Accountable care rebadged to escape toxic image
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Bevan's NHS – a huge advance
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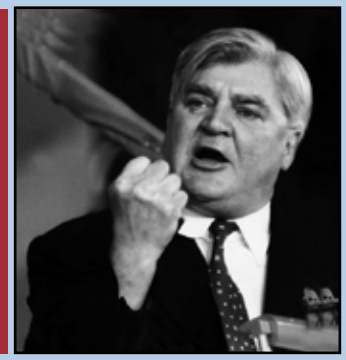

UNISON's Sara Gorton writes on Subcos
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HEALTH CAMPAIGNS TOGETHER

#ourNHS

● Quarterly ● No. 10 April 2018 ● FREE ● @nhscampaigns

#ourNHS70

Celebrate and Demonstrate

LONDON

Saturday 30 June

Assemble 12 noon Bring banners

Portland Place London W1A

Organised by:

● TUC ● UNISON ● Unite ● GMB ● RCN ● BMA ● BDA ● Health Campaigns Together ● People's Assembly. (more TBC)

94.4%
average of general and acute beds full, winter 2017/2018

20
hospitals averaged 99%+

4
days average was below 90%

6.2%
increase in **population** aged 65+ between 2013/14 and 2016/17

12%
increase in **emergency admissions** for over 65s in same period

530
Number of cancer operations cancelled over 3 months of winter

109
Number of cancer operations cancelled by leeds Teaching Hospitals Trust

18%
portion of population aged 65+

43%
of emergency admissions were patients aged over 65

65%
emergency bed days for 65+

1.6%
increase in attendances at A&E in winter 2017/18 compared with previous year

6%
increase in emergency admissions in the same period

Tens of thousands back our Feb 3 Day of Action

An estimated 60,000 people from all over England braved the weather and thronged the streets of London on the #FundOurNHS demonstration on Saturday Feb 3, called by Health Campaigns Together and People's Assembly.

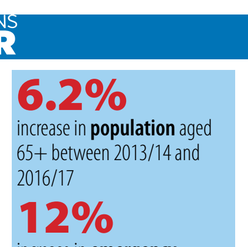
Thousands more joined local protests outside hospitals and in town centres in over 50 more events, and there were supporting demonstrations and protests in Belfast and Enniskillen in Northern Ireland and Glasgow as well as contingents on the march from Aberystwyth and Welshpool in Wales.

In England there were protests from Cornwall to Carlisle, from Hereford to Norwich and from Newcastle to Whitstable: many managed to get local and regional press and TV coverage, and many of these also managed to make clear it was a national day of action on a common theme.

Our NHS has been desperately and deliberately under-funded by a government more intent on privatisation than maintaining safe services even for people in their own party's heartland constituencies.

A brilliant panel of speakers at the London rally outside Downing Street managed to retain an audience despite the freezing conditions: speakers included actor Ralf Little, speakers from of UNISON, Unite, RCN, campaigners, junior doctors, nurses, patients – and shadow health secretary Jonathan Ashworth.

We knew there would be a need to



display the mounting public anger at the state of our NHS – and this march was successfully mobilised in less than a month.

We also know it has not been enough to shift the course of Theresa May's government, which keeps hiding behind spurious statistics and claims to have already given the NHS more money – even while hospital Trust deficits are rising towards £2 billion.

With Trusts facing additional costs of anything up to £1.3 billion for the cancellation of an estimated 55,000 elective operations in January to free up scarce beds for emergency patients, the NHS is headed into 2018-19 with a millstone of debt hanging heavy on 8 out of 10 trusts.

More action will be needed, at local and national level to keep up the pressure for a change of course – or, if need be, a change of government.

So we are asking for more support. We have growing commitments for building the campaign, but we have no core funding: we depend on donations and affiliations.

Whether you joined us in London or supported local events, or even if you could not get to either, please consider getting your trade union, campaign, Labour Party, pensioners group or other organisation to affiliate to Health Campaigns Together if they have not already done so – and make a donation towards campaigning in 2018 if you have.

And if you are a member of a national organisation make sure they also affiliate to Health Campaigns Together.

Full details of how much it costs and how to pay can be found on the back page of this newspaper.

HCT is an alliance – and a very effective one so far, having staged two successful national demonstrations and a major conference last November.

We can and must reach wider, build stronger and do even better: help us do what we need to defend our NHS against cuts and privatisation, and reinstate it as a fully publicly owned, delivered and accountable service free at point of use and available to all.

A lively contingent from Bedford, Luton and Milton Keynes. Above (right) Unite West Midlands activists (left) actor Ralf Little marched and spoke at the rally.

New figures confirm scale of winter crisis

Figures compiled by the House of Commons Library show the extent to which 2017/18 has been the worst ever for the NHS.

With 1,100 fewer front line beds open than the previous year, numbers of A&E attendances went up by 1.6%, but emergency admissions soared by 6%.

Numbers of patients kept waiting over 4 hours rose to a new peak – 22.9% (846,000) – almost four times the level they were at in 2010/11 when the spending freeze began.

The ten trusts with the most 4 hour-plus waits in A&E had levels of 37% and above (Blackpool, Hillingdon, Cornwall (Truro), university Hospitals North Midlands, Norfolk & Norwich, Worcestershire, Lancashire, Shrewsbury & Telford, Imperial (North West London) and Portsmouth). Only 13 trusts had fewer than 10% of delays.

Eight trusts registered diverts of ambulances from hospitals full to capacity; one trust alone (Worcestershire) accounted for almost a third of the national total of 329 occasions.

The numbers of ambulance handovers delayed by over 30 minutes is also an indication of capacity problems: United Lincolnshire Hospitals delayed almost half of all ambulance handovers (48%) by 30 minutes, and one in five ambulances were stuck there for over an hour – with consequent delays to full treatment of emergency patients.

Worcestershire is again in the top ten of delayed ambulance handovers, but other hospitals with more than 25% delays include Kings Lynn's Queen Elizabeth Hospital, Harlow's Princess Alexandra, the merged Peterborough and Hinchingbrooke (North West Anglia) and Nottinghamshire's Sherwood Forest Hospitals.

The highest bed occupancy figures (all above 99% for the whole of the winter) included Walsall, North Middlesex, Princess Alexandra, Hillingdon, Northampton, Basildon, james Paget (Great Yarmouth), Kettering, King's Coilege Hospital and Worcestershire.

All of the figures on the winter crisis underline one hard fact: the NHS is already under-resourced and struggling to cope. Any further cuts in beds will make matters worse.

Why you should join the big march and celebration June 30

As the NHS approaches its 70th birthday on July 5, there is plenty for us to celebrate and defend.

Despite 30 years of repeated attempts by government "reforms" to fragment and distort it, and to divert a growing share of the NHS budget into the coffers of profit-seeking private companies, it remains at core what it was in 1948: the world's first universal, publicly-funded health care system, delivering care on the basis of clinical need, not ability to pay.

It employs over 1 million well-trained, dedicated staff who daily show their commitment to the values of the NHS as a public service.

And, despite widespread misconceptions that those rich enough can buy themselves an equivalent service privately, the NHS is the only provider of emergency and trauma care, the provider of the vast majority of all forms of elective treatment, and the only service that does not pick and choose its patients.

The tiny private sector, with its tiny hospitals are only interested in simple elective operations – and depend for their existence on the NHS training staff, filling empty private beds with NHS-funded pateitns, and providing intensive care and treatment of complex cases.

Of course the NHS, and the quality of care it can deliver, has been damaged by eight years of effectively frozen funding since 2010, and before that by a succession of ideologically driven neoliberal policies that have sought to break it up into competing units, outsource and privatise support services and clinical care, privatise the provision of capital (PFI) and maximise the openings for grasping private companies at home and abroad.

Performance on all fronts has been falling, capacity reduced to well below equivalent health services elsewhere, staffing levels reduced to levels that run high risks of service failure, staff pay frozen below inflation since 2010, training of new staff hit by scrapping bursaries, and the NHS itself in England repeatedly reorganised, top-down, into more secretive, unaccountable units.

Nor is it at all reassuring now to hear Theresa May, whose party and government have repeatedly lied and deceived the public on the levels of funding they were providing, promise a new NHS 'long term funding plan' – possibly financed through an extension of regressive taxation through National Insurance.

But the fact May has to pose as a supporter of the NHS, the fact that privatisation has been restricted in scope and many local plans for cuts in service have been blocked or delayed for years at a time indicates that campaigners are having an impact: if we fight we can win.

It's partly because of the giant protest on March 4 last year, called and organised by Health Campaigns Together and People's Assembly, that May could not secure the majority that would have let her pass new legislation for even more "reforms".

So it's important we build a massive show of strength on June 30 in London – to celebrate and defend a service many of us literally can't live without. let's step up the pressure.

Be there; join us, and bring your banners – and a smile: it will be big!

Jess Hurd, www.reportdigital.co.uk

GP at Hand protest

GP at Hand's adverts promise quick access to a NHS GP via your mobile. Sounds great? But that's not the whole story. GP at Hand's business model is set to undermine NHS general practice.

It is a GP practice, based in west London, which is using IT to hoover up NHS patients all round London, using NHS money.

GP at Hand claims patients can get a same or next day face-to-face appointment if needed at five clinics around London.

One of these is Newby Place Health Centre, near Poplar, east London, and on March 30 it was targeted for a protest by campaigners raising the simple call 'GP at Hand should be banned.'

The online service stands accused of draining resources from NHS GP practices across London, cherry-picking younger, healthier patients, and taking resources from local NHS general practices that offer long-term care to all.

Tower Hamlets Local Medical Committee (LMC) chair and Bow GP, Dr Jackie Applebee, explained:

"Surgeries like my own are now getting lots of calls from angry former patients, who didn't realise that by using GP at Hand they were deregistering from their usual surgery," she said.

Promised extra money for 2018:
Now you see it … now you don't!

In November the chancellor Philip Hammond announced there would be £1.6 billion "extra resource spending" for the NHS in 2018. But as so often has been the case, this figure is completely deceptive.

A February blog ('With strings attached') by Nuffield Trust analyst Sally Gainsbury explained why in practice much of the extra money can only be used to bail out deficits – and virtually none can be used as extra spending to expand services.

One of the more shocking facts to emerge is that the past eight years have seen successive reductions in the real terms value of the "tariff" that fixes the prices paid to hospitals for each patient they treat: Gainsbury points out that:

"This means that this year, NHS trusts will make an average 5% loss on each patient they treat, reflecting the gap between how much they are paid to treat each patient and the actual costs of providing that care."

Too low for trusts

And while the prices paid are too low for the trusts to cover their costs, leaving them working harder to deepen their deficits, they are too high for the limited budgets of the Clinical Commissioning Groups to meet the 3% annual increase in demand from a growing population and a rising number of older people;

95 CCGs were in deficit by the end of 2017, with CCG deficits estimated to reach £400m or more by April.

The trusts' share of the "extra" money turns out to be £650m which will be funnelled through what was once called the Sustainability and Transformation Fund, but which has now been so milked of resources to prop up debt-ridden trusts it is now rebranded as the Provider Sustainability Fund.

5%
average financial loss to trusts on every patient treated in hospital

£400m
estimated total deficits of CCGs by April 2018

But there is a catch here too: trusts are only eligible for a share of the bail-out cash if they comply with the cash limit imposed by NHS England as a "control total".

As Gainsbury argues, this means to gain extra funding they must first make cuts:

"There is ultimately only one way a provider can consistently do that, and that is by reducing the average costs of caring for each patient it treats […] For trusts this year, that will mean real-term cuts to their spending per patient of 4.2%."

But even if they get an extra slice of cash they cannot spend it on patient care, since that would increase their spending above the "control total": so the extra money must remain unspent as a way of scaling down the end of year deficits – without any benefit to patients.

The further catch is that if the trusts do succeed in meeting the control total, this will almost certainly mean they face another massive target for cost savings in 2018/19 … the pressure is unending.

About 300 people joined a pro-NHS march through York on April 7, supported by local Labour MP Rachael Maskell and former Health Secretary Frank Dobson. The march was supported by Leeds KONP and York Defend our NHS

DRIP FEED

A round-up of news

Hunt pats himself on the back

Sam Ingrams

Amid widespread complaints over growing staff shortages in frontline NHS services, in February health Secretary Jeremy Hunt was awarded a Humanitarian Award at a Patient Safety summit – which he had partly organised himself.

The award was presented by the Patient Safety Movement's (PSM) founder Joe Kiani on 24 February to recognise Hunt's "global leadership on [patient safety]".

However, the recently-promoted Secretary of State for Health & Social Care is individually named on the PSM's website as one of the supporters organising the 6th Annual World Patient Safety, Science and Technology Summit.

Twitter users criticised Hunt for neglecting to credit healthcare professionals for progress in patient safety. He was also a keynote speaker at the event, alongside former US president Bill Clinton and World Health Organization Director General Dr Tedros Adhanom Ghebreyesus.

According to *The Guardian*, Hunt's speech announced a crackdown on drug dispensing errors, which may cause up to 22,000 deaths a year.

Jeremy Hunt and the Department of Health have been approached for comment.

Milton Keynes ACS

An open and shut Board

The Labour leader of Milton Keynes council Peter Marland is embarked on his own private mission to establish an 'Accountable Care System' – working primarily through the unusual route of the council's Health and Wellbeing Board – a body which until now has been largely limited to vague waffle about "ageing well" and "living well".

This neatly avoids dealing with the abject failure of the "Better care Fund" in Milton keynes to deliver its planned reductions in delayed Transfers of Care (78% over plan), increase provision of residential care (32% below target) and reduce non-elective admissions (running 13% above target).

To drive the confused process on, Milton Keynes' Health & Wellbeing Board has now proceeded to set up its own "Integration Board", consisting of a dozen bureaucrats from the CCG, council, hospital and mental health trusts, etc.

The terms of reference make clear that this new Board's meetings "will not be held in public," and that far from integrating the local health system, the commissioners (council and CCG) may need to meet separately from the providers.

Perhaps the most laughable statement, therefore is the insistence of the Chair, from the local CCG, that the success of the Board would be down to "openness and transparency".

Fat chance.

35%

Reduction in applications for midwifery courses since 2013, with decline pre-dating abolition of bursaries.

CCGs short changing mental health

More than one in ten Clinical Commissioning Groups were expecting to end the latest financial year spending less on mental health than they did in 2016/17 according to the Health Service Journal. The total falling short (32) is fewer than the 50% of CCGs who were found by Labour MP Luciana Berger to have reduced mental health spending.

Leicester City and Trekin top this list of shame, with projected reductions of 22% and 24% respectively, while Cornwall (NHS Kernow) and Tower Hamlets were both reporting spending 12% lower than last year, while Hammersmith and Central London were both above 10%.

The concerns of NHS England over the failure of CCGs to deliver the promised increases in mental health resources have been demonstrated by the letter from NHSE's mental health director Claire Murdoch to all 207 CCGs warning them that they will face direct pressure from national level if they don't.

Psychologists matter for excellent mental health

Colenzo Jarrett-Thorpe, National Officer, Unite the Union

Dozens of applied psychologists from all over England lobbied Parliament on Tuesday 20 March to tell their MPs why #appliedpsychologistsmatter for mental health services.

Applied Psychologists are mental health specialists who have completed extensive higher education, post graduate training and further specialist training after qualification. They are trained in evidence based therapies to help people suffering with emotional or psychological problems.

The public seek the help and support of applied psychologists for all sorts of problems – NHS mental health services, physical health care, social care; children & adolescents, adults, older adults, people with disabilities and those who have addictions.

Over recent years, there has been investment into IAPT (Improving Access to Psychological Therapies) services; there are concerns about how these services are being compromised.

Concerns

There are major concerns for Specialist Psychological Services which help the most unwell and vulnerable people:

1. Public access to specialists, and specialist posts are being lost. The public are waiting longer for help, travel further or if they can, or even paying to go privately for therapy (which poses a risk, as they are vulnerable to linking with unregulated private practitioners). We are losing expertise in the NHS as a result.

2. The funding landscape of mental health is barren. Promised funds are not evident at the front-line. This is having a huge impact on services, stretched so thin that holes are appearing. This directly impacts on public health, and means that the levels of mental distress are climbing, especially in young people.

3. The current pressures on many members of the public mean they need more support, not less. Many services offering early help are disappearing, which means that people have to be very unwell and in crisis before they can actually get help. Some people are simply falling through the net.

4. Access to training future Psychologists is being reduced. This threatens the future of the profession, and the diversity of backgrounds of those coming into the profession.

5. Staff well-being is also being compromised – the workforce is under significant stress, and this must be addressed if we are to continue helping the public. The recent Health Education England NHS workforce consultation document showed the vacancy rate for clinical psychologists was the 3rd worst profession, just behind learning disability services and mental health nursing.

The message to politicians is simple and clear:

- Press the government for the promised funding to mental health
- Raise the profile and importance of protecting Psychology as a profession
- Urge local CCGs for evidence that their spending on mental health and psychology services is at parity with local physical health care services, and that they have a strategic plan on mental health spending which reflects the Five Year Forward View

Ask local CCG or mental health trusts for evidence they are investing in specialist psychology posts to work with the most vulnerable groups, and that these are reaching minority and disadvantaged groups in line with equality law

Protect appropriate specialisms and ensure funding reaches NHS services, rather than private providers, who often can't hold complexity and refer back to the NHS anyway.

We hope campaigns and activists in Health Campaign Together will be able to join us in our quest.

- For more information check out: ***http://www.unitetheunion.org/how-we-help/list-of-sectors/health-sector/healthsectorcampaigns/psychologists-matter/***

Crisis in CAMHS services

Shocking figures in recent months have highlighted the desperate shortage of beds, staff and funding for children's mental health .

In Derbyshire there are no child and adolescent mental health (CAMHS) beds in the whole county. Beds in Nottinghamshire and Leicestershire are often full.

As a result, fourteen Derbyshire children in nine months have been transferred to other parts of the country for an NHS mental health bed. One child with "extremely complex mental health and social issues" had to wait at the Royal Derby Hospital for 145 hours - six days – until they could be transferred.

No such beds

A spokesman for Derbyshire Healthcare NHS Foundation Trust said: "The Trust is not commissioned to provide children's mental health inpatient beds, and there are no such NHS beds in Derby or Derbyshire."

The opposite problem prevails in Norfolk and Suffolk, where nearly half the brand new mental health beds for young people, built at great expense, have never been slept in: NHS England won't fund them: instead, huge sums are spent transporting young people in crisis sometimes hundreds of miles from home.

In Shropshire & Telford & Wrekin the service to support children with autism, ADHD, eating disorders and teenage depression has been renamed the 'Emotional, Health & Wellbeing Service': but it is still underfunded, and now in a major crisis.

Two child Psychiatrists have just left as this newspaper goes to press, having only been there a few weeks. Their departure leaves just one Child Psychiatrist to cover the whole of Shropshire and Telford & Wrekin, an area 2.25 times the area of Greater London with over 500 families needing support.

One teenage lad sadly lost his life recently, by walking in front of a train at Harlescott Crossing, after waiting 3 months for a crisis appointment!

On April 3 families from Jigsaw Family Group, a group of parents who access Children's Mental Health Services, staged a protest (above) at the desperate state of services.

June 30 – London – NHS@70 – Party and Protest for our NHS!

Dr Bawa Garba and nurse made scapegoats

Campaign calls for justice

Dr Tomasz Pierscionek

Many doctors, nurses and NHS workers were appalled to learn that the General Medical Council (GMC) appealed against the decision of their own tribunal in order to push for the erasure a doctor from the medical register.

The Medical Practitioners Tribunal Service (MPTS) had originally suspended Dr Hadiza Bawa-Garba's license to practice for 12 months. However, the GMC won a legal challenge in the high court to permanently prevent her from practicing medicine.

Dr Bawa Garba and nurse Isabel Amaro were convicted of manslaughter on the grounds of gross negligence in 2015 following the tragic death of six year old Jack Adcock at Leicester Royal Infirmary in 2011.

Overstretched

In the opinion of many health care workers familiar with the conditions that exist within an increasingly underfunded and overstretched NHS, Dr Bawa-Garba and nurse Amaro should not have been sanctioned by their respective professional bodies let alone found guilty of manslaughter by gross negligence.

The consensus amongst healthcare professionals is that Dr Bawa-Garba and nurse Amaro were let down by their trust and scapegoated by the GMC and careless media reporting, which chose to overlook the many factors contributing to a tragedy.

The tragic loss of Jack Adcock was not due to gross negligence but rather the inevitable result of a system under pressure and the expectation that NHS staff work above and beyond what is humanly possible.

The GMC's successful drive to remove Dr Bawa-Garba from the medical register roused medics in a manner not seen since the junior doctors' contract dispute and spurred them to undertake a number of grassroots actions independent of the British Medical Association.

Doctors who are generally reticent to complain about let alone take action against workplace injustice were outraged at the treatment of Dr Bawa-Garba, knowing they might one day find themselves in her shoes.

Amongst the many campaign actions organised in support of Dr Bawa-Garba, a crowd-funding appeal was set up to raise funds for a legal team to take her case to the Court of Appeal and challenge the ruling that led to her removal from the medical register. The crowdfunding campaign has thus far raised over £360,000.

Separately, a few colleagues and I organised a march to raise awareness of the unjust nature of Dr Bawa-Garba's conviction and campaign for the following:

- Overturn Dr Bawa-Garba's conviction of gross negligence manslaughter and have the Court of Appeal review the High Court decision to remove her from the medical register.
- Lobby the GMC to reconsider its position in striking Dr Bawa-Garba from the medical register.
- Demand CLEAR guidance on what a doctor should do in situations where they are faced with covering extra duties.

Supporters outside the High Court show Dr Bawa-Garba is far from alone

The march was attended by a few dozen doctors, nurses, other NHS workers and supporters from outside the healthcare sector.

As the march passed by the Royal College of Paediatrics and Child Health, we were invited into the building to speak with the RCPCH's CEO (a former paediatric nurse) to discuss why we were marching.

As doctors working within the NHS we often find themselves in similar situations to Dr Bawa-Garba, where we are compelled to cover the work more than one colleague. As we juggle an ever-increasing number of balls, mistakes will inevitably occur because we are only human. Some of these errors may have fatal consequences.

Yesterday it was Dr Bawa-Gaba, tomorrow it could be me or anyone of my colleagues. To ensure similar situations do not occur in future, Dr Bawa-Garba's case must be viewed within the context of the conditions in which she was working.

If we allow Jack Adcock's death to be explained away by placing all blame on one or two individuals, we reduce the chance of preventing similar deaths occurring in future.

Not much Success from Essex Regime

Eric Watts

The Essex Success Regime was announced by Simon Stevens in June 2015: the county along with areas in Devon and Cumbria had been singled out because of serial budgetary overspends.

In Essex, after a year of behind the scenes deliberations, plans were announced to downgrade two of the three A&E depts. But these plans have since been revised after much public opposition.

The Regime morphed into a Sustainability & Transformation Plan. It appears to be one of the most advanced in terms of planning, being one of few that have been put out to public consultation.

However some questions posed a year ago remain unanswered.

The STP ' attitude is that good things are happening and that all will turn out well. The published results of the 9 Vanguard Sites do not support this optimism. One of the main reasons for the STP is to shift care out of hospitals and into the community but NHS England figures show that, over the measurement period, there was a larger reduction in the rate of hospital bed days in non-vanguard areas.

Undaunted we still hear managers speaking of the need to reduce hospital attendances, particularly to A&E.

Southend's "right royal" protest

To their credit the STP commissioned Healthwatch to survey people in A&E: they found that 80% of A&E attenders were there on the advice of a health professional, and most of the other 20% went there directly because they could not access urgent care elsewhere.

NAO finds no evidence

The National Audit Office released a report on emergency admissions on March 2, finding nothing to confirm the views of McKinsey that 40% of admissions are avoidable.

Other areas for concern include a belief in hi-tech solutions such as monitoring COPD patients through oximetry: though studies have shown some success, a more detailed investigation showed that it was the presence of the nurse specialist conducting the study that improved care – not the readings from the instrument.

Another area where a seemingly good idea has had poor results is the GP extended hours initiative – where some GPs went to work at a 'hub' at weekends: but in Essex patients calling at the weekend were told they had to wait for days – all the weekend appointments had already been booked by patients calling during the week.

The practices whose partners took part in the hub project had a higher rate of their patients going to A&E. This suggests that the hub consultations were inadequate, whether due to insufficient time or lack of continuity of care. We need to understand better why people go to their GP before rolling out more wasteful schemes.

Our position is that we must have adequate care established in the community before starting any initiatives to direct patients away from A&E departments.

■ One other issue of concern is the local pathology service. This is part of an ongoing saga of abandoned plans and missed deadlines. A joint venture with a private supplier was set up but has lost thousands of results and become a laughing stock.

On March 15 Hands Off HRI made legal history

In Leeds Crown Court Judge Mark Gosnall agreed there were important matters of law raised by the plan to close acute services on the Huddersfield Royal Infirmary site which must be tested in a full Judicial Review.

We expect the hearing to take place in June. The hospital trust has so far considered itself to be beyond reproach, but they will now have to account for their proposals in court.

This is a huge blow to the Trust and a massive victory for the people of Huddersfield who have stood shoulder to shoulder with this campaign. It has taken two years of hard work and perseverance to pull this off but we have been rewarded.

The Judge approved the referral to the High Court on the following grounds:

- A serious matter of public law needs to be tested
- Consideration of the consultation exercise
- Examination of alternative community care provision
- Potential breach of Equality Law
- Lack of travel and transport provision

Our campaign group will now be shifting up a gear to ensure all possible approaches are explored to win this legal case.

Of course we still await the outcome of the Independent Reconfiguration Panel which is now with the Secretary of State but undoubtedly this legal case will focus his mind!

Of course this is not the end of the road; we now have to win our Judicial Review but our legal team are up to the challenge and we know we will continue to have your support. This challenge has local and national consequences.

It is the first serious legal challenge of its kind. If we win, it doesn't just help our hospital, it will give encouragement to all campaign groups fighting for their own services.

However we will need ongoing public support. We estimate we need to raise another £10,000 to bring our legal case and that is where you come in.

We have now proved this is not a done deal and that People Power CAN work. Join our Facebook page Facebook: HandsoffHRI.

This is a fight for Huddersfield and the wider NHS, and we can win. Let's do this together. HANDS OFF HRI!!

You can donate directly by bank transfer into the Hands Off HRI account. Sort code: 20-43-04 Account number: 93119130

For local contact details, please email: **info.handsoffhri@gmail.com**

Rebranding of ACOs shows NHS England in retreat on key plans

It's becoming very difficult for NHS England to sneak any changes past increasingly suspicious campaigners and an increasingly vocal local public: that's the encouraging message from their decision back in February to discard the US-inspired term "accountable care organisations" and rebrand the same projects as "integrated care organisations" instead.

Pressure to halt the dash towards "accountable care" models was increased by the Chair of the Commons Health Committee Sarah Wollaston urging Jeremy Hunt to put the process – and the new regulations to empower the new ACOs – on pause pending a committee review. She in turn was clearly responding to public pressures and concerns.

This is far from the first time NHS England has found itself effectively hog-tied by a combination of public opposition, professional reservations and the political impasse of a government which, especially since the June 2017 election does not have a stable parliamentary majority to change the law and step away from the disastrous 2012 Health and Social Care Act.

To make matters worse, as a recent National Audit Office Report has again pointed out, few if any of the new models of care and new ways of working favoured by NHS England have any evidence to support them.

Pressure to discharge people more quickly from hospital is also having at best mixed results, with emergency readmissions up by an estimated 22% over 4 years to 2017, double the increase for emergency admissions.

One of the key factors in the various plans to remodel services has been the need to expand community services to care for people outside hospital.

But there is no new money to invest in it, and as the NAO notes, the Department admitted last October that they had no clear plan for how the estimated £10 billion spent on community health care could be better used to manage current and future demand.

The proposed Forward View for community services was abandoned in February.

Campaigners, many led by Health Campaigns Together, made it impossible for NHS England to carry through their original plan for Sustainability and Transformation Plans in 2016, and made the term itself politically toxic in 2017.

Then widespread anger at the potential impact of the "Capped Expenditure Process" to restrict spending to NHS England-dictated "control totals" meant that approach too was swiftly ditched.

Attempts to switch the focus to "Accountable Care" last summer and autumn triggered two Judicial Reviews, still pending as we go to press, and increasing public rejection of any "American" model – with even the King's Fund warning the ACO concept was "deeply unpopular" with the public.

Judicial Reviews are also hampering NHS England efforts to drive through any of its plans for reconfiguration of services in several areas.

Even since the change of label to "Integrated Care" private sector companies have made it clear that they do not expect to be winning contracts to run the new systems, as many people had feared.

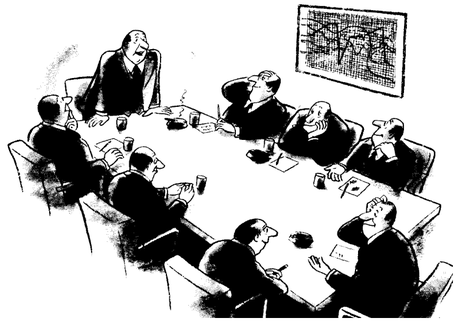
Indeed the only big contracts to have been awarded have gone to existing NHS providers, not multinational corporations – not least because of the pitifully low levels of funding now available for the new contracts.

We are not out of the woods yet: but it is clear that especially in this 70th anniversary year when people are more conscious of the strength of NHS values we are a long way from any major new private sector inroads.

However we facing see the private sector contract failures and counting the cost of the dysfunctional market system and irresponsible CCGs imposed on the NHS by the 2012 Health & Social Care Act. We fight on.

"Then again, gentlemen, we're in complete agreement in the sense that nobody knows the answer to any of the questions that have been raised."

Drawing by Stan Hunt; © 1983 The New Yorker Magazine, Inc.



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

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

Circle and CCGs tied up in Notts

Hot on the heels of Virgin screwing an undisclosed settlement out of the NHS in Surrey for not renewing the firm's 3-year contract, Circle, the company best-known for screwing up the privatisation of management at Hinchingbrooke Hospital, is also threatening to sue the NHS, even after the company itself decided to pull out of bidding for a contract.

This time Nottinghamshire health chiefs are in the sights of corporate lawyers – for not offering enough money to guarantee a fat enough profit for the private equity fund that has now bought up Circle, despite its long and unbroken series of losses on most of its operations. Circle's tiny private hospitals depend upon revenue for treating NHS patients.

In a sign of the times in a cash-strapped NHS, the Greater Nottingham Clinical Commissioning Partnership put the a year contract to run one of the largest elective treatment centres surviving from the New Labour period in the 2000s out to tender at just £50m, a reduction of over 25% on the £67m paid in 2017-18.

Circle argue that the reduced funding assumes drastic cuts to services: they may be right, but there will be little public sympathy for a company that effectively drove away dermatology consultants in Nottingham, who refused to work for Circle after CCGs gave the firm a contract at the expense of the local hospitals trust.

It appears many of these companies have failed to grasp the financial facts of life in post 2010 NHS, 8 years into a funding freeze.

The *Health Service Journal* has quoted Justin Crowther from Catalyst Corporate Finance admitting that a number of private contracts had proved "relatively uneconomic" and not as profitable as private firms had expected.

Nottinghamshire campaigners travelling to February 3 London 'Fund Our NHS' demonstration: they have a full agenda of local battles to fight now

STP sent back to drawing board

Plans drawn up by Nottinghamshire's Sustainability and Transformation Partnership to close 200 hospital beds have been called into question by the chief executive of the county's largest acute hospitals trust, after the area's health services were overwhelmed by "extraordinary" winter pressures.

The controversial STP, says Nottingham University Hospitals boss Tracy Taylor was just "an aspiration."

But the winter had shown "we need to think more carefully. … I think the STP will need to be reviewed."

Speaking to the *Health Service Journal* in March, she said the trust "struggled" with inadequate capacity: "we planned to cancel 25 percent of electives, but we have cancelled almost all of them since January."

Despite all the brave talk of integrated services and a swift move towards an Accountable Care System, the grim reality of last winter has shown that none of the basics have been put in place.

The county's community services were not staffed or geared up to handle "sub-acute" patients discharged from hospitals.

'Out of hospital' contract awarded – out of the NHS

Amid a host of misleading rumours and reports, Nottingham CityCare Partnership has announced that it has been awarded a 7-year, £206m contract to deliver Out of Hospital Adult services in the Nottingham City area.

The CityCare partnership make the point on their website that they are a social enterprise, and "not the NHS".

However given the obsession of local CCG bosses with the proposal to establish a local "Accountable Care System" there will be some relief that they have the contract, and not the US insurance company Centene, whose £2.7m contract to advise on the ACS is drawing to a close.

None of the results of this work have yet been published, although the recent winter chaos in the county must raise new doubts over the prospects for an ACS.

Another tough year coming

BMA forecasts summer beds crisis

Several trusts are keeping extra winter beds open into the summer as they struggle to cope with demand.

Indeed the NHS can expect to see performance this summer as poor as that seen in recent winters, as so-called "winter pressures" extend right through the year, according to new analysis from the British Medical Association.

Forecasts

Using official data from the last five years, the BMA's health policy team drew up a number of forecast scenarios for this summer's NHS performance (July, August and September 2018) , measured in A&E attendances, waiting times, admissions and trolley waits.

The worst-case scenario would see a summer-months repeat of scenes experienced during winter 2016.

Best-case scenario:

- 5.89 million attendances at A&E
- 613,000 waiting 4-hours+ at A&E
- 89.6 per cent of patients seen, admitted or discharged within 4hrs
- 1.51m emergency admissions
- 127,000 4-hour plus trolley waits

Comparable winter: 2015

"I'm not a visitor - just next in line for that bed when you're done with it."

Worst-case scenario:

- 6.2 million attendances at A&E (5% higher)
- 774,000 people waiting over four hours at A&E (26% higher)
- 87.5 per cent of patients seen, admitted or discharged within 4hrs
- 1.57 million emergency admissions (4% higher)
- 147,000 trolley waits of four or more hours (16% higher)

Comparable winter: 2016

It's not clear whether or not these scenarios factor in the possible implementation of planned bed cuts and service reductions mapped out in Sustainability and Transformation Plans and other controversial reconfiguration plans.

Some of these planned reductions have been scaled back after hospitals have failed to cope this winter.

NHSI calls in McKinsey

NHS Improvement (NHSI), the regulator tasked with upholding standards and values across the NHS in England, recently decided to spend £500,000 to bring in management consultants McKinsey – to help "clarify its purpose."

The fact that the people charged with steering the NHS feel they need to bring in private sector consultants to tell them what to do and why tells us NHSI have little confidence in their own highly-paid team of directors and "very senior managers," and that much of NHS senior management has now become almost totally reliant on external management consultancy.

Yet recent research which has confirmed (as many have suspected for years) that external consultancy work has not delivered efficiency improvements – indeed NHS trusts work better without them.

Kent contract

Nonetheless in Kent and Medway health chiefs have forked out paid more than £6million to private consultants to help put together a plan to reconfigure health services.

In North West London last November more than £4.5m has been already spent with various 'external experts' purely on preparing, writing, 'assuring' and 're-writing' the Strategic Outline Case for reconfiguration of services.

This followed the rejection by of the first draft of the SOC (also expensively compiled by management consultants) NHS England and NHS Improvement last September. Tens of millions have been squandered on producing such documents in NW London since 2012.

CQC figures confirm the decline of social care

While the population and the numbers of frail older people continue to increase, there are fewer nursing homes and places available than there were in 2015.

The full grim picture emerges from the latest ratings from the care Quality Commission.

A survey of all care services shows almost one in five (18%) "require improvement", while 353 (2%) are deemed "inadequate". The services with most problems are nursing homes, with more than a quarter (27%) needing improvement and another 3% inadequate.

The largest percentage of services needing improvement are in the North West (21%) and Yorkshire and Humber (22%).

Even in the best performing region (East of England) one service in eight requires improvement.

The national figures show 2,131 fewer nursing home places than 2015: over 200 homes have closed since 2015, and over 2,000 residential homes have closed since 2010.

Private ownership of the majority of homes severely limits the possibilities for local councils to reverse the trend, even if they had any money and political will to do so.

But without adequate provision and quality of social care, any plan assuming "integration" remains no more than a pipedream

62%
increase in numbers of elderly patients taken to hospital as emergencies from care homes since 2010

"Care BnB" rides again

The controversial plan dubbed "Carebnb" because of depressing similarities with the highly popular "Airbnb" system for travellers to book rooms seems to be back in another East of England county after being hastily dropped in Essex in a tide of hostile publicity and criticism.

This time Cambridgeshire County Council is setting up a group to discuss encouraging homeowners with no health qualifications to rent out spare rooms and supply meals to self-funding patients freshly discharged from hospital treatment – for up to £1,000 per month.

This DIY alternative to social care could apparently run with no support from the NHS because it offers no care or support to the client. The company floating the plan, CareRooms, claims it had 600 potential hosts interested when the scheme was first publicised and dropped at the end of last year.

Starting a discussion on social care solutions

A discussion article by Professor Bob Hudson – Adult social care: an irretrievable outsourcing? – explores the complexity of the crisis in social care, and the problems to be encountered in unpicking the mess that has been made through 25 years of underfunding and privatisation.

Check it out on the Health Campaigns Together website www.healthcampaignstogether.com/pdf/Hudson Social Care 2018.pdf – and tell us what you think.

Hot and Cold Americans

While many fear an imminent invasion by US health corporations seeking to scoop up NHS contracts, it appears that many of them are yet to show any interest, while some private corporations are pulling back from contracts they already have.

Hospital Corporation of America has just ended a 7-year deal in which they rented "spare" space in Romford's otherwise massively over-stretched and hugely expensive PFI-funded Queen's Hospital.

HCA delivered private cancer treatment from 14 beds, consulting rooms, its own pharmacy and other facilities: the Barking Havering & Redbridge University Hospitals Trust claimed the £5m a year contract delivered a surplus – although they had been unable in any case to afford to open NHS beds in the space, which had stood vacant.

Last summer plans were announced for a £65m, 138 bed new hospital on land owned by University Hospitals Birmingham Foundation Trust, providing 66 private beds, run by HCA Healthcare, with 72 NHS beds leased to the trust, a new radiotherapy unit and operating theatres.

Netcare pull out of UK

South African hospital group Netcare, owners of Britain's largest private hospital chain, BMI, have announced they are to sell up its holding and leave the UK market. They blame high rents and a weak Private Medical Insurance market.

£500 billion cost of US health billing

Research by Dr. Vivian S. Lee, a radiologist at the University of Utah, and Bonnie Blanchfield, a senior scientist and former CPA at Brigham and Women's Hospital in Boston, has revealed staggeringly high costs of managing the inflated bills in US health care.

"The unnecessarily complex, fragmented, and inefficient system of billing, coding, and claims negotiations in the US health care system employs enough people to populate small nations," the pair wrote in an editorial in the Journal of the American Medical Association.

"The process of moving money from payer to hospitals and physicians in the United States consumes an estimated $500 billion per year," they continued.

Inverse care law - US style

Adults in the USA with multiple physical or cognitive problems are twice as likely to struggle financially and avoid getting the care they need, according to the US-based Commonwealth Fund.

● June 30 – London – NHS@70 – Party and Protest for our NHS!

People queue in the rain to sign Newcastle petition, February 3

North Tyneside Council votes to oppose ACO/ACSs

Well done Councillors Lesley Spillard, Sarah Day and Wendy Lott who brought the motion to the council, and to Councillors Leslie Miller, Kenneth Barrie, Margaret Hall, Gary Bell and Alison Wagott-Fairley who all spoke in favour of the motion.

In her introductory speech at the full Council meeting, Cllr Lesley Spillard stated: "There are huge concerns and objections to the 'elephant-in-the-room' which is not being widely promoted by NHSE and local CCGs. It is not benign.

"The NHS England policy is to move STPs through "systems" (whether these be named "Integrated Care" or "Accountable Care") en route to Accountable Care Organisations, with plans to put ACOs to tender inviting bids from the private sector.

This is in conflict with current legislation, and will lead to the large scale privatisation of our NHS".

All Councillors spoke with great commitment and knowledge about the matter in hand, being clear about what is at stake.

Absolutely no-one opposed the motion, and no abstentions – the vote was carried unanimously by North Tyneside Councillors….an example of excellent cross-party work by North Tyneside Councillors.

The agenda from the meeting, and the motion in full is here:

"This council agrees that there is a growing body of evidence questioning the wisdom of a key project from the NHS 5 Year Forward View: Accountable Care Organisations/ Integrated Care Systems (ACO/ICS).

In theory an ACO/ICS provider accepts a contract based on a fixed capitation -based fee to cover all of the designated health care issues for a local population and deliver an agreed range of outcomes.

The ACO/ICS notion of a fixed capitated payment is complicated by the fact that in almost every instance in the NHS, commissioners have seen the new structures as a way to make substantial savings.

However, if there is insufficient money in the contract to deliver adequate care, yet providers remain accountable for delivery of specified outcomes, then providers will be unable to continue.

This is what happened with a contract tendered out by Cambridgeshire and Peterborough CCG when a 5-year contract collapsed within just 8 months.

After a prolonged hiatus, a contract to organise cancer services for much of Staffordshire has also been abandoned before the contract was even signed, when the company named as preferred provider 'couldn't convince us they could deliver with the resources available. They couldn't meet the required evaluation criteria.

This council agrees to oppose any proposal to implement the delivery of health care in North Tyneside via an ACO/ICO, a project which in the North Tyneside CCG's own report was stated to be high risk."

February 3 - campaigners outside James cook University Hospital, Middlesbrough

Independent Reconfiguration Panel critical of Oxfordshire CCG ,but

Has the Horton been saved?

Oxford KONP - Gus Fagan

In 2016 Oxfordshire Clinical Commissioning Group announced the planned closure of obstetrics at the Horton General Hospital in Banbury and the centralisation of obstetrics at the John Radcliffe Hospital.

The Horton would retain a midwife-led unit. The closure was part of Phase 1 of the Oxfordshire Transformation Plan. The first of a two-phase consultation on the Plan was announced in January 2017, including the permanent closure of obstetrics at the Horton.

The consultation was described by Oxford Keep Our NHS Public (KONP) as 'a sham' and there was strong popular opposition to the plan in Banbury, led by the campaign group, Keep the Horton General (KTHG).

As a result of popular opposition across the county, the Health Overview and Scrutiny Committee (HOSC) of Oxfordshire County Council referred the matter to the Secretary of State.

The HOSC made the referral to the Secretary of State on two grounds – that the consultation undertaken was inadequate and that the proposal would not be in the interests of the health service in its area.

The Secretary of State sent the referral to the Independent Reconfiguration Panel (IRP) for advice.

In February 2018 the IRP delivered its advice. It agreed with campaigners and HOSC that the consultation, especially the way it was split in two

"… has added more to the confusion and suspicion than helped move matters forward. In the Panel's view, decisions about the future of obstetrics at the Horton must inevitably influence proposals that remain to be consulted on including around the future provision of MLUs in Oxfordshire."

According to Oxford University Hospital Trust, the unit at the Horton needed to close because it had been unable to recruit obstetricians to work there. The IRP agreed with critics that, since the Trust had already decided it wanted to close the unit,

"… it is not surprising that scepticism exists in some quarters about the extent of the Trust's efforts to attract the skilled and experienced staff required to reopen the unit."

The IRP concluded that the CCG needed to look again at its options for the Horton:

"In the Panel's view, a further, more detailed appraisal of the options, including those put forward through consultation, is required and needs to be reviewed with stakeholders before a final decision is made."

The MP for North Oxfordshire, Victoria Prentis, said it was a 'huge relief' to hear the IRP's conclusion.

"The IRP's conclusion that further work needs to be undertaken comes as a huge relief and is recognition of what many of us have been saying repeatedly since the flawed consultation process began."

Future uncertain

But on the heart of the matter, the future of obstetrics at the Horton, the advice from the IRP was anything but a clear victory for the Horton:

"First, that action to consider alternative options is needed because the problems with sustaining the obstetric service at the Horton that led to its temporary closure in 2016 are real and the prospects for returning to the earlier status quo are poor given a national shortage of obstetricians…

"Secondly, that this consideration must be driven by what is desirable for the future of maternity and related services and all those who need them across the wider area of Oxfordshire and beyond rather than a search for any possible way to retain an obstetric service at the Horton."

The campaign group, Keep the Horton General, was more critical of the IRP decision:

"The IRP is effectively leaving the CCG to its own devices in terms of the final decision for maternity, in spite of significant evidence that it would be unsafe to leave vast, semi-rural population without reasonable access to obstetric services. …

"KTHG considers the IRP has missed the opportunity to examine or take into account the national factors that are being used as a justification to downgrade hospitals all over England - e.g hospitals being denied training accreditation at precisely the time when shortages of specialists were anticipated."

According to Roseanne Edwards of KTHG:

"Everyone's talking as though the Horton is reprieved but I see it as a severely weakened hospital that they can see is needed with the extraordinarily dire winter pressures, but it will only, effectively, have an A&Ee and children's ward, which will be highly vulnerable. Already they are sending anything that needs a senior consultant down to the JR."

"The IRP is effectively leaving the CCG to its own devices."

No commitment

In March 2018 the Clinical Commissioning Group gave its first response to the IRP proposals. On the core issue of the campaign, it made no commitment to retaining obstetrics at the Horton:

"… the future provision of an obstetric service or change to a permanent freestanding midwife led unit at the Horton General Hospital will be determined by the outcome of the work undertaken to address the recommendations from the Secretary of State."

It also decided that "there will be no phase two consultation". Instead, a new phrase has entered the CCG vocabulary: 'co-production'.

Rather than consult the population in the county about a general plan, there will be engagement at a more local level:

"looking at the population's health and care needs so we may co-produce a health and social care system that is fit for the future".

In the meantime, the emergency department and paediatric services will be retained at the Horton. The CCG also is making no commitment to retaining community hospitals:

"The community hospitals must be considered within the context of the health and care needs of the local populations they serve, the state of the actual buildings, the rurality and size of the local population (including growth).

"The CCG and OHFT have agreed that discussions need to be more about what services are required in localities and how best the community hospitals might support, rather than a county-wide consultation on whether they should be removed or remain."

In general, the initial response of KTHG seems correct: "The IRP is effectively leaving the CCG to its own devices."

The fight goes on.

Why we don't need NHS 'cross party' initiatives

Carol Ackroyd, KONP

Shadow Health Secretary Jon Ashworth and the Greens are right to reject yet another call for a cross-party review of long-term funding for the NHS. It would be a dangerous platform for calls for social insurance models and top up payments that are less democratic and more expensive ways to pay for a health service that would bring greater social inequality – precisely the opposite direction to the founding principles of the NHS.

And to fund the NHS we need go no further than the democratic principle of payment from taxation – underpinned by the policy shift away from market competition and privatisation which have failed to deliver any benefits.

Cross-party talks require some common basis of agreement. But there are starkly opposing views.

Most MPs and peers calling for cross-party talks on the NHS have long-ago rejected support for the Bevan model of a comprehensive NHS, fully funded through taxation and available to all.

There is no common cause between those calling for cross party talks who believe the NHS is too expensive, who are happy to see private companies and giant corporates playing an increasing role in the NHS, who want "accountability" through commercial contracts, want to see the introduction of payments, private insurance or further restrictions of what treatments can be offered or who is entitled – and those of us wanting an NHS that is available to all, fully funded through taxation, publicly provided and publicly accountable.

There is talk of Hunt calling for a Royal Commission, under pressure after his disastrous 'Winter' Crisis. And some think tanks such as the Centre for Policy Studies are jumping in.

John Harris, www.reportdigital.co.uk

Jon Ashworth – right to reject proposal

Support for commissions and cross party talks comes from the same Conservatives and LibDems who in coalition pushed through the disastrous Health & Social Care Act 2012 which has enforced privatisation, allowed NHS foundation trusts to raise up to 49% of their income from private sources, fragmented the NHS and removed accountability of the Secretary of State.

From the right wing of Labour, those supporting the call include Alan Milburn, Blair's chief architect of the Labour Government's partnerships with the private sector in the NHS, and peers like Lord Warner who have championed payments for hospital stays. Many supporters of cross party talks have consultancies with, or stakes in, private sector healthcare.

KONP urges politicians of all parties to reject these approaches which threaten to further undermine the founding principles of the NHS.

Why KONP says 'no' to funding NHS through National Insurance

At the current time around 80% of NHS funding comes from general taxation. General taxation is the most efficient way of raising money, having very low overheads relative to the money raised.

Taxation is also the most equitable approach to funding: tax is progressive: companies and individuals with more income and wealth pay more; financial and health risks are pooled, so sick people do not pay more than those who are well.

National Insurance (NI) is used primarily to fund state benefits, including unemployment, maternity allowance, sickness benefits and state pensions. NI is a regressive tax since there is a cap on the top contribution, NI contributions stop when the individual reaches pension age, and contribution levels are not related to ability to pay. The level of benefits paid out is related to the NI contributions an individual has made.

International comparisons [1] have repeatedly demonstrated that funding through taxation is by far the most efficient mechanism and, indeed, the only successful route for providing comprehensive medical coverage in low and middle income countries [2].

Time and again, surveys have demonstrated that the British public is willing to pay more tax in exchange for well-funded, free and comprehensive healthcare.

Dorset campaigners win full hearing on Judicial Review

Debby Monkhouse, Dorset KONP

We are delighted to report that we've been granted a Full Hearing for our Judicial Review into Dorset CCG's plans, which are to downgrade 1 of our 3 A&E's, close 1 of our 3 Maternity's with a 2nd under threat, close Community Hospitals and/or beds in 5 of 13 Dorset locations, and close 245 acute beds.

The plans leave the future of Poole General Hospital in doubt. Poole Maternity site appeared in Poole local plan as 'existing site allocated for development' in June 2016, 6 months before the 'Consultation' on the changes even began.

We now need to raise the £10,000 Community Contribution needed for the final stage costs: ***https://www.crowdjustice.com/case/save-poole-ae-and-maternity-and-nhs-beds***

Our JR could be of benefit to campaigners across the UK as the arguments the Judge has accepted for full hearing are:

1) Unsafe Travel Times: That the plans to downgrade Poole A&E and close Poole Maternity will move emergency and Maternity services out of safe reach for tens of thousands of Dorset residents.

We have a Claimant who has been granted legal aid who is severely affected by the loss of Poole A&E, as her condition can deteriorate rapidly, and potentially be fatal. She is blue lighted to Poole regularly (8 times last year).

2) Failure to meet Beds Duty: That it is unlawful for Dorset CCG to close NHS beds without having replacement staffed services in the Community that are proven to reduce the demand for NHS beds.

We are also arguing for a third argument to be heard at Full Hearing

3) That aspects of the Consultation were so misleading as to be unlawful. There are another group in Dorset who are aggrieved about the Local Government Unitary Authority Consultation.

This was carried out by the same company, Opinion Research Services, who did the Consultation on the NHS cuts. This group are starting JR proceedings having been advised that it is illegal to create, or use, a Consultation designed to give a defined outcome.

Please support us!

https://www.crowdjustice.com/case/save-poole-ae-and-maternity-and-nhs-beds

We also continue to fight for our Dorset NHS at Local Authority Health Scrutiny Meetings.

Follow our campaign on our FaceBook page: ***https://www.facebook.com/defenddorsetnhs/***

NHS Reinstatement Bill back in Parliament

The NHS Bill, written by Professor Allyson Pollock and Peter Roderick, will be back in parliament Wednesday 11 July for the first time since it was tabled by Margaret Greenwood (Labour) MP for Wirral West under the Ten-Minute Bill procedure in July 2016.

It failed to get any further parliamentary time. Now Wolverhampton West Labour MP and retired nurse, Eleanor Smith has said she is delighted to table the Bill.

Once again this is under the 10 minute Rule procedure which allows the mover 10 minutes to speak for the Bill. There may be one opposing speaker and then there is a vote. Usually it is allowed through and if passed, this process is taken as the First Reading.

The Bill would then go into the schedule for Second Readings of private members bills later in the parliamentary session. Eleanor is new to parliament, elected in June 2017, and was a theatre nurse for 40 years.

She says she is a passionate supporter of the NHS: 'It's my cause – I was meant to do this!'

Ex-nurse Eleanor Smith MP now tabling the Bill

Health Campaigns Together is delighted that the Bill has another life during this parliament and we will be supporting events on the day.

https://www.parliament.uk/biographies/commons/eleanor-smith/4609

June 30 – London – NHS@70 – Party and Protest for our NHS!

1948: Bevan's great modernisation

The imposition of brutal charges for "overseas" patients accessing hospital treatment has been followed by Theresa May's shameful refusal to intervene in the case of Albert Thompson, the London cancer patient who was asked to pay £54,000 for treatment at the Royal Marsden Hospital, despite having lived in the UK for 44 years.

This has underlined the Conservative Party's conscious abandonment of the key founding principle of the NHS – that it should be free at point of use to those who need it.

Tens of thousands of people could find themselves in a similarly uncertain immigration position, while of course the actual numbers of so-called "health tourists" cynically exploiting NHS resources is minuscule and an irrelevance in the context of the £120 billion annual NHS budget.

As campaigners have pointed out, the imposition of charges on "foreigners" means many who are NOT foreigners will have to prove their ID – in the end we could all need to show passports to access NHS treatment – even where lives are at stake.

Tories of course, including Jeremy Hunt who instigated the new charges, have tried to claim that their party have always subscribed to the principles of the NHS, and that it would have been established whichever party had won the 1945 election.

Comprehensive

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.

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

He 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.

By contrast 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.

No consensus

Bevan made clear he had not felt any consensus behind him as he fought to get the Act passed and implemented: only the landslide Labour majority in 1945 ensured repeated Tory attempts to defeat the Act and block the launch of the NHS were beaten back.

And with calls for "hypothecated taxes," the use of National Insurance to fund the NHS, or insurance based systems now doing the rounds once more, it's useful to note Bevan's argument that by raising the necessary funding through taxation rather than insurance, the NHS worked effectively 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? I know how enthusiastic they have always been in following that up.

"The redistributive aspect of the scheme was one which attracted me almost as much as the therapeutical."

Bevan in 1958 explicitly refuted suggestions the NHS would be paid for through National Insurance, and stressed that the confusion was because of the misleading use of terminology. He also argued:

"I rejected the insurance principle as being wholly inapplicable in a scheme of this kind. We really cannot give different types of treatment in respect of a different order of contributions. We cannot perform a second-class operation on a patient if he is not quite paid up."

Sadly the current government is trying to roll back the wheel of history. Bevan's principles must be upheld.

No charges at all for early NHS

The early NHS, funded almost entirely from general taxation, 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 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 (see above).

Despite claims that they raised extra resources towards the cost of the NHS, the amounts raised from 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 £8.60 per item – are big enough to pose a real problem for the working poor, but raise less than 0.5% of the NHS budget.

Charges mainly deter or exclude people from accessing the full treatment they require – regardless of their level of need for treatment.

Did you know?

The NHS has from the very beginning been dependent on staff recruited from overseas. In 1949, the first full year of the NHS the Ministries of Health and Labour, in conjunction with the Colonial Office and the Royal College of Nursing launched campaigns to recruit hospital auxiliary and nursing staff directly from the Caribbean.

A 2011 article by Stephanie Snow and Emma Jones explains:

"By 1955 there were official nursing recruitment programmes across 16 British colonies and former colonies. Over the next two decades, the British colonies and former colonies provided a constant supply of cheap labour to meet staffing shortages in the NHS, […] By the end of 1965, there were 3,000-5,000 Jamaican nurses working in British hospitals, many of them concentrated in London and the Midlands."

The NHS also needed doctors, especially after the Tory government in 1957 accepted the Willink Committee's proposal that student numbers should be cut by 10% between 1961 and 1975 because of the risk of overproduction. Snow and Jones report:

"within months of the report's publication, it became evident that in fact a shortage of medical personnel was imminent."

This drove the first mass wave of medical recruitment from India, Pakistan, Bangladesh and Sri Lanka:

"by 1960, between 30 and 40 per cent of all junior doctors in the NHS were from these countries.

"In 1961, Lord Cohen of Birkenhead told the House of Lords: 'The Health Service would have collapsed if it had not been for the enormous influx from junior doctors from such countries as India and Pakistan'."

However deep-seated racism was a problem from the outset:

"Many overseas nurses were forced or even duped into State Enrolled Nurse (SEN) training rather than the more prestigious and more highly valued SRN qualification. … the SEN was not an internationally-recognised qualification and limited overseas nurses' options for returning home."

Stephanie Snow , Emma Jones ***www.historyandpolicy.org/policy-papers/papers/immigration-and-the-national-health-service-putting-history-to-the-forefron***

NHS Dentistry: the poor relation?

Henrik Overgaard-Nielsen, Chair of the British Dental Association General Dental Practice Committee

The NHS is supposed to be free at the point of delivery, but across England, CCGs are bringing in 'demand management' strategies, to try and lower costs. We might look at NHS dental services, to understand where that could lead.

Not many people realise that the government only commissions dentistry for 56% of the population, so it is no wonder that people struggle to access an NHS dentist.

Charges for dental work in many adults were introduced in the 1950s, to try and lower demand, but since 2015, charges have increased by an inflation-busting 10%, while direct government investment has fallen by £170 million since 2010.

We are on course for patient charges contributing one third of the total dental budget by 2021.

Deterrent

Charges are certainly deterring patients, with one-fifth of adults delaying dental treatment because of cost and a quarter saying their choice of treatment is affected by cost.

The result – 135,000 patients a year are visiting A&E and 600,000 patients a year visit their GP for toothache or abscesses, at a cost of £26 million, and usually ending with a referral back to an NHS dentist anyway.

Fines of £100 are being levied on people claiming 'inappropriate' access to NHS dental treatment, disproportionately hitting patients with dementia, learning disabilities and their carers. 90% of appeals against these fines succeed, but they are putting off the patients who need it most.

Charges are also causing confusion for parents. A quarter do not realise dental check-ups are free to children under 18. Nearly 5 million children fail to attend an NHS dentist each year.

This confusion may be a factor in 42% of children failing to attend a dentist annually and tooth decay being the leading cause of children to be admitted to hospital.

Shambolic contract

The shambolic introduction of a new NHS contract for dentists in 2006 has added to the problems: 10% of dentists left the NHS at that point. That contract rewards curative treatment, rather than preventative care and dentists are paid the same for doing one filling as for fourteen.

It has led to associates and practice a real terms cut in income of 35% for owners in England and Wales. Those in Scotland and Northern Ireland have lost about 25% of income.

Since 2011, a new pathway has been piloted which rewards prevention and which allows treatment to be focussed on the individual patient. Dentists and patients have shown their approval, but the government has refused to embrace the need for a new contract.

If the government is truly committed to NHS dentistry, and the importance of prevention, now would be a very good time to prove it.

10-fold
Increase in consultant numbers since 1949 from 5,000 to 49,000 in 2017.

3-fold
Increase in nursing numbers (from 125,000 to 367,000).

2,688
Number of hospitals nationalised by NHS on July 5 1948

£11.4bn
1948 budget for NHS in equivalent 2011 money

£121 bn
2010-11 NHS budget

FBU celebrates 100 years

Firefighters and health workers unite in fight for public services

Dave Green, FBU national officer

This year 2018 is significant for both the National Health Service and the Fire Brigades Union (FBU). This is our centenary, one hundred years as an independent trade union representing firefighters across the UK.

Meanwhile, the NHS celebrates its 70th birthday this year. Both represent all that is good in the public sector. Both are frontline services, assisting everyone in our communities who ask for help and who need our help.

The similarities do not end there. While our members and NHS staff provide the service 24/7, whatever the circumstances, whatever the prevailing political climate and whatever the pay, we are both fighting for our very existence.

Politicians – especially the Westminster variety – praise those who work in the emergency services, while at the same time they starve our services of funding, rip up our pensions and offer derisory wages to frontline workers.

These politicians continue to make us pay (and those who rely on us) for the economic crisis that started a decade ago. A crisis made by the wealthy, but a crisis paid for by slashing workers' living standards.

The FBU has fought for public safety and for firefighters throughout our history. Without the FBU, there would be no professional fire and rescue service in the UK. The union has fought for new safety laws and better equipment. It has held employers and ministers to account for fire safety – right to the top of government. We will do so again in the Grenfell Tower inquiry.

Yet the recent Westminster funding settlement cut another 15% from fire service funding to 2020.

No new investment in firefighters to inspect buildings, respond to calls, install safety measures and rescue people in their hour of need. Just more of the same austerity.

NHS workers and firefighters are passionate about the values of our services. Yet we operate under senior managers who don't dirty their hands on the frontline and have sometimes never even been there, but are paid extraordinary sums for managing cuts, a role they seem to relish.

They are advocates of the private sector and seek to hive off lucrative parts of our services to their wealthy friends.

The FBU will fight for firefighters, for public safety and for public services, because that is what we do.

We will campaign for investment in our industry and the NHS. Fight for public services to be proud of – services worth defending.

No to Sub-Co!

Sara Gorton, UNISON Head of Health

Tory under-funding of our NHS has had many damaging consequences. The latest is the alarming number of trusts in England seeking to set up wholly owned subsidiary companies.

These new organisations, that are often being used to deliver services such as estates and facilities, are set up at arm's length but still owned by the trust.

Trusts are saving money in part by exploiting a tax loophole that allows them to avoid VAT, but also by planning to employ new staff on non-NHS terms and conditions with no access to the NHS Pension Scheme.

Most regions of England are now affected by this new drive, with UNISON raising particular concerns in the South West and Yorkshire and Humberside where a significant number of trusts are proposing to transfer hundreds of staff outside the NHS.

The trusts are all paying "advisers" to assist them, resulting in money leaking away from patient care.

Some trusts have refused to make public their business cases and one has refused to consult with its staff reps, despite the obligations placed on trusts by the NHS Constitution.

The vast majority of trusts plan to employ new staff on less favourable contracts and so far none have secured access to the NHS Pension Scheme for new starters, even though UNISON has been advised that they should be able to.

So it is hard to see this initiative as anything other than a blatant bid to make staff pay for the financial crisis in the NHS.

One of the benefits claimed is that it will enable greater staffing flexibility and will leave trusts free to focus more on delivering healthcare. But this ignores the fact that all staff are part of one NHS team that works best when it is pulling together for the same organisation.

A two-tier workforce is in no one's interest and yet this is exactly what is being created. The NHS can ill afford the further damage to teamwork and morale that comes from employing transferred staff on different pay, terms and conditions from new starters.

UNISON and other unions fighting back against subcos in Gloucester (above) and Harrogate.

UNISON believes this is yet another fragmentation of our NHS and, unless trusts give firm guarantees that new companies will never be flogged off to the highest bidder, a potential step towards full privatisation.

Past experience of privatisation shows that any savings from such exercises will be entirely short term, if indeed they materialise at all.

UNISON is working hard with Health Campaigns Together, the Labour Party and other unions to fight these developments.

In its 70th year our NHS needs to be brought back together not pulled further apart.

It is hard to see this initiative as anything other than a blatant bid to make staff pay for the financial crisis in the NHS.

June 30 – London – NHS@70 – Party and Protest for our NHS!

HEALTH CAMPAIGNS TOGETHER #our NHS

#ourNHS70

JOIN the march on June 30

Jonathan Ashworth,

Shadow Health and Social Care Secretary says:

"As Labour's shadow Health Secretary I'm calling for all who care about the NHS to join us as we together march for its future on 30th June.

"The creation of the NHS 70 year ago was socialism in action and today our NHS stands tall as the pride of Britain.

"But its future after years of Tory austerity, cuts and privatisation is in peril.

"It doesn't have to be like this.

"Our NHS is not for sale, nor will we let austerity sap confidence in it.

"Join NHS staff, patients, trade unionists and activists as we celebrate and demonstrate, demanding our NHS is rebuilt, fully funded and restored as the universal public service that people rightly expect."

Help us build J30 march – and the fight for our NHS

Health Campaigns Together has been in existence since the end of 2015: in less than three years we have built a base of support that has enabled us to hold three successful national conferences and two major national demonstrations, on March 4 2017 and on February 3 this year.

We have also begun to build regional networks, and held two major conferences in Leeds reaching out to campaigners and union activists in Yorkshire and the North of England.

We are expecting strong support for the June 30 demonstration and celebration from the trade unions and local TUCs, Labour Parties, and other political and campaign groups across the country.

But we don't want just to build a one-off, one-day event, we want to extend, broaden and strengthen the network of campaigners, with powerful local campaigns that can put local politicians on the spot, block cuts and closures, halt privatisation and hiving off staff to "subcos", and stand up for safe staffing and quality services throughout the NHS.

To do that we need resources, for publicity, for travel costs of sending speakers, for meeting rooms: that's why we want every organisation supporting our aims and supporting the June 30 march to affiliate to Health Campaigns Together.

Affiliated organisations pay a contribution, but then through regular affiliates' meetings get to decide policy and elect the officers who speak for HCT. You also get access to information and to links with other campaigns and campaigners in your area.

If you want to go further and work with us to organise a regional network in your area, sign up now and let's get going.

We are an alliance, not a party. We have no "line" that must be followed. As an alliance we reach out to those who back our basic principles, and work on the basis of the maximum joint action on agreed policies: but where organisations don't share a policy there is no requirement to comply.

HCT is not affiliated to any political party, although parties that share our principles may affiliate to us.

So far that has been the basis for several national trade unions, dozens of union branches, Labour Parties, local TUCs, Keep Our NHS Public and other campaigns to affiliate so far this year: we would prefer this to be hundreds rather than dozens.

Nobody else is doing the work we have been doing: HCT is a unique alliance – why not join us and help achieve even more?

All details for affiliation, and subscription to our quarterly newspaper are available – along with lots of other info and details of our work – at www.healklthcampaignstogether.com / joinus.php

Unions, campaigners, join us!

HEALTH CAMPAIGNS TOGETHER is an **alliance** of organisations.
We ask organisations that want to support us to make a financial contribution to facilitate the future development of joint campaigning.
REAFFILIATION DUE NOW FOR 2018. WE WELCOME SUPPORT FROM:

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

The guideline scale of annual contributions we are seeking is:

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

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

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

☐ For organisations unable to make payments online, cheques should be made out to **Health Campaigns Together**, and sent c/o 28 Washbourne Rd Leamington Spa CV31 2LD.

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

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

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

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

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