatment unaffordable to most.

So while **City am** bigs up a "0.4% increase" in self pay in 2023 compared with 2022, **Actuarial Post** is almost alone in flagging up the relatively small scale of this market, and pointing out the obvious:

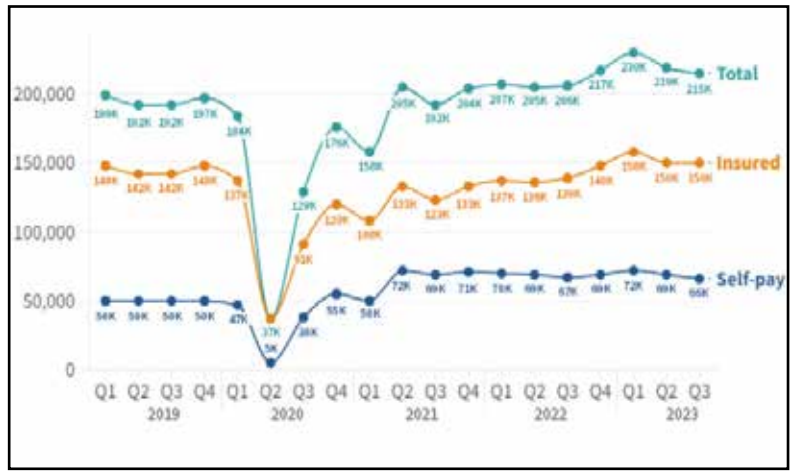
"… self-pay admissions are plateauing due to a natural limit on the amount of people able to fund expensive treatments entirely out of their own pocket."

Private health insurers (seeking to maximise their own profits) have become more canny in holding down the prices they pay to private hospitals, whereas self-pay patients can be charged whatever the hospitals think they can get away with.

So a market so clearly dominated by privately insured patients is bad news for the hospital bosses.

But if the private self pay sector has not been able to grow significantly and rapidly during the past few years, it's arguable that it will never have a better chance, since the growth of the NHS waiting list after the peak of the Covid pandemic has been faster than any other period in its history.

It's this clear evidence of the lack of any sustainable organic market for private health care which means despite all the claims of booming demand the private hospital sector is still eager to grab more contracts to treat NHS-funded patients to fill otherwise empty beds.



PHIN data: in-patient/day-care admissions comparison Q1 2019 – Q3 2023

Private sector eyes on booming profits – from NHS cataract ops

Tony O'Sullivan, Co-chair of Keep Our NHS Public and retired NHS paediatrician

There are areas of the NHS now where care is either unavailable (**dentistry**) or disrupted and dangerously close to being only provided by the private sector (ophthalmology – eye care).

These situations are beyond 'canaries in the mine' – they are symptoms of a dangerous situation.

Ophthalmology is in danger of following the road of NHS dentistry, where in many areas of the country it is already impossible to get any NHS care, and where even NHS charges – let alone sky high private charges – are for many unaffordable in the cost of living crisis.

The **Royal College of Ophthalmology** is concerned that so many integrated care boards are now commissioning cataract surgery from private companies like SpaMedica that in some areas NHS-run general and emergency ophthalmology departments are in jeopardy.

Soaring costs

Many patients are being offered cataract surgery prematurely, and the commissioning costs are going through the roof.

At the end of last year the front man for the private hospital sector, David Hare of the Independent Healthcare Providers Network (IHPN) was boasting of the way the system has been **set up to funnel patients straight in to private clinics**:

"Ophthalmology eRS [electronic] referrals are up 130 per cent compared with 2019 – but total referrals across all other specialties remain 10 per cent lower than pre-pandemic.

"We know some of the reasons why. **High-street optometrists refer, via eRS, directly to independent providers.** Patients can see their options, choose the providers with shorter lists and get the quickest possible access to treatment."

So the private sector profits and expands, while NHS commissioners have no choice but to foot a growing bill, and revenue is drained from the NHS into private sector shareholders' pockets.

Research by **the CHPI think tank** has shown that the percentage of NHS cataracts delivered by the private for-profit sector has increased from 24% in 2018/19 to 55% in 2022/23.

78 new private for-profit clinics focused on cataract operations have been opened over the past five years.

This is threatening vital funding for NHS care, as surgeons are being offered up to three times their NHS pay, taking them away from NHS work. Patients are literally going blind on NHS waiting lists that have not been touched by this private jamboree in cataract surgery.

Eight percent (one in twelve) of the total NHS waiting list is patients waiting for eye clinic appointments – and this has not fallen.

Worse still, the harvesting of NHS funding by the private sector means that funding for **key sight-saving care** like glaucoma clinics and macular degeneration care is threatened.

CHPI research has also exposed on Newsnight (BBC 14.3.24) the way private cataract clinics have been gaming of NHS coding to maximise the fees they charge to the NHS.

NHS losing consultants

The president of the Royal College is worried that soon it will be hard to access eye care provided by the NHS which is '**losing consultants, money and trainees to the private sector**'.

Bear this in mind when Labour says it will provide an open door to the private sector and use it more efficiently than the Tories.

There is no spare capacity in the private sector that does not further undermine the publicly provided NHS.

There is only one pool of trained clinical staff: as extra staff are lured to work in the private sector it makes it even harder to fill NHS posts.

Contracted staff win lump sum

Two days of strike action in February have helped persuade Sodexo to pay 300 hospital staff in North Devon (pictured above) the lump sum from last year's NHS pay award, worth at least £1,655 for full-time health workers, including porters, domestics, sterile services and catering staff.

Sodexo initially agreed to pay 80% of the sum, but applied for funding for the pay deal from the Department of Health and Social Care, and was successful, so the remaining 20% will be in staff April pay.

UNISON South West regional secretary Kerry Baigent said: "Sodexo generates huge profits and had the ability to pay its staff all along. It could have easily avoided these strikes.

A two-day stoppage has also won a similar pay out for hundreds of support staff employed by Wiltshire Health and Care.

This is the subco, or "Limited Liability Partnership", created in 2014 by 3 NHS trusts (Great Western Hospitals, Royal United Hospitals Bath and Salisbury NHS Foundation Trust.)

Research finds no benefit from privatisation

Privatisation of healthcare results in a reduction in quality of care according to a review **paper published in The Lancet**. The study's authors from the University of Oxford, concluded that:

"At the very least, health-care privatisation has almost never had a positive effect on the quality of care."

They add that their review "provides evidence that challenges the justifications for healthcare privatisation and concludes that the scientific support for further privatisation of health-care services is weak."

The published review looked at studies made of healthcare systems in eight high-income countries, where privatisation has been taking place over the past 40 years. Studies included those from the UK, USA, Canada, South Korea, Germany, Sweden, Croatia and Italy.

Longitudinal studies (performed over time) provided some of the most useful information. The researchers found a consistent picture of privatisation adversely affecting the quality of care.

And although outsourcing can reduce costs, this was at the expense of standards.

The review findings "do not align with the expectations of mixed markets, namely that they would improve quality by increasing competition."

Transition to not-for-profit private organisations was also found to frequently have a detrimental effect on the quality of care, although to a lesser extent than moving to for-profit provision.

The studies tend to focus on inpatient care, and there are very few studies on other aspects of health care such as community, primary, and ambulatory care. The studies also often ignore public and patient perceptions of the services provided.

The Lancet review is not the first to look at the effect of private ownership on the quality of care in healthcare.

Last **August the BMJ published** a systematic review – **Evaluating trends in private equity ownership and impacts on health outcomes, costs, and quality** – which looked at the takeover of healthcare companies by private equity funds, and found that ownership by private equity companies is associated with a worse quality of care and higher costs.

The authors of the review, which was led by the University of Chicago, found that private equity ownership was "most consistently associated with increases in costs to patients or payers" and was "associated with mixed to harmful impacts on quality." Furthermore, the review identified "no consistently beneficial impacts of PE ownership."

Taken together the two reviews provide good evidence that taking publicly-run services, such as those of the NHS, out of public hands and into the private sector is a bad move for quality of care, even if the organisation is run on a not-for-profit basis.

Extracted from The Lowdown article, March 2

Greater Manchester KONP members present petition to Sir Richard Leese, Chair of the ICB. It calls on the ICB and the Integrated Care Partnership (ICP) (the body which involves local authorities and providers) to support the KONP demand to restore and rebuild the People's NHS.

£480m headache for Greater Manchester health chiefs

Caroline Bedale, Greater Manchester KONP

Health campaigners in Greater Manchester want to know how the Integrated Care Board (ICB) will protect NHS services and staff in the face of a massive £180m financial deficit at the end of March.

But the budget submitted to NHS England (NHSE) for 2024/25 shows an even greater problem: £298m deficit in revenue expenditure and over £125m for capital – which it is known that NHSE will not accept.

There will be further efforts to get a 'compliant' budget by early May.

Meanwhile NHS buildings are literally crumbling, with necessary maintenance – including to replace RAAC roofs in at least two major hospitals – constantly deferred.

Private management consultants (PwC) and a national 'turnaround' director have been brought in by NHSE to oversee the work on Greater Manchester ICS's finances – at what cost?

And what about the supposed autonomy which devolution was supposed to bring?

Responses to Freedom of Information requests have provided complex information about cost improvement, efficiency, challenges, mitigations, 'grip and control', but no clarity about what that really means for services and for staff.

Although they have said that "Any proposed changes to patient services as a result of the financial position are subject to a quality and equality impact assessment, and where applicable public consultation", the promised 'public engagement exercise' has not yet started.

For 2024/25, Greater Manchester will get an allocation from NHS England of £7.2 billion. This includes growth funding of £241.2m to cover inflation, demographic/population growth, increased demand for services, investment in mental health services and in the Better Care Fund (for social care).

But giving with one hand is offset by taking away £60.7m with the other – as Greater Manchester is deemed to have had more than its 'target' allocation based on population needs, despite having some of the most deprived areas in the country.

That allocation also assumes Cost Improvement Plans (CIP) will 'save' £103m and that 'slippage' (cuts by any other name) a further £42m.

One proposal which campaigners do welcome is to reduce the dependency on the private health care sector, especially the use of 'out of area placements', mainly for mental health beds for people with individual packages of care. But without substantial investment in services within Greater Manchester it's hard to see how that will be achieved.

The ICB itself is having to reduce its running costs by 30% by 2025/26. Experienced staff have already been made redundant, which must affect the capability to commission services effectively.

It is assumed there will be no growth in the workforce of local NHS providers, and indeed overall the workforce will reduce. Yet there is also a commitment to shift from using expensive agency staff to cover the thousands of vacancies. How will they do that with a shrinking, poorly paid workforce?

It is ominous to hear that "cash flow remains a material risk for the GM system" and that several providers will need to take out loans to manage their financial obligations. They already have the long term PFI debts to cover: saddling NHS providers with more debt cannot be sensible.

Where is the money to fix crumbling hospitals?

Adapted from The Lowdown March 23, 2024 and December 15 2023

The spring budget gave the NHS's capital budget, used for infrastructure, a boost of £3.4 billion, but there is a catch. It is all earmarked for technology, digital and AI projects and is dependent on "productivity increases" that are almost double anything asked for previously.

Meanwhile, parts of NHS buildings are falling on patients and injuring staff. In a single 24-hour period **a ceiling collapsed onto a patient** in the intensive care unit at the Royal Alexandra Hospital, Harlow, and a lift failure at the Royal London Hospital, Whitechapel, resulted in a surgeon breaking a leg.

Matthew Taylor, CEO of the NHS Confederation wrote in the HSJ that although the £3.4 billion is "much-needed and to be welcomed" it does not begin until 2025-26, and bigger productivity gains "will only be realised if crumbling estates are addressed too; a problem exacerbated by regular raids on the capital budget to fund day-to-day cost pressures."

The **NHS Confederation** calls for an extra £6.4 billion in capital funding a year to repair crumbling estates and invest in the latest digital technology and equipment.

Taylor added that "Images of new computers sitting in outdated and sometimes dangerous buildings could become a symbol of the failure of joined-up policy."

Massive backlog

In December 2023 government **figures** showed that England's NHS backlog of maintenance had rocketed by 13.6% in the last 12 months to **a massive £11.6 billion**, having almost doubled from £6.5m in 2018/19.

Thousands of props hold up Queen Elizabeth Hospital Kings Lynn

And while around **half (£3 billion) of the backlogs** in 2018/19 were seen as 'high' or 'significant' risk, that proportion has now grown to 67%.

High risk is defined as "where repairs/replacement must be addressed with urgent priority to prevent catastrophic failure, major disruption to clinical services or deficiencies in safety liable to cause serious injury and/or prosecution."

An ITV News report in 2023 revealed that **nearly half of NHS hospitals in England** have been forced to close wards and vital services due to flooding, power cuts and structural problems. Plus there are now 54 hospitals listed as having faulty concrete.

Four trusts now have "high risk" backlogs of more than £100m. Worst hit is Airedale FT, one of the hospitals in need of rebuilding due to the use of defective "RAAC" (**'reinforced autoclaved aerated concrete'**) concrete, with almost the whole of the trust's £353m backlog classed as "high risk"

Almost half (£319m) of the **£769m total backlog** in Imperial College Healthcare Trust in North West London is high risk, including the crumbling St Mary's Hospital (£145m) and the massive £174m maintenance backlog at Charing Cross Hospital.

Sixty percent (£102m) of Buckinghamshire Health Care's **£168m backlog bill** is also "high risk" – most of this at Wycombe General Hospital (£84m). And over 60% (£106m) of Croydon's **£170m backlog** is also high risk.

Nottingham University Hospitals has seen a dramatic worsening in its state of repair, with its Queens Medical Centre now in need of **£239m of repairs and upgrades**, half (£121m) of which is either high or significant risk, out of a trust total backlog of **£438m**.

However Hillingdon Hospitals has inexplicably reduced its estimated backlog from **£236m in 2019-20** to £153m in the latest figures.

Last summer a **National Audit Office report noted** 22 hospital trusts in England were facing backlog maintenance bills in excess of £100m.

Now 29 trusts have topped the £100m mark, and these numbers are set to increase.

Hutton goes in to bat for PFI investors

A former New Labour health minister who **signed off thirteen NHS Private Finance Initiative (PFI) projects** in 2002] was **appointed last month** … to speak up for private sector investors. They are preparing for likely disputes as some of the earliest PFI contracts draw to a close.

(Now Lord) John Hutton has been installed as the chair of the Association of Infrastructure Investors in Public Private Partnerships (AIIP), a body specifically formed to represent the investors' view.

The private consortia are eager to head off the danger of legal battles over liability for repairs and other costs in the final few years of contracts, when the private sector has least incentive to upgrade equipment or carry out maintenance.

The issue is complex because as the NAO emphasised **in a major report in 2020**, "the PFI model is designed to be self-monitoring."

One of the supposed benefits of PFI was that the assets were supposed to be maintained throughout the contract before being handed over to the public sector.

The **most recent Treasury figures**, which appear to be in cash terms, show the average total cost of NHS PFI schemes over their lifetime is seven times the initial cost: almost all NHS schemes have been an index-linked cash cow for PFI consortia, with many if not most of the profits flowing to offshore tax havens.

Greed

So cutting back on maintenance or replacement of clapped out equipment or fittings is simply driven by greed for even higher profits at the expense of the NHS and its patients.

Sadly the private firms are able to take advantage of too many ill-prepared public sector bodies.

The **NAO survey** of 571 PFI schemes in England and 129 in Scotland, Wales and Northern Ireland found 30% of survey respondents were not monitoring annual maintenance spending, and around 35% of respondents stated they had insufficient access rights to monitor the maintenance programme adequately."

Lord Hutton's **new role will be** to chair an organisation "formed to defuse disputes between investors and public sector over financing deals," but it's clear from the outset which side of the fence he is on: and it's not the public sector.

When questions were **raised by the BBC** about the soaring costs and alarming consequences of PFI school contracts, the PFI bosses' response came from Lord Hutton, who blamed inadequate school budgets, and told the BBC the contracts "do reflect good value for money for the taxpayer."

99% vote NO to new GP contract in referendum

GPs in England have voted overwhelmingly to reject the contract changes that are being imposed by the government and NHS England from April 2024.

With a **61% turnout, and 19,000 voting**, the outcome of this referendum means over 60% of all BMA GP members have voted against the contract.

As of January 2024, there were 37,177 individual fully qualified GPs working in the NHS in England, equivalent to **27,534 full-time** fully qualified GPs.

The changes they object to include a baseline **funding uplift of just 1.9%** for England's general practices, way below inflation in recent years, meaning many practices will struggle to stay financially viable over the next six to 12 months and risk closure.

The payment per patient (to cover all consultations) in 2022/23 **averaged just £164.64 per year**, less than £1 more than the **£163.65 average in 2021/22**.

Primary medical care's share of NHS spending in England was planned to **fall to 8.4 per cent in 2023-24**,nearly a percentage point lower than 2020-21, when it hit a high point of 9.2 per cent, and the lowest share of spending in eight years.

The changes in the new contract also include controversial incentives which push practices further away from traditional GP-led care and access to GP and practice nurse appointments.

Dr Katie Bramall-Stainer, chair of GP Council England at the BMA, said:

"When I qualified as a GP in 2008, general practice was 'the jewel in the crown of the NHS'. Fast forward to 2024, we are witnessing a 'constructive dismissal' of general practice across England where £1.4bn of Treasury funds for practice staff are forbidden to be spent on recruiting more GPs and practice nurses.

"In fact, we now have hundreds of GPs unemployed – this is madness."

GPs are feeling especially threatened because the controversial Additional Roles Reimbursement Scheme (ARRS) offers funding to employ a dozen different types of health worker **(See inside, page 4)**, but not GPs or nurses.

Meanwhile the number of fully qualified GPs has fallen by 2,000 in the last decade and 1,300 practices have closed.

Dr Bramall-Stainer added: "In 20 years, I've never known GPs to be so frustrated, angry and upset. We are unable to offer our patients the care they want and need."

The BMA says this 'temperature check' (which was not a formal trade union ballot for action) "signals the start of our fight back, and we will bring our patients with us."

The referendum went ahead **despite the contract being imposed**, and NHS England saying it is final.

The BMA has discussed the possibility of moving to **industrial action in late November or December** with the possibility of it coinciding with the looming general election.

Any action is likely to concentrate on measures that would disrupt interaction with NHS England rather than close practices.

The referendum on the GP contract has come on the eve of its imposition by NHS England. Meanwhile junior doctors have again voted for further rounds of strike action: their demand to restore the lost value of their pay remains unresolved.

Reaching out to build support

Last year teams of volunteers helped to promote Health Campaigns Together and Keep Our NHS Public at the Durham Miners' Gala in July, and at a number of the main health union conferences.

Many thanks to all involved.

This year we are again keen to make sure we have stalls and displays at as many conferences of trade union and TUC bodies as possible.

Please contact us if you will be a delegate or visitor to a conference this summer.

If your organisation has not yet affiliated to HCT/KONP, why not do so for 2024 and help us build a network that can stand up for our NHS in this toughest of all periods? Details on how to do so in blue box below.

Since our organisations merged affiliates to HCT have the option of also affiliating free of charge to KONP, and linking with local campaigns.

- **HCT/KONP is eager to receive invitations to speak at trade union branch and regional meetings, local campaigns, pro-NHS political parties and especially Student Unions and societies.**

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

Massive new hike in fees to deter migrants

In February the **Immigration Health Surcharge** in England increased by 66% – from £624 per year to £1,035 per year. The increase since 2015 (when the surcharge was introduced at £200 per year) has been more than a five-fold.

The Government introduced these charges for healthcare as part of their policy of creating a 'Hostile Environment' – a range of policies designed to deter migrants by making their life in the UK unliveable.

In doing so they have fundamentally altered the principles that underpin the delivery of healthcare in England: that it should be about need, not ability to pay.

The detail has changed over time, but now most people who migrate to this country, but who have not got indefinite leave to remain, will have to pay for the NHS – whether through the Immigration Health Surcharge in addition to taxation, if they are on a Visa (see other briefing note), or through inflated charges if they do not have 'status'.

UK visa fees were already eye-wateringly high, with migrants in this country paying some of the highest costs in Europe.

Raising fees still further risks pushing thousands deeper into poverty and insecurity, and deterring health workers from coming with their families to help fill chronic vacancies in NHS staffing.

These are also people who, in many cases, have already been living in our communities, working and paying taxes for many years.

It would now cost a family of four building a life in the UK almost £68,000 for visa fees.

But this is not really about money: the Government used to collect the figures about the amount of money these charges raised – but it was so small, they stopped publishing them.

The policy fits with Tory governments since 2014 scapegoating people who are migrant, for political purposes. But it seeks to make 'normal' the idea that NHS charging is OK, and that some people 'deserve' to be charged.

In doing so it has also set up a system which could be adapted to charge us all.

- Info from **Greater Manchester Patients Not Passports**

AFFILIATE for 2024

Health Campaigns Together is a broad campaigning coalition of trade unions and health campaigners, established in 2016. All three major health unions are affiliated HCT, and we support them in their campaigns. We also have great support from non-health unions.

HCT and Keep Our NHS Public played a key role in the establishment of the broad SOS NHS coalition launched in January 2022. This coalition won the support of 55 organisations including 18 national trade unions, and gathered over 345,000 signatures on a petition demanding emergency funding to save a struggling NHS.

It held a successful conference with speakers from several trade unions and held a national demonstration**.**

We hope your union branch, regional committee or local TUC will wish to affiliate for 2024. 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.

Affiliation to HCT will also bring with it the option of a complimentary affiliation to KONP and a voice in its decisions.

HCT holds affiliates meetings online, and our affiliates decide policies and campaigning priorities.

We are only as strong as our affiliates. We value your support.

Please affiliate (or reaffiliate) for 2024 – if possible **ONLINE** at ***https://healthcampaignstogether.com/joinus.php***

(where you can also find details on how to pay by bank transfer or by cheque)

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:

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