HEALTH CAMPAIGNS TOGETHER
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7-year fight saves Ealing and Charing Cross hospitals

Finally – at last, the Government has admitted the horrible 'Shaping a Healthier Future Plan' (SaHF) for axing two whole hospitals in Charing Cross and Ealing is not workable.

It's dead!

Since they first announced the SaHF plans to cut nine major hospitals in North West London down to five, Ealing Save Our NHS has been campaigning against it side by side with Save Our Hospitals Charing Cross and the Councils in Ealing and Hammersmith & Fulham (whose council leader Steve Cowan joined the celebrations, pictured left).

SaHF had offices in posh Marylebone and spent upwards of £60m of NHS cash on management consultants, producing reams of poorly argued documentation. All for nothing.

Secretary of State for Health, Matt Hancock, has admitted that the Department of Health no longer supports their half-baked plan.

The application for £500m by local health bosses had been turned down twice because the figures didn't work, as campaigners, studies, and a Commission led by Mike Mansfield have pointed out since 2012.

This battle is won, and will inspire many similar campaigns elsewhere.

More inside, p4

NHS England talks of opposing privatisation . . . while rolling out more contracts!

MIXED SIGNALS

At its Board meeting on February 28, NHS England launched "a broad process of engagement" to "build the case for primary legislative change" – new legislation to revise the 2012 Health and Social Care Act (see p10).

Since then they have been attempting to gather sufficient political momentum to motivate government to act: they have even been reaching out for the first time to trade unions, campaigners, and opposition politicians seeking endorsement.

Competition

Their proposals do, indeed seek to remove some of the objectionable elements of the 2012 Act: ending the involvement of the Competition and Markets Authority (which is supposed to regulate mergers of supermarkets and bus companies, and has no NHS expertise) in deciding whether or not NHS trusts can merge, for example.

Even more popular and far-reaching is the proposal to remove the requirement on Clinical Commissioning Groups to put services out to tender:

"We propose that the regulations made under section 75 of the Health and Social Care Act 2012 should be revoked and the powers in primary legislation under which they are made should be repealed."

At first this looks positive: however there are two big problems:

- one is that the proposals are tied up from the outset with various other proposals we do not accept;
- the other is that the sincerity of the proposals themselves are thrown immediately into doubt by NHS England's insistence on driving through highly contentious contracting-out and privatisation of services even as they launch their "engagement process".

For example the first of a series of eleven major contracts for PET-CT scanner services in England has been secretly awarded in Oxfordshire by NHS England to a private company, triggering immediate furious opposition from consultants, campaigners, and MPs of all parties. (**see page 8**).

Yet rather than drop this plan NHS England has made only the most meaningless concessions – and threatened legal action against anyone raising concerns about clinical standards and care. A similar contract in SE London has also been awarded to a private-led consortium.

The Long Term Plan itself proposes to set up large-scale networks to provide pathology and imaging services: but it's already clear from the PET-CT fiasco and the first big pathology network being tendered in South London and the South East that this means lining up even more major contracts for private companies.

Private hospitals

NHS England and NHS Improvement discussions also appear looking to private hospitals to treat thousands of NHS-funded elective patients – diverting more funds and vital front line staff away from struggling trusts and compounding the long term problems of inadequate NHS capacity.

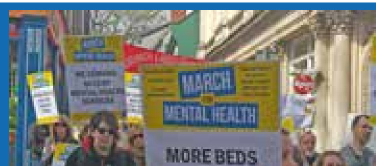
Private hospitals have even been supplied by NHS Improvement with a list of 54 trusts likely to have growing waiting lists: the *HSJ* estimates up to 250,000 extra NHS funded patients could be sent to private hospitals under new waiting time proposals.

Meanwhile in the Bristol, North Somerset and South Gloucester STP area the CCG has decided to put all the adult community health services services out to tender, as a single 10-year, legally binding contract. There is no sign of any intervention from NHS England to change their minds.

If NHS England want their new progressive image to be taken seriously, they must turn words into deeds and show a commitment to rein in privatisation rather than rolling it out. Our campaigning will continue till we win.

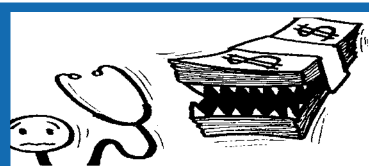
● **NHS England's proposals – p11**

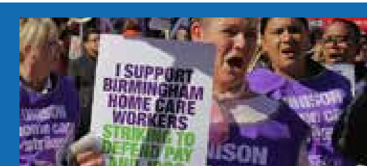
Healthworkers fight callous NHS charges on migrants - p3



Mental health trust leaders point to resource gaps –p5

The fight for safe staffing – England lags behind - p7


Rationing NHS care – a slippery slope as more excluded– p9



Social care - profits for companies, cuts for poorest – p6

Friarage hospital fights again for survival

@SaveTheFriarage

The big march of 2012, featuring bright sunshine and then Tory MP Wiliam Hague.

With Middlesbrough's James Cook Hospital taking to Twitter on March 7 to warn that patients with minor injuries would be in for "a long wait" because its A&E was struggling to cope, local campaigners were even more concerned at the imminent "temporary" closure of A&E at the Friarage Hospital in Northallerton.

The Friarage is a small hospital serving a rural population of 120,000, but faces a minimum 6-month closure from March 27, allegedly as a result of staff shortages, meaning the nearest alternative is the pressurised Middlesbrough hospital 23 miles away.

During the 6-month A&E closure it is to be replaced by a 24/7 "urgent treatment centre".

Patients with more serious health needs will then have to be sent on to Darlington Memorial or James Cook Hospital – each around 30 minutes away.

The local Hambleton Richmondshire and Whitby CCG has accepted the closure, and decided to carry on with the planned public consultation on the future sustainability of services at the Friarage.

Petition

Over 5,000 local people quickly signed an online petition to Save the Friarage.

Mark Robson, leader of Hambleton council, told NHS Executive magazine that the permanent closure of the hospital felt like an inevitable "fait accompli".

One member of staff at the hospital also told the *Northern Echo* "It just seems as if it's death by a thousand cuts. The consultant led maternity unit went, mental health wards have gone, and it's as if there is this ongoing reduction in services."

Repeated battles have had to be fought to defend the hospital in the last 10 years.

A major demonstration in 2012 included Richmond's Tory MP at the time William Hague. He may be gone, but the fight goes on.

(This article was first published in ***The Lowdown***, March 9)

Telford council refers Shropshire plan to Secretary of State

A hammer blow to Future Fit

Behind the brave talk from Shropshire's health bosses, their 'Future Fit' strategy for cuts and closures of front line services, and centralisation of A&E, women's and children's services in Shrewsbury, are in desperate trouble.

Telford and Wrekin councillors voted unanimously on February 18 to refer the Future Fit decision to the Secretary of State for Health, who has in turn now referred it on to the Independent Reconfiguration Panel.

This, set alongside a continued public campaign against Future Fit, creates a very real prospect the defeat of these disgraceful plans, especially in view of the potential political and even electoral embarrassment for the county's Tory MPs.

Councillor Andy Burford, Chair of the Health Overview and Scrutiny Committee and Joint Chair of the Joint HOSC with Shropshire Council, introduced the motion for referral. He made a calm, measured and well-informed speech – impressive in its careful demolition of the case for Future Fit.

The consultation process on Future Fit was flawed, not least by allowing insufficient time for consultation with the JHOSC.

But the proposals themselves are also seriously flawed, and potentially put at risk the health services for Telford and Wrekin and the wider Shropshire area.

The consequences the plan would potentially include severe financial dislocation of NHS commissioners and providers in Shropshire, Telford and Wrekin, severe reductions in services for local people across the whole area, and significant gaps in services for many older people and other potentially vulnerable and deprived groups who depend on access to health care.

The consultation was mistakenly focused on an artificial choice between one acute hospital or the other, whereas campaigners have pointed to the increasing evidence that the demands of the growing population of this unique rural area and geographical location require services to be available on BOTH sites, and for the Shrewsbury & Telford Hospitals Trust (SaTH) to develop an appropriate plan to meet patients' needs.

Neither the two Clinical Commissioning Groups (Shropshire and Telford & Wrekin), nor the hospital trust are achieving their own targets.

Not delivered

But more worryingly, they are simply not delivering the changes which are assumed as the basis for implementation of the Future Fit project. Indeed their situation is worsening, and very different on many fronts from the optimistic assumptions of Future Fit:

- CCG and SaTH board papers show that demand for emergency services and emergency admissions are running far above assumed levels in both Shropshire and Telford and Wrekin;
- The Future Fit website and the board papers of the Shropshire Community Health trust show that there is no serious, costed strategy, resources or implementation plan in place for any expansion of community-based health services;
- The problems and potentially increased pressures on primary care are barely discussed, while the effect of reductions in out of hours services can be seen in rising pressure on hospital care;
- The financial plight of both CCGs and SaTH are now known to be significantly worse than projected and resulting in planned cutbacks, with no possibility of any investment in developing new services out of hospital.

On this basis the Future Fit reconfiguration of acute care, which relies on a substantial reduction in inpatient caseload – and assumes a reduction in nursing staff and no increase in bed numbers – can't deliver a safe service.

SaTH's most recent 2017/18 Annual Report notes (p10) that

"There has been a consistent rise in emergency admissions from 38,562 in 2005/06 to 62,531 in 2017/18. They have increased by 13.28% from 2016/17 to 2017/18."

We know from recent figures that this increase is still continuing. So far Future Fit has not shown any reason to assume numbers will not continue to increase as the population grows and within that increase the numbers of older people who on average make more use of emergency care.

The PCBC projections are for non-elective inpatients to increase in number to just 66,462 by 2024. However on recent performance this level seems likely to be the figure next year, with growth continuing well beyond that to 2024.

The pressure on SaTH's current level of 636 "general and acute" beds across the two hospitals is already significant – occupancy rates averaged 92.2% in Q3 of 2018/19, and average over 90% year round. The Pre-consultation Business Case notes:

"These pressures in A&E; the growing age and acuity of those patients presenting, and the continued bed capacity deficit which routinely prevents timely patient flow, combine to significantly elevate risks in both the immediate term and for the foreseeable future." (p56)

With no extra beds to meet rising demand, the model of hospital care based on the centralisation of both acute and planned care will reduce access to healthcare for all of its catchment area of 2000 square miles and its catchment population in Telford & Wrekin, Shropshire and Mid Wales.

There are also significant concerns around workforce planning, finance, and the long term consequences of establishing an acute-centric model of care that is strongly at odds with the broader direction of travel outlined in the NHS Five Year Forward View and the NHS Long Term Plan.

With the matter now in the hands of the IRP, and local elections under way, it's to be hoped that time is taken for serious reflection on the weaknesses of the plan, and Shropshire's irresponsible health bosses are told to think again.

South Tyneside children's services at risk

The Save South Tyneside Hospital Campaign (SSTHC) has focused on opposing the downgrading of vital acute health services at the District General Hospital, and defending the high performing and vital children's 24 hour A&E, one of the best full maternity services and Special Care Baby Units.

They are also campaigning for the restoration of stroke rehabilitation services at the hospital. These services are all being downgraded as part of government's plan for the NHS in England.

Last May the matter was referred to the Secretary of State by the Joint Health Scrutiny Committee which challenged the validity of the consultation, and said the plans were not in the best interests of the people of South Tyneside.

This referral was (unsurprisingly) rejected by the government that is initiating these plans.

Following that in December 2018, SSTHC took the case challenging the unlawful nature of the consultation to a High Court Judicial Review in Leeds – which was funded by local people of South Tyneside and Sunderland.

So far this legal challenge has been unsuccessful, but the government, Theresa May and NHS England cannot pretend that the public are behind the so-called path to excellence.

The campaign has been waiting to receive the full judgement of the judicial review regarding phase-1 of the consultation, and will consider it along with our legal team – and have not ruled out an appeal.

If implemented, this Phase of the plan could put the Paediatric A&E and the attached paediatric assessment unit at risk.

The campaign has also spoken out against Phase 2, and given evidence to the South Tyneside and Sunderland CCG Listening Panel and set out views on criteria for evaluating local services.

www.savesouthtynesidehospital.org/

Health campaigning in solidarity with migrant groups

Mike Aiken and Madeleine Dickens

Fighting the government's Hostile Environment policy to restrict access to healthcare is a battle for us all say Mike Aiken and Madeleine Dickens from Sussex Defend NHS.

That's why they are asking campaigners to sign a pledge against NHS charges and the sharing of personalised data.

The policy of creating a hostile environment to migrants, created by Theresa May, has affected access to health care for many.

Identity checks, complicated forms and uncertainty among health and administrative staff have created barriers to health care especially for certain migrants.

In response, campaigners in Sussex Defend NHS worked in solidarity with nearly a dozen local campaigns working with migrants.

They have created a pledge to oppose restrictions to healthcare for all vulnerable groups.

Since the Immigration Act of 2014 some groups of people can be charged for accessing health services. In some surgeries administrators and health workers have started asking for identification documents before offering medical treatment.

This process involves extensive bureaucratic form filling. It can also mean the collection and storage of sensitive personal data.

In some cases, people are being charged large amounts for healthcare and are getting into debt which could affect their immigration status. These policies may start with the most vulnerable groups abut then be extended to others.

The Windrush scandal illustrated the importance of building support against such policies.

The Pledge provides an important campaigning tool against the hostile environment policy.

It also offers a way to build broad-based support for an NHS free for all at the point of delivery, without discrimination, and for the benefit of everyone's better health.

Sussex Defend NHS is encouraging individuals and campaign groups in towns and villages across England to sign the pledge – or adapt it to local circumstances.

Sign the pledge:
https://pledgeforthenhs.com

Follow Sussex Defend NHS:
http://defendthenhssussex.weebly.com

Andrew Wiard reportphotos.com

With memories of the still unresolved Windrush scandal and anger at the imposition of NHS charges on overseas patients thousands of health workers joined the demonstration through London on March 16 to mark the UN Day against Racism. It was organised by Stand Up to Racism and Love Music Hate Racism, and supported by TUC and major unions

Healthworkers challenge NHS charges on migrants

Greg Dropkin, Merseyside KONP

Healthworkers at the Royal Liverpool University Hospital are challenging the charges imposed on migrants for NHS care. An open letter, inviting signatures, is online here: ***https://www.medact.org/RoyalLiverpool***. It begins with a Junior Doctor:

"As a doctor I find it appalling that my employer could encourage me to provide substandard care for a patient because of their nationality.

"Recently I saw a 'cost recovery staff' document in a very sick young female's notes that staff should "refrain from providing non-urgent treatment because she is chargeable for her care and has not yet paid a deposit". Patients will suffer.

"Either through direct clinical neglect, or (more likely) through delayed presentation to health services due to fear of financial ruin or being reported to authorities.

"As the open letter explains, the charging policy conflicts with our duty towards patients, and, by turning clerical and clinical members of staff into an extension of the UK border force, undermines trust and distracts from our role as health care professionals.

Targets vulnerable

"Furthermore, we believe the policy targets a vulnerable population, threatens public health, and is likely to lead to increased morbidity and mortality. Although there is emerging evidence of harm, the true economic, public health and personal healthcare effects of this policy have not yet been properly evaluated.

"Our group's mission is to campaign for healthcare charging of migrants to be suspended, and for Sections 38 and 39 of the Immigration Act (2014) to be repealed.

"Until this occurs, we are calling on the Royal Liverpool University Hospital to make a public statement acknowledging the concerns of its staff and supporting the Royal Colleges' call to suspend charging [see HCT #13], and to take immediate interim measures to reduce harm to vulnerable individuals."

Docs not Cops are also active challenging charges for NHS care in Bristol, where a lively protest "No Borders in Maternity Care" took place on International Women's Day, March 9.

The march from St Michael's Hospital to the Bristol Royal Infirmary demanding "Free NHS care for all" was supported by Project Mama, Bristol Refugee Rights, Bristol Defend the Asylum Seekers Campaign, Protect our NHS and others.

Liverpool has learned from campaigns in London around Barts [HCT#12] and Homerton Hospitals, and developed a strong base inside the Royal.

Consultants

Around a hundred Consultants, including 4 entire Departments, and an even larger number of Junior Doctors told the Trust of their opposition in February.

Their campaign is backed by the joint union staff-side, collectively representing nurses, allied health professionals, technicians, admin and clerical staff in the hospital.

The action emerged from a vibrant meeting of over 60 medics and public health experts in January, convened by Consultant microbiologist Dr Jonathan Folb after a conference organised by Keep Our NHS Public and Save Liverpool Women's Hospital last November.

Dozens of Royal Liverpool medics expressed their anger at being instructed to withhold care, in violation of their training, medical ethics and professional responsibility.

Dr Kitty Worthing of Docs Not Cops (***http://www.docsnotcops.co.uk/***) updated on the campaign in Barts, and Lesley Mahmood (SLWH) read excerpts from Rayah Feldman's Maternity Action report "What Price Safe Motherhood?" (***https://www.maternityaction.org.uk/2018/09/what-price-safe-motherhood/***)

"Natasha" overstayed her student visa and was deserted by her partner when she became pregnant.

After her miscarriage, Natasha received an invoice for £4,900, a letter requesting payment within 7 days, and a letter from a Debt Collection Agency. She was afraid to go back for a check-up.

"My baby was buried and I couldn't even go. I was just so scared they were going to come and detain me. I went to see my GP, I was still bleeding then.

"They had to take me to the theatre to do a D&C. I haven't had any examination to see if it is all OK. At times my period is so painful, I feel cramps when I sit down, when I get up I can hardly walk sometimes.

"A lot of clots... I am scared to go to the hospital because I don't know how I will be able to pay. Even just to hear what caused the death of my baby. I am just thinking 'was I stressed?', 'was I not eating well?', 'was it a time I slipped on the stairs?' Or was it a medical problem? I don't know."

The Pre-Attendance form is another focus.

Migrants are told to supply extensive personal details and sign a declaration allowing these to be passed to the Home Office, law enforcement and debt recovery agencies for purposes including national security, before they receive treatment.

Violation

This fishing expedition flies in the face of Caldicott Principles applied throughout the NHS to limit the collection of data to what is strictly necessary, and protect patient confidentiality. It also violates Guidance from the General Medical Council.

Alongside the Royal, the UNISON branch organising Liverpool community services has submitted a motion to the union's national delegate conference, calling for opposition to all NHS charges for migrants.

A system to check eligibility for healthcare can be aimed at any of us in future.

Healthworkers and communities across the UK can develop a national movement to defend universal healthcare free at the point of need, for all.

Contact Docs not Cops:
http://www.docsnotcops.co.uk/

Charing Cross and Ealing Hospitals saved to fight another day: councils' stand pays off

Hancock finally scraps flawed West London closure plan

Eric Leach

The NHS North West London 'Shaping a Healthier Future' (SaHF) reconfiguration has finally been abandoned by the Department of Health. Secretary of State Matt Hancock MP announced the end of SaHF in the House of Commons on 26 March 2019 in response to a question asked by Greg Hands MP for Chelsea and Fulham.

This ends years of SaHF failings and NHS bosses being in complete denial.

It also marks a campaigning victory for many people, especially Ealing Save Our NHS (ESON), Save Our Hospitals (Hammersmith & Fulham) and Brent Patient Voice.

Changes to Ealing and Charing Cross Hospitals mandated by SaHF will not now be implemented.

SaHF all started in 2012 with an awfully flawed public consultation which effectively set up nine NHS

Ealing council leader Julian Bell with campaigners outside Ealing Hospital

North West London 'Major' Acute hospitals to compete with each other for survival.

SaHF promised '…changes that will improve care both in hospitals and the community and will save many lives each year'.

Annual savings of 4% were promised. SaHF promised that these changes would take 'at least three years.' By 2013 Ealing Hospital and Charing Cross Hospitals were singled out in SaHF to be closed down as 'major' hospitals. Minimal facilities were to be rebuilt on small parts of each site, with the rest sold off.

In September 2014 SaHF closed A&Es at both Central Middlesex and Hammersmith Hospitals. A&E performance throughout the whole of North West London dropped immediately and massively.

It has never really recovered over the last 4.5 years. Subsequently Ealing Hospital's Maternity unit and Paediatric units were closed down.

Mansfield Commission

In 2015 Michael Mansfield QC led a masterful Independent Healthcare Commission which concluded that SaHF – which was reaching towards a £1 billion cost for capital – was neither affordable nor deliverable.

In 2016 Hammersmith & Fulham and Ealing Councils commissioned Roger Steer, John Lister and Sean Boyle to review SaHF and the related NHS NWL Sustainability and Transformation Plan (STP). The authors also recommended that SaHF should be abolished/suspended.

In November 2017 after years of painstaking research and data collection Colin Standfield reported that NHS NWL had spent over £88 million on management consultancy since 2009/10 – the bulk of it on SaHF.

What a tragic waste of public money. No SaHF cost savings have been announced.

In December 2016 SaHF asked NHS bosses for £513 million for building work, which was refused. NHSE/I London described the SaHF business case logic as 'counterfactual'.

In 2018 SaHF asked NHS bosses for £260 for building work. It received only £10 million but kept on believing it was going to get the big bucks – until Hancock's answer in Parliament, when reality hit hard.

Doubts over assurances in East London

John Lister

The long-running battle against 2011 plans to run down and close A&E and other acute services at King George Hospital, Ilford is caught yet again in a web of confusing and ambiguous statements, as the projections of repeated "planning" exercises prove to be inaccurate.

It seems on the face of it that a celebration along the same lines as North West London could be called for – if the latest assurances can be taken at face value: but almost a decade of deceit and ambiguity means there are reasons to be cautious.

The official line is that King George's A&E is to stay for the foreseeable future. On the eve of a protest in defence of the hospital outside Ilford Town Hall, Redbridge council leader Jas Athwal, who has not supported demands for full publication of all of the plans and proposals, announced just this to the media.

This was accompanied by the publication of an 'Open Letter' co-signed by leaders of the three local councils (Redbridge, Barking & Dagenham and Havering), by the interim chief executive of the Barking Havering & Redbridge University Hospitals Trust which runs King George's and by the managing director of all three local CCGs.

The letter stated that

"We want to be very clear, the threat of closure of the Accident & Emergency unit arising from decisions in 2011 has been removed.

"There will continue to be an Accident & Emergency unit at King George Hospital."

They now say that (as campaigners have argued for years) this is because the local population has "changed significantly, and will continue to change further" since 2011.

However this statement has come before any conclusion from the apparently unending "review" of emergency and urgent services in King George and Queen's Hospitals that has dragged on for 8 years.

And it appears to contradict the 107-page Strategic Estates Plan for North East London adopted only last October, which talked of a "new model of urgent and emergency care" (p37) and aimed to move "more non-elective work" from King George's to Queen's, where the plan was for "reconfiguration" to include emergency services (p41).

To make matters worse, in several recent pronouncements elsewhere the term "accident & emergency unit" has been stretched by NHS managers to cover an Urgent Care Centre from which any serious cases would need to be transferred (for example in Huddersfield – see page 11).

The confusion in East London is worsened by Trust's refusal to divulge the content of a £49m bid for capital to "reconfigure" King George Hospital, as has been requested by local MP Wes Streeting, and GLA member Keith Prince.

There is no doubt that emergency services in the area are under massive pressure: BHRUHT is one of the trusts that has suffered the biggest deterioration in A&E performance in the past two years, with just 55.4% of the most serious Type 1 A&E patients being treated or admitted within 4 hours in January 2019, down from 74.3% in 2017.

The Trust Board report shows a 13% increase in numbers attending A&E in February compared with a year ago.

Trust figures show that around 40% of the Trust's 25,000+ per month A&E attendances are currently seen at King George's, with a slightly higher percentage of the 16,000+ Type 1 patients per month: so any substantial reduction of the services at KGH would completely swamp facilities and staff at Queen's Hospital.

NHS figures on March 3 show the trust as a whole had 98.4% of its beds occupied – with King George playing a key role.

There is no spare capacity, and if the East London Health and Care Partnership (aka STP) has finally seen the light and abandoned plans for cutbacks that were never viable, it is a welcome step forward.

But given the many years of mistrust, double-speak and evasion we can only celebrate a real change of heart and direction when all of the documents are published and new plans including KGH as full acute hospital are adopted and published for all to see.

Anger over cut-price sale of Epsom Hospital land

The collapse of the NW London reorganisation comes as one of the original architects of that plan, Daniel Elkeles, now chief executive of Epsom & St Helier hospitals trust, is under fire for pushing through a bargain bucket sell-off of "derelict" land and buildings, equivalent to 20% of the Epsom Hospital site.

Local people had demanded that if the NHS land had to be sold, any development on it include social housing and social care.

However, while the sale has now gone through for £18.5 million, it appears that the Trust have managed to secure no commitment or obligation n the use of the land.

It seems the Trust did not even get the best price on offer: according to the local Epsom Comet, the trust had earlier been offered up to £40m. It is apparently to be used for a "later living community for over 65s" – code for high-cost retirement homes, very different from social housing.

Meanwhile the Epsom & st helier UNISON branch is bracing for a long-awaited consultation on the future of acute services, warning that "selling off land assets in advance of any longer term decision seems bizarre".

"After more than two decades of efforts to reconfigure hospital services in Merton, Sutton and Surrey Downs we are now being told the decision is about where to build a new £250-£300 million "major acute" hospital. . . .

"Our fear is that a deal has been done behind the scenes – to build a new 400-bed hospital on the Sutton site that will be controlled by the Royal Marsden Hospital next door – leaving our Trust as a shell and few if any acute services at St Helier or Epsom."

THE lowdown

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Sign up now to the new E-Bulletin with up to date NHS news, analysis, comment and explanation aimed to inform and empower activists!

The Lowdown has been launched with generous start-up donations from UNISON and Unite, and aims to develop as a free access publication and resource, which we aim to fund through supporting donations rather than subscriptions and a £paywall.

We have just published our fourth, 16-page pdf edition, breaking new stories and giving insight on others as they develop.

Make sure you get each issue as it appears, by registering your email address at ***https://lowdownnhs.info/***.

CQC report sounds alarm over patients' rights

The Mental Health Act 1983 (MHA) is the law that provides authority to detain and treat people who have a mental illness and need protection for their own health or safety, or the safety of other people.

It also provides more limited community-based powers, community treatment orders (CTO) and guardianship.

The MHA not only provides powers for clinicians to intervene in the interests of a person's health or safety, but also includes safeguards for people's rights when they are being detained or treated under the MHA.

Doctors, managers and staff in provider services and Approved Mental Health Professionals (AMHPs) should have a detailed knowledge of the Code and follow its guidance, or document the justification for not doing so in any individual case.

However in surveying the Act in practice the Care Quality Commission s now raising serious concerns on a number of issues:

"Our greatest concern is about the quality and safety of care provided on mental health wards; in particular on acute wards for adults of working age.

"a substantial proportion of the care plans of detained patients that we have examined are still of a poor quality. We continue to find examples of poor planning, lack of patient and carer involvement, and no evidence of consideration of patients' consent to treatment on admission to hospital.

"Available data continues to show overrepresentation of Black and minority ethnic (BME) groups in the detained population. The broad BME group 'Black or Black British' has the highest rate of detention (288.7 per 100,000 population), more than four times that of the broad 'White' group, which has the lowest rate (71.8 per 100,000 population)."

■ CQC Monitoring the Mental Health Act in 2017/18, https://www.cqc.org.uk/sites/default/files/20190226_mhareport1718_report.pdf

Mental health conference to be called

Health Campaigns Together is calling a national conference on the crisis in mental health, working with national health unions and other affiliates, 'Mental Health -Time For Action' and other campaigns across the country.

It's clear from all the available evidence, and every fresh report appearing, that the situation facing mental health services continues to worsen.

Promised resources fail to appear, Clinical Commissioning Groups continue to take perverse decisions to limit or cut spending, to fragment and contract out services, and to ignore national policies that proclaim the objective of "parity of esteem". And cash-strapped trusts are increasingly failing to maintain the quality and safety of care that patients should be able to expect.

Please put Saturday 28th September in your diary. The London venue is yet to be confirmed.

Our AGM on April 6 will take these plans further in discussion with the TUC and partners.

Full details will be published on our website as the campaign for it takes shape.

Organisations wishing to participate in the organisation of this conference are invited to contact us at healthcampaignstogether@gmail.com.

Donations towards the considerable costs of this conference are also invited via https://healthcampaignstogether.com/donate.php.

Mental health leaders point to resource gaps in broken system

John Lister

Shocking new findings from NHS Providers' latest survey of frontline mental health trust leaders include the fact that fewer than 10% of trusts reported that they currently have the right staff in the right place to deliver services.

A massive 95% of people responding to the survey, which was conducted last November, do not believe overall investment will meet current and future demand.

The most recent increases only raise the share of NHS funding spent on mental health by 0.5%; this rise is not adequate to close the care deficit: and too little of the new money that is available is reaching the front line of service delivery.

"This raises questions about how much of the NHS long term plan can be delivered and how fast."

More than two thirds of mental health leaders said they are worried about maintaining the quality of services over the next two years.

An overwhelming majority (81%) of trust leaders said they are not able to meet current demand for community CAMHS and more than half (58%) said the same for adult community mental health services; more than half (56%) could not meet demand for crisis resolution teams.

In relation to overall community provision, 85% either disagreed or strongly disagreed with the statement that there are adequate mental health community services to meet local needs.

37% of trust leaders said they had to change or close services such as alcohol and substance misuse services, homelessness services and some inpatient services as a result of financial pressures, while more than half (55%) said they had changed or closed similar services or withdrawn mental health primary care provision due to commissioning issues.

> **Of the external factors driving increased dependence on mental health services,**
>
> **92%** said **changes to benefits/universal credit** – with **63%** saying the impact was high, making it the most significant factor
>
> **98%** said financial hardship
>
> **97%** said housing
>
> **97%** said loneliness and isolation

A small number of trusts across the country felt that the amount of time people are waiting to access services such as psychiatric liaison, community CAMHS and inpatient CAMHS is decreasing. However, far more trusts Told NHS Providers that waiting times were increasing:

*58% reported an increase in waiting times for community CAMHS and community adult mental health services

*44% had seen an increase in waiting times for crisis resolution home treatment.

* And 41% increased waits to access inpatient adult mental health services

There have been large numbers of 'out of area placements' (OAPs) for lack of local capacity, with 70% reporting OAPs in acute inpatient treatment, 63% in CAMHS tier 4 patients and 58% for rehabilitation patients.

There is significant unmet need for a number of mental health conditions – particularly community services for adults and children, gender identity services and crisis home treatment teams.

Despite all of the government and NHS England rhetoric in the NHS Long Term Plan, and the *Five Year Forward View for Mental Health* before it rguing for "parity of esteem" and improving resources, and a decade of campaigning to dismantle the stigma of mental ill health and achieve equity between the treatment of mental and physical health, NHS commissioning decisions are still resulting in services being cut or reduced.

Nearly two thirds of trust leaders are 'very concerned' about the numbers and skills of staff in two years time.

And an indication of the impact of austerity cuts on NHS services is the fact that too much current staff capacity is being diverted to support service users with a greater number of non-clinical issues "such as negotiating the benefits system".

"Demand for services is outstripping supply and socio-economic factors are contributing to this. 92% of trusts tell us that changes to universal credit and benefits are increasing demand for services, as are loneliness, homelessness and wider deprivation.

Council cuts

"Cuts to services funded by local authorities also mean that preventative approaches and early intervention services are less available.

"Mental health leaders pointed to rising demand during winter but it is clear that these pressures on services are a year-round phenomenon."

NHS Providers argues that to redress these issues:

"national policy must focus on increased support for both mental health and public health. There also needs to be greater realism about the levels of demand and what is needed to meet them, as well as better planning with inputs from trusts, commissioners and the national bodies."

Not surprisingly, action on workforce is identified as "a top priority", with calls for a national plan, with appropriate focus on the mental health workforce, coupled with "adequate funding from the comprehensive spending review that meets the plan's education and training budgetary requirements."

■ Article from ***The Lowdown*** 23/3/19

Grim legacy of Lansley's 2012 Act

The fragmented health care system entrenched by the 2012 Health and Social Care Act is clearly seen by many mental health leaders as an obstacle to progress. When asked what changes would most alleviate the pressures on services, trust leaders said called for ending block contracts, but also:

* "delegating commissioning to providers" and

* "reducing tendering activity"

Other suggested changes were "investing in core services beds and community mental health teams, assertive outreach, crisis care, CAMHS"; "incentives to increase the workforce" and "capital for investment in estates".

Just over a third (36%) of trust leaders said they were satisfied or very satisfied with how mental health had been prioritised within their STP/ICS/ local system and 32% said they were neither satisfied nor dissatisfied.

> **1,310,985** people in contact with NHS funded secondary mental health, learning disabilities and autism services, Nov 2018
>
> **51,496** Increase per month compared to last year's average

Birmingham's budget cuts hit social care

Profits for companies: cutbacks for the poorest

Birmingham Against the Cuts

Last November Birmingham City Council published a 66 page Budget Consultation document. It proposed "savings" of £50m in 2019/20, rising to savings of £86m in 2022/23.

These reductions would be achieved by a combination of "efficiency savings" and cuts in services.

Following the consultation the totalsavings in the 19/20 budget were reduced to £46m.

Two thirds of the £46m reduction in 19/20 are to come from service delivery and 20% from job cuts, which will save £9.2m in 19/20 (p40): almost 14,00 jobs will have been cut between 2010 and 2022/23.

According to the Plan the reductions are 'after consulting with staff and Trades Unions.'

The report acknowledges that there are a number of 'proposals that have a high risk of impacting on older people'.

The root cause of the savage year on year cuts in Birmingham's social services is of course the ruthless austerity policy of the Tory government, and the solution is a change of government.

Many people will agree, but will also say surely if the Council has to make cuts it shouldn't be choosing ones that hit services needed by some of the most vulnerable people and families in the city.

The consultation wasn't about the whole Budget, only about the Council's planned cuts, which represent less than 5% of the total Council Budget.

The Reclaim Social Care campaign, which has emerged from the successful conference last November organised by Health Campaigns Together, with the Socialist Health Association, National Pensioners Convention and other organisations, has continued to meet and discuss policy and campaigning.

Reclaim Social Care is about to launch as a fully-fledged affiliate of Health Campaigns Together, which will continue to host its material on our website and carry updates in the paper.

To join the campaign email *reclaimsocialcare@gmail.com*

Social care

By far the biggest area of spending is the Health and Social Care Portfolio. For 18/19 it is £336.232m, which is about 39% of the Total Net Expenditure on Services.

And for 19/20 it is £325.706m, which is about 38% of the Total Net Expenditure on Services.

Almost 60% of that money flows out to the private sector.

The minutes of the Health and Social Care Overview and Scrutiny Committee meeting on 20 November 2018, reveal that:

"The total budget in 2018/19 for the portfolio is £336.1m. [ ]

- 59% of the net total budget is allocated to external packages of care.
- 9% is spent on specialist care services.
- 11% is spent on assessment and support planning (Social Work).
- 7% of the budget is spent on Supporting People.
- 14% is spent on commissioning and other services.'

So about £200m – not far short of a quarter of the whole Council budget of £855m is allocated to 'external packages of care'.

Across the West Midlands 165,000 workers are employed in the social care sector. According to ***Social Care as a Local Economic Solution for the West Midlands*** 77% of these are employed in the private sector and just 7.5% directly by local authorities.

Many of those in the private sector will be working in care homes – there are about 350 care homes with contracts with BCC. Others will be providing domiciliary care – care in the home.

This raises a whole series of unanswered questions, including:

- Who are the providers?
- What are the contracts?
- What are the profit margins?
- How much do they pay their employees?

Adult social care market

Thatcher created a lucrative new market in social care by forcing local authorities to spend 85% of their social care budget in the private sector, decimating local authority provision.

The failure of privatised adult social care in England: what is to be done? a 2016 report by The Centre for Health and the Public Interest, says:

"In 1979 64% of residential and nursing home beds were still provided by local authorities or the National Health Service; by 2012 the local authority share was 6%; in the case of domiciliary care, 95% was directly provided by local authorities as late as 1993; by 2012 it was just 11%."

The profit margins can be huge. According to ***Social Care as a Local Economic Solution for the West Midlands***

"big care providers expect to offer 11% returns to investors (including costly debt repayments which often return to the parent operating company).

"The business models of the largest five residential care chain companies in the UK offer returns to investors that account for as much as 29p in every £1 of their costs – the second biggest drain on expenditure after wages." (p12)

But not all are making such profits: the care market is in complete crisis because the savage government cuts in local authority budgets have squeezed the flow of profits to the care businesses.

More than 400 care home operators have collapsed in the last five years, including over 100 in 2018 (*Guardian* 12 March).

Birmingham City Council should open the books

The first thing the Council should do is end the secrecy and open the books, and stop funding these big care home businesses by adopting as policy the final two Recommendations of the Centre for Health and the Public Interest report:

Organisations with a social purpose should be defined as the preferred providers of care and support services.

Steps should be taken to rebuild providing capacity in the statutory and not-for-profit sectors.

The aim should be, in the words of the model resolution published by **Reclaim Social Care**, the new national campaign:

"Publicly, democratically run services, designed and delivered locally, co-productively involving local authorities, the NHS and service users, disabled people and carers', in the framework of national standards."

Getting the market out of adult social care is supposedly already the policy of Birmingham's Labour Council.

A year ago ***Building a Better Birmingham: Labour's Local Manifesto 2018-2022***, gave the following commitment under the heading 'A Rebirth of Municipal Socialism':

"We will re-state the case for the municipal provision of services in Birmingham, heralding a new age of municipal socialism.

"And the Labour council in Birmingham will lead by example, calling time on the misplaced notion that the private sector always trumps the public sector by adopting a policy of in-house preferred for all contracts. " (p6)

Since then there is little – in fact no – evidence of the Council pursuing this policy, in fact the opposite, most notoriously the privatisation of the 14 day nurseries.

Of course getting the market out of adult social care would require the repeal of the 1990 Act which imposed the 85% private compulsion on local authorities, and Labour nationally should be giving this commitment loud and clear.

■ **This article is heavily abridged from a longer article published in full on our website, *https://healthcampaignstogether.com/socialcare.php*, which gives full links for the quoted documents.**

Hammersmith CCG faces bill for Brummie patients!

Birmingham's GPs, are complaining that the CQC has not yet reported on the quality of the digital first GP at Hand service in London.

They are for the disruption of a roll-out of the controversial video consultation service, which could follow the model of London and poach tens of thousands of younger, fitter patients from local GP lists and undermine the financing of other practices,

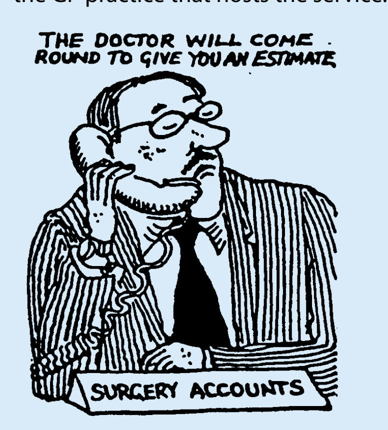
The west London GP practice that hosts GP at Hand was inspected in November 2017 and subsequently rated 'good': however - the CQC has yet to publish a report or rating of the digital-first video consultation service, which now to be spread into another big city.

Birmingham LMC executive secretary Dr Robert Morley told ***GP Online*** he was 'astonished' that the CQC had yet to update its report on the service He described the planned expansion to Birmingham as 'very concerning'.

RCGP chair Professor Helen Stokes-Lampard echoed these concerns, warning:

'It is difficult to see how a practice based in London will be able to deliver meaningful population-based care to patients who live in Birmingham. The expansion appears to undermine the efforts to improve place-based care that are stated in the NHS long-term plan."

Meanwhile the financial consequences for other practices hit by GP at Hand's expansion are still emerging. Hammersmith & Fulham CCG has wound up stuck with a £10m bill for the GP practice that hosts the service.



If there are no changes, the CCG could also wind up forking out millions more for services to online patients in Birmingham, 130 miles away.

The promised NHS England bailout has – perhaps predictably – failed to materialise. The CCG is warning that without it "there will be a material worsening of the financial position of the CCG, potentially jeopardising other health and care services in Hammersmith & Fulham".

The Fulham core practice's patient list has grown in 15 months from about 4,000 to more than 40,000 patients, with the vast majority drawn from other parts of London.

As ***Pulse*** magazine points out, "the host CCG, Hammersmith and Fulham has to pay for these new patients' NHS healthcare, despite most of them living and receiving much of their care outside the CCG's catchment."

So far only north west London CCGs have agreed to help Hammersmith and Fulham meet the cost for patients living in their area, while other London CCGs have refused to pay up.

Legislating for safe staffing levels

England lags behind Wales and Scotland

Wales was the first country in Europe to introduce a law about nurse staffing levels, in 2016.

However England has as yet made no move to follow suit, despite growing concerns and now a campaign by the RCN for legal enforcement of staffing levels

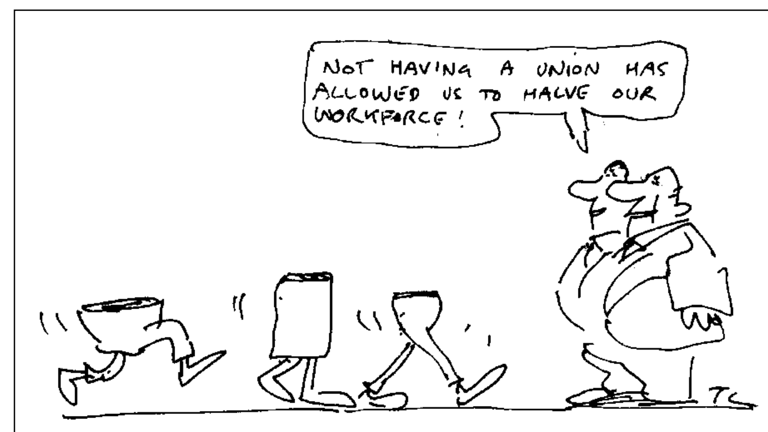
Since April 2017, under the Nurse Staffing Levels (Wales) Act 2016, health boards and NHS in Wales have been required to have workforce plans in place to ensure they have enough nurses in all NHS adult acute medical and surgical inpatient wards in the country.

It places a legal duty on Health Boards and NHS Trusts in Wales to ensure they employ enough nurses to provide sensitive patient care in all settings and specifically an appropriate number of nurses are on shift in adult care settings.

The law also requires Health Boards to report on how Trusts are performing, and take action if failings occur.

Statutory guidance

Since April 2018, they are required to have calculated nurse staffing levels using a specific method, set out in statutory guidance.



A "designated person" who must be a nurse or midwife, must carry out the calculation; frontline nurses are able to contribute their views.

NHS employers must take "all reasonable steps" to maintain the required nurse staffing levels and must make this information available to patients.

The Welsh law was the result of growing concerns and reports which showed that poor nurse staffing levels increased mortality by up to 26 per cent, compared to better staffed wards.

Studies into legislation in California found safe staffing legislation had reduced 30-day mortality rates by between 10 and 13 per cent.

Follow up campaign

The Nurse Staffing Levels (Wales) Act received Royal Assent on 21 March 2016, but had to be followed up by a campaign for its effective implementation.

This meant ensuring that statutory guidance, produced by the Welsh Government for Health Boards, was as robust as possible.

The final guidance was published on 2 November with a number of key changes, which the RCN campaigned for, including recognition of the supernumerary role of the ward sister or charge nurse, and explicit reference to nurse-patient ratios.

Since the legislation has come into force, the Welsh Government has invested heavily in nurse training and education, thanks, in no small part, to campaigning by the unions.

John Gomez / Shutterstock.com

Scottish Bill aims to set general guidelines

In May 2018 the Health and Care (Staffing) (Scotland) Bill was published. The bill places a legal requirement on NHS boards and care services to ensure appropriate numbers of suitably trained staff are in place.

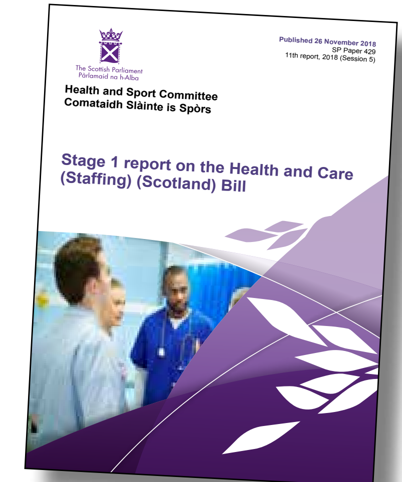
The legislation, if passed, will place a legal requirement on NHS boards and care services to ensure appropriate numbers of suitably trained staff are in place, irrespective of where care is received. It will also build on Scotland's innovative, evidence-based and profession-led approach to nursing and midwifery workload planning by facilitating the future development of this approach across health and care settings.

However a Stage 1 Report on the Bill makes clear that it is setting out only general principles, and that:

"The legislation is not intended to set out or prescribe minimum staffing levels or fixed ratios; this would be at odds with the Scottish Government's established policy approach and could potentially undermine innovation in service provision.

"Rather, the legislation will support local decision-making, flexibility and the ability to redesign and innovate across multi-disciplinary and multiagency settings."

However for areas where one of the 12 staffing tools currently exist, "the Bill will make it explicit that health boards are expected to:



- apply the common staffing method (further details of this can be found in the next section);
- use the output from the tools along with professional judgement, local context and quality measures to underpin and inform decisions about staffing requirements;
- make sure a consistent approach is taken to identification and lessening of risk, take account of appropriate clinical advice and consider whether services can be redesigned;
- ensure staff are properly trained to apply the common staffing method and tools, engage with the process and understand the decisions made in relation to staffing decisions;
- monitor and report on how they have achieved all the above and provide assurance regarding safe and effective staffing.

The Bill explicitly recognises that among the guiding principles must be "ensuring the wellbeing of staff," and "being open with staff and service users about decisions on staffing". It also requires ministers to consult with trade unions before issuing guidance.

Health Boards in Scotland will have a duty to:

- ensure appropriate staffing – of registered health care professionals, and senior registered nurses;
- have real-time staffing assessment in place; have a risk escalation process in place, including a procedure for notification of every decision taken to be notified to those who have identified the risk, and for any disagreement with decisions to be recorded;
- and a duty to follow a common staffing method.

Every Health Board must ensure individuals working for them receives appropriate training for the work they are to perform

There are similar requirements for social care staff.

The Health and Sport Committee of the Scottish Parliament, reviewing and pushing for further amendment of the Bill in February 2019 noted that the Law Society summarised initial thoughts of a number of witnesses when they stated:

"the guiding principles are unobjectionable, but so general and multi-factorial as to leave plenty of scope for subjective judgement and the inevitable juggling of competing priorities....

"It is difficult to assess from the face of the Bill whether the main policy objective of appropriate staffing will be met, as the Bill is largely a vehicle for more legislation to come."

The Committee goes on to argue:

"We believe there must be more clarity on where accountability for the provision of appropriate staffing in health boards and care services lies.

"Whilst the Policy Memorandum advises it will lie with organisations we believe unless there is a named accountable officer there is a high likelihood, particularly in health board settings, for those at ward level to be held or feel accountable.

"We would be grateful if the Scottish Government would advise of their position on this."

The Bill is still proceeding through the various stages in the Scottish Parliament, and a supplementary financial memorandum has estimated the additional costs of back-filling jobs for senior nurses to be supernumary and focused on managing the system, and for additional training of doctors and other professionals.

Our call for a conference on safety

Health Campaigns Together at its February 2 affiliates meeting agreed to seek to advance our campaign to "Make our NHS Safe for All" by working to establish a broad-based national conference on the issue in the autumn of this year.

Since then we have approached the key unions involved, receiving a positive response, and progress has been made, although we have yet to get a firm commitment from all of the main players, pending decisions to be taken by their relevant committees.

So we are unable to launch the conference campaign from this issue of the paper as we had hoped. But do expect to be able to do so through the website in May, and in our next issue.

Donations towards the considerable costs of this conference are also invited via https://healthcampaignstogether.com/donate.php.

No U-turn from NHS England on Oxfordshire PET privatisation

The controversial NHS England decision to award a 7-year contract for PET-CT scanning services to private contractors InHealth rather than the specialist unit of the local NHS trust has united MPs from all parties across the county in angry opposition.

And when NHS England tried to fob off local opposition by conceding that the service could be run by the staff at Oxford University Hospitals Trust, Oxfordshire KONP was among the first to insist that, contrary to the misguided ***Guardian*** headline "This is not a U-turn. Far from it."

Their statement went on:

"The local leadership of OUH has not challenged this 'in principle' agreement for a private company to own our precious PET scanning service.

"InHealth, it is proposed, will use OUH as their subcontractor. KONP see the so-called ' partnership' as pulling the wool over our eyes.

"The detail of the contract with In-Health - and of InHealth with the OUH must be revealed before we can even consult on it.

"We want HOSC to refer the whole sorry procurement process for our world class PET scanner service to the Secretary of State on the grounds that it was a flawed process, with no proper consultation.

"We believe that the current proposed 'deal' will lead to a worsening of service across the region.

"This is not 'outsourcing' like the Carillion contract. This is direct privatisation of a part of our NHS. We demand a halt to the process."

Prior to this, as the volume of criticism began to grow, there were signs of mixed messages between ministers and NHS England.

Challenged by Oxfordshire Council's Senior Policy Officer Sam Shepherd on whether the contract was a done deal, NHS England responded

"No we are not ready to sign any contracts on this lot just yet as we need to first complete any necessary public engagement that may be required and listen to people's views."

By contrast (then) junior health

minister Steve Brine, challenged on how the decision had been made without any local consultation appeared unrepentant in a written answer that claimed the decision had flowed from "a 30-day public engagement" … three years ago!

"Where new service proposals would result in substantial development or variation, such as location change, further public involvement activities will be undertaken."

MPs challenge decision

His words have cut little ice with his Tory colleagues in Oxfordshire, or with local LibDem and Labour MPs, all of whom have written to question the decision and the way it has been arrived at.

Banbury's Tory MP Victoria Prentis has written to NHS England chief Simon Stevens expressing "extreme concern" that patient care would suffer.

Oxford East Labour MP Anneliese Dodds has written to NHS England chair Lord Prior demanding a halt to privatisation of PET-CT services.

She has also written to Simon Stevens NHS England chief executive demanding answers to five key questions:

"1. What is the basis for the 'partnership' being concluded between In Health, NHS England and OUH NHS Trust?

"2. Specifically, how is it consistent with the Secretary of State's recent contention that there would not be any further privatisation of the NHS?

"3. Who exactly negotiated the 'partnership'?

"4. Why was it felt necessary to include In Health in the 'partnership', given that it appears not to have even fulfilled the requirements of the initial tender (let alone been the most appropriate bidder, especially in relation to the existing NHS service)?

"5. Why has NHS England threatened legal action against those who might raise concerns about the impact on patient care, resulting from this peculiar 'partnership'?"

Local GP Dr Helen Salisbury in a BMJ blog explained the longer term threat of the contract:

"Currently radiologists are part of a multidisciplinary team who discuss and plan treatment for patients. If the NHS does not provide the service, how will we train the next generation of specialist cancer radiologists?"

Medics in the Oxford University Hospitals trust have also spoken out strongly, arguing that the decision risks harming patients. Their stance seems to have eventually drawn endorsement from the trust's chief executive Bruno Holthof, who has also said he has concerns for "quality and safety" of the proposed contract.

But the strongest condemnation of the privatisation has been from Oxford University's Professor of Oncology Dr Adrian Harris, who added two further sharp questions:

" Why is an NHS service being handed to a private company, particularly when they admitted to NHSE and the Trust, that actually although they bid for the service in Oxford they cannot provide it, as they did not fulfil the requirements for the tender? and

"If the proposed service is so excellent, why did NHSE mislead the local Oxford CCG … telling them that they couldn't discuss it and wouldn't review the tender, when there was no reason for it not to be openly discussed?"

Prof Harris has added even more detailed critique of the InHealth deal.

He points out that all 'profits' from scans from private patients and funded trials will go to private company, not to the hospital, where the staff and scanners are, "so no reinvestment for our benefit from our work."

It will mean patients in Swindon and other areas now having to be scanned in a hospital car park, a policy which is "against the NHS's own paper on PET-CT stating that where possible, it should be performed in fixed-sites."

Prof Harris warns that "patients in Oxfordshire will have a 2 tier system", with patients further away being scanned in hospital car parks "with poor access machines", whereas Oxford patients will be seen at at the Churchill Hospital centre.

"The new scanners at Oxford are 10 times more sensitive than mobile ones. … The patients scanned in mobiles cannot have the complex scans using state of the art technology used in Oxford. Where will in-patients, immobile patients, or patients requiring a hoist be scanned? They cannot be scanned on mobiles.

"The cover for the mobiles is being provided by a doctor in her late 60s: who is going to provide this cover when she is away?"

"The doctors in Oxford have made it clear that they do not wish to be involved with this service, which they think has a significant number of potential disadvantages for patients": so who is going to report the scans performed on the mobiles?

"Where are they going to send the scans, as there are no other PET-CT reporters working in these hospitals."

The specialist centre will not be able to do research, which is a major detriment to Oxfordshire patients, and to medical science.

Oxford itself has a fantastic reputation for its PET -CT centre and large research funding from MRC CRUK, and others, many millions of pounds per year, to develop imaging techniques, to look at tumour metabolism, brain metabolism, important for dementia research and cancer research.

Kent Council puts off fight for stroke services

The battle over the future of Urgent Stroke Services continues in Kent and Medway, even after a unanimous decision of the Joint Committee of Clinical Commissioning Groups to nod through a controversial plan to centralise services in new specialist units in Maidstone, Dartford, and Ashford.

Four hospitals now stand to permanently lose their existing stroke services: Medway, Maritime, Tunbridge Wells Hospital; Queen Elizabeth, the Queen Mother Hospital in Margate; and Kent & Canterbury Hospital.

The long distances involved, with journey times increasing at peak times of congestion, delaying even blue light ambulances, are a major concern for urgent stroke care.

The longest journeys would be for stroke patients from Margate: from there to Ashford is 40 miles, while Maidstone, is five miles further away.

Medway Council has voted unanimously to refer the decision back to the Secretary of State, and confirmed that it will seek a judicial review: but Kent County Council has ignored a growing petition and opted to defer its decision on whether to refer back the plan to a meeting in May.

Taking the message to parliament

How Come We Didn't Know? the photographic exhibition by artist photographer Marion Macalpine of Hackney Keep Our NHS Public, was hosted last month by Labour MP Eleanor Smith and Keep Our NHS Public at the Houses of Parliament.

It deals with on the under-reported corporate take-over of the NHS, and this event aimed to inform and influence parliamentary political figures, many of whom are woefully unaware what is happening on their watch. The event was packed and many of the contributions from the floor were emotionally charged and powerful.

The exhibition explores the diverse forms that privatisation takes, including PFI contracts; private health companies masquerading as NHS

including many GP clinics and diagnostic centres; private hospitals which cherry-pick 'low risk' patients; lucrative contracts for highly specialist treatment; healthcare corporations with a history of fraud or tax-avoidance.

The exhibition highlights critical links between politicians at all levels and private healthcare corporations.

If you're interesting in borrowing the exhibition, please email: ***marion.macalpine@gmail.com***

Hundreds joined the lively Health Campaigns Together march through Leeds on March 30, led by Leeds KONP

Rationing care – a slippery slope

John Lister

Attempts to ration access to various treatments by NHS patients which have been made sporadically by local bodies since the 1990s are now becoming widespread and more wide-ranging.

The argument is that a significant number of hitherto routine treatments can be dismissed as "'Procedures of Limited Clinical Value' (or 'Limited Clinical Effectiveness'), terms normally reserved for complementary therapies or cosmetic procedures where there is little evidence to prove their cost effectiveness or clinical benefit.

Last summer NHS England kicked off a new round of exclusions when it put pressure on local CCGs to cut funding for 17 procedures of allegedly limited effectiveness or clinical value – with an eye to making potential savings.

Four procedures for which there is a widely accepted lack of evidence (injections for non-specific low back pain without sciatica; knee arthroscopy for patients with osteoarthritis; dilatation and curettage for heavy menstrual bleeding in women;

STOLEN TREATMENTS

https://media.bnssgccg.nhs.uk/attachments/Commissioning_Policies_-_Jun_2018_v1819.1.01.pdf

"This document contains a list of all interventions that have been considered by the Commissioner and to which access has been restricted within the Bristol, North Somerset and South Gloucestershire (BNSSG) area." (This means that GPs can only refer patients in particular circumstances.)

Criteria Based Access and Prior Approval Policies

Acupuncture
Adenoidectomy
Alfa Pumps
Benign Skin Lesions
Blepharoplasty
Botox - Botulinum Toxin Treatment
Breast Reconstruction post-Cancer
Carpal Tunnel
Cataracts
Chalazia
Chronic Fatigue Syndrome / ME Referral for Adults
Continuous Glucose Monitoring Systems
CPAP for the Treatment of OSAHS
Desensitising Light Therapy in the Management of Severe Polymorphic Light Eruption
DXA Scanning to help target Treatment in Adults at Potential Risk of Osteoporotic Fracture
Dupuytren's Contracture Release
Ectropion and Entropion Repair Surgery
EXOGEN Ultrasound Bone Healing System
Female Sterilisation
Foot Treatments – Surgical Options
Gallstones Removal (Laparoscopic Cholecystectomy)
Grommets – for Adults over 18 with Otitis Media with Effusion
Grommets – for Children under 18 with Persistent Otitis Media with Effusion
Grommets - for children under 18 with Recurrent Otitis Media
Haemorrhoidectomy
Hernia Repair in Adults
Hip Replacement Surgery
Hip Surgery (Open or Arthroscopic) for Pain including Femoroacetabular Impingement
Homeopathy
Hysterectomy for Menorrhagia
Intrauterine Coil Insertion and Removal in Secondary Care
Knee Arthroscopy and Irrigation
Knee Replacement Surgery
Laryngeal (Voice Box) Surgery
Low Back Pain and Sciatica in over 16s
Microsuction for Ear Wax, Discharge or Debris Removal in Secondary Care
MRI Breast Screening
Nasal Treatment – Non Cosmetic (all ages)
One-Stop Nucleic Acid Amplification
Open MRI Scanner at Cobalt Health Cheltenham
Paediatric Speech and Language Therapy in Secondary Care
Penile Conditions – Surgical Opinion and Treatment including Circumcision - over the age of 18
Penile Conditions - Surgical Opinion and Treatment including Circumcision - under the age of 18 yrs
Polysomnography Tests for Children
Radiofrequency Ablative Therapy for the Treatment of High Grade Dysplasia in Barrett's Oesophagus
Raised Intraocular Pressure
Rectopexy and STARR
Reversal of Vasectomy or Female Sterilisation
Selective Dorsal Rhizotomy Post Op Physiotherapy
Shoulder Impingement Surgery for Subacromial Pain
Skin Camouflage Services
Spinal Surgical Opinion – Referral for Assessment
SpyGlass® Direct Visualisation Cholangioscopy
Strabismus or Amblyopia in Adults (Surgical Correction)
Syndactyly – Surgical Correction of the Fingers
Tattoo Removal
Tongue-tie Division Surgery
Tonsillectomy – Referral for Assessment (All Ages)
Trigger Finger
Varicose Veins Surgery
Vasectomy
Weight Management Service – Tier 3
Weight Management Service – Tier 4

Individual Funding Request Policies

Abdominal Loose Skin Removal
Anal Skin Tags
Breast Surgery – Female (not post-Mastectomy for Cancer)
Breast Surgery - Male
Chest Wall Deformity (Correction of) for Cosmetic Purposes
Chiropractic Assessment and Treatment
Closure of Patent Foramen Ovale for Migraine
Congenital Ear Deformity Correction Surgery including Pinnaplasty
Cosmetic Contact Lenses
Cosmetic Surgery or Treatment
Diagnostic Dilatation and Curettage (D&C)
Divarication of Recti
Drop Foot - Surface Orthotic Functional Electrical Stimulation for Drop Foot of Central Neurological Origin
Elective Treatment in Northern Ireland, Scotland and Wales
Epididymal Cysts
External Ear (Pinna) and Lobe Repair
Extracorporeal Shockwave Therapy (ESWT)
Facial Surgery and Treatment
Female Genitalia Surgery
Ganglion Removal
Hair Removal (including Electrolysis & Laser Therapy)
Hydroceles in Males
Hyperhydrosis Treatment
Ingrown Toenail
Laser Eye Surgery for Refractive Error
Laser Hair Removal for Pilonidal Disease
Liposuction to Reduce Fat Pockets and Deposits
Multifocal Lenses
Multiple Chemical Sensitivity (MCS) & Clinical Ecology/Environmental Medicine
Percutaneous Tibial Nerve Stimulation (PTNS) for Urinary Incontinence in Adults
Population Screening outside of National Screening Committee guidelines
Post Clinical Trial Treatment
Skin Contouring
Snoring (Surgical Intervention for Simple Snoring)
Temporomandibular Joint Motion Rehabilitation Devices
Testicular Prosthesis Insertion
Uvula Removal
Vitreous Floaters
Wigs, Hairpieces and Hair Replacement Systems

NHS FOR SALE
Myths, Lies & Deception
Jacky Davis, John Lister, David Wrigley

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

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and surgery for snoring) were to be funded only in exceptional circumstances.

But a further 13 procedures, including breast reduction, varicose vein surgery, removal of benign skin lesions, and tonsillectomy – some of which have good evidence they can be effective, are to be performed on the NHS only when specific clinical criteria are met.

£400m savings targiet

The NHS is aiming to more or less halve the number of these procedures, from 350,000 to 170,000 a year, and save almost half the current spend of £400m a year.

Conspicuously as NHS bodies draw up longer lists of treatments they won't pay for, private hospitals begin advertising a similar range of services for those willing and able to pay: a two-tier system is emerging.

NHS England gives the impression that the proposals are fully in line with national clinical guidelines published by the National Institute for Health and Care Excellence (NICE), the recognised authority advising clinicians on the current state of research evidence, whose logo appears on the cover, and that NICE was a source for the proposals.

But in fact, as Keep Our NHS Public has revealed, NHS England's proposals to withdraw 17 NHS clinical procedures contradict existing guidance from NICE. Instead KONP research found that:

"For nine of the 17 procedures, NHSE does not cite any evidence at all from NICE. For five procedures the NICE evidence cited does not support the NHSE proposal and for one, the NICE evidence cited gives only partial support. For only two out of seventeen withdrawn procedures does the cited NICE evidence back the NHSE proposal."

However as we headlined in HCT #12, the initial list of 17 treatments was always seen as a first step, and some CCGs have gone far further and faster down the route of excluding services and effectively rationing care – leaving patients with the stark choice of going private or going without.

Bristol campaigners have been protesting over "Stolen Treatments" after the list of excluded treatments chiefs in the Bristol, North Somerset and South Gloucestershire (BNSSG) area reached a whopping 104. They complain that:

"GPs can no longer decide when to send patients to see a consultant at a hospital. Instead they must follow strict rules which mean they can only refer patients who are most severely affected.

"Some patients are being left with pain and disability and placed at increasing risk of severe complications. In addition, GPs' professional opinions are being overridden by non-accountable panels and committees."

CCGs forced into line

In North Central London, the five CCGs have been corralled by the Joint Commissioning Committee into signing up for an extended list of 29 treatments, more than NHS England and the London Regional Directorate's lists put together. One of the North Central CCGs, Enfield, began its deliberations by discussing an even longer list of 192 procedures.

Keep Our NHS campaigners are angry that the changes once agreed by Enfield were rolled out "across the other four boroughs … without public consultation. It is arguable that this is another breach of CCGs' statutory duty to consult the public before a significant change in services."

The same process is taking place in many CCGs across England. In Milton Keynes the CCG has a list of 26 Musculoskeletal (MSK) treatments which are either "restricted" or "not routinely funded" with a much more lengthy list under "general".

Now research by the Medical Technology Group ("a coalition of patient groups, research charities and medical device manufacturers working to improve access to cost effective medical technologies for everyone who needs them") has found that rationing of care through these measures is increasingly widespread.

Cataract

Most CCGs are restricting patient access to proven treatment including cataract surgery; over half of all CCGs (104 of the 195 CCGs in England) include cataract in lists of treatments they deem to be of "limited clinical value.

Yet national clinical guidelines published NICE in 2017 cite the cost effectiveness of cataract surgery, stating that it has 'a high success rate in improving visual function, with low morbidity and mortality'.

The result of CCGs' restrictions on cataract surgery is that patients across the country are being denied access to a procedure that they are entitled to, which could restore their eyesight and prevent accidents, such as trips and falls.

The MTG study looked at other treatments, including surgical repair of hernias and hip and knee replacements. It found that most CCGs still commission hernia repair, but many apply onerous conditions. Almost half (95) limit access and many take a 'watchful waiting' approach which can mean an increase in emergency cases and worse patient outcomes.

78 CCGs include hip and knee replacements on their list of restricted treatments, despite the procedures being proven to be effective in keeping people mobile.

Campaigners will want to use some of this research evidence, which is pressing for improvements in the NHS, even if they are not attracted to the MTG itself, which admits its membership "ranges from national charities to international companies."

International campaigning

Ontario fights Bill to sweep away any local control

The Ontario Health Coalition is energetically campaigning to block a vicious new "Omnibus Bill" tabled by neoliberal provincial premier Doug Ford. Here is a shorter version of the summary of the threat the Bill poses to Ontario's health services.

Powers to force mergers, privatisation

What *is* in Mr. Ford's health care omnibus bill is a new "Super Agency" forged out of 20 existing agencies with widely disparate mandates, histories, levels of effectiveness, and cultures.

But that's not all. Written in the new law are vast powers that the government has given itself and its political appointees in the new "Super Agency" for a wholesale restructuring of our local hospitals, long-term care, home care, community care, mental health, health clinics and so on.

Restructuring powers are defined in the legislation as not only service coordination but also mergers, amalgamations, transfers of all or part of a service, closures of a service, and entire closures of local health services.

In the law itself these are not simply "voluntary", as the Minister describes them. What is actually written in the legislation is a set of virtually unfettered powers that take away any last remaining vestiges of local control. The only public governance of health care will be from a "Super Agency" run out of Toronto.

A Gift to Corporations

Doug Ford's new omnibus health care bill does not add to or expand health care for people. But it does focus on restructuring without adding anything to front-line care. The evidence shows that restructuring costs a lot of money and often leads to local towns losing services.

Already the attention of every CEO and manager in the health system has turned to restructuring. The reality is, the large for-profit corporations will seek to expand their "market share" and profits using the new opportunities afforded in this legislation.

The evidence does not support the contention that "Bigger is Better". In fact, many towns lost local services in the last round of restructuring, never to get them back.

The Provincial Auditor reported that the last hospital restructuring cost $3.9 billion. That was billions of public dollars spent to cut $800 million and lay off nurses and staff, close down local services, then rebuild them elsewhere. That money was lost to frontline care forever.

New bureaucracy

At the end of the years of mergers and takeovers and partnerships and so on, the current Minister envisions 30 - 50 giant health care conglomerates running virtually all services for up to 15 million Ontarians.

Each conglomerate would be made up of hundreds of mergers, service transfers and takeovers, but also some separate entities. Each conglomerate will need a new tier of administration to run the relationship between its various parts of the conglomerate.

That equals 30 – 50 new uber administrations plus the mother Super Agency, as compared to 14 Local Health Integration Networks and 6 agencies that exist at present. Furthermore, the administration of the conglomerates will be owned by the providers themselves in their interest, not public oversight in the public interest.

This is worse, not better. You can see why the leadership of chain companies and large CEOs are salivating. They've just been given carte-blanche to take control over our local health care services.

No Public Consultation

Virtually all the democratic protections that we won in previous legislation have been stripped in the new omnibus law.

There are no open board meetings. No public right to access restructuring documents. No appeals.

There is only the weakest possible language in the new legislation regarding community engagement (that's what they now call democracy or public input).

There is no evaluation system for the vast new restructuring.

There was no public consultation prior to this Bill, and there is no opportunity for any meaningful public input into the health system that the public funds and that should be ours, as the people of Ontario.

What Can We Do

In the strongest terms possible we urge the Ford government to hit "pause", to engage in proper public consultation, and to make a new priority of actually improving access to public health care services for the people of our province.

We've seen victories in the campaign for the NHS

by Jonathan Ashworth, Shadow Health & Social Care Secretary

NHS campaigners, patient groups, trade unions and the Labour Party have led community campaigns against proposed cuts and privatisations have seen victories in recent days.

But our campaigning must now gather pace.

In recent days campaigners, local Labour MPs and councillors have celebrated victory in West London as Tory ministers were forced to U-turn on plans to demolish Charing Cross Hospital.

It's a welcome reminder that when we campaign with passion and make the argument persuasively based on the evidence we can win.

We've forced hospitals to pull back from outsourcing staff to 'wholly owned subsidiaries' and will continue to campaign in solidarity with affected staff where trusts are still considering staff transfers.

I've repeatedly pressured ministers in the Commons to block the privatisation of the cancer PET-CT scanning service in Oxford.

The scanning service will stay at Oxford following campaign pressure but the contract will still be handed over to a private company. Our campaigning will continue.

It's our outright opposition to privatisation that drove our

fight against new Integrated Care Partnership contract in the Commons recently.

Tory ministers tried to push the regulations through Parliament with no scrutiny under cover of the Brexit mess. Quite simply I wasn't prepared to allow that.

Rule out privatisation

A House of Commons debate and vote on the new regulations was forced following a motion put down in Jeremy Corbyn and my name to annul the regulations. We pushed ministers to rule out privatisation.

They couldn't, and Labour MPs voted against the ICP regulations.

Labour will continue to fight NHS privatisation. Our research recently revealed over 20 contracts worth millions recently put out to tender, and we've demanded ministers put an end to the process.

Meanwhile our shadow Communities Secretary Andrew Gwynne has announced Labour's intention that public sector contracts will come back in house across the board with a Labour government.

Staff are left demoralised by the Tory privatisation agenda.

Our NHS continues to struggle with 100,000+ vacancies. Since 2011 we've seen 200,000 nurses leave the NHS, across all staff voluntary resignations are up 55 per cent.

It's my intention that the NHS under a Labour government will be best employer in the country.

I've recently announced plans under a Labour government to restore the nurse bursary and reverse cuts for staff development budgets. NHS staff care for all of us: it's time we cared for them.

Yes, no and maybe: some initial answers to NHS England's mixed bag of ideas to change the law

John Lister

The joint board meeting of NHS England and NHS Improvement on 28 February discussed the primary legislative changes for the NHS in relation to the 2012 Act – as referred to in the NHS Long Term Plan.

The new NHSE/I proposals perhaps predictably opt not to follow the route of reform suggested by the NHS Reinstatement Bill.

So while it's clear that important changes are being proposed, two key measures flowing from the Bill are not even mentioned by NHSE/I:

- reinstating the duty of the Secretary of State to provide or ensure a comprehensive, publicly-provided NHS is available, free at point of use and funded through general taxation.
- restoring the accountability of NHS England to the Department of Health (and thus to the Secretary of State and through that office to parliament and the electorate).

Both of these are necessary to restore proper accountability and integration of the NHS at national level.

Two of the proposals that are listed are definitely positive.

Campaigners have always opposed the dis-integration of services driven by the "internal market" from 1991: we are still fighting to stop contracting and the competitive market which have extended to cover clinical care since 2000, and which were entrenched and deepened by the 2012 Health and Social Care Act.

There seems to be no sensible reason why campaigners who fought to prevent the 2012 Health & Social Care Act ever going through would now want to keep some of its most controversial clauses – which have led to the carve-up of the NHS into contracts and a competitive market.

Yes to scrapping Section 75

So NHSE/I's proposal that: "We propose that the regulations made under section 75 of the Health and Social Care Act 2012 should be revoked and the powers in primary legislation under which they are made should be repealed," makes good sense.

Excluding the Competition and Markets Authority from any regulatory role in the NHS is also a good move: it has no legitimate role in the NHS or public services.

However campaigners will still oppose going beyond this to give NHSE/I any new statutory rights to impose mergers of hospitals/services, or to bypass full public and parliamentary consultation.

While campaigning for better integrated delivery of care, we focus on the literal meaning of the word "integration" rather than NHS England's use of it as shorthand for their notion of "Integrated Care Systems" and the controversial "Integrated Care Provider" contract, which most campaigners would not accept.

Nonetheless if NHSE/I, in preparing for these, are talking of merging (reintegrating) commissioners and providers into genuinely joint bodies, we should call for legislation to do this properly.

We should abolish the separate structures, and create new Health Boards as public bodies that will meet in public, publish their board papers, be subject to the Freedom of Information Act, and bring in elected council members, trade union and lay reps.

Rather than one ICS for each of the 44 STPs, let's have up to 150 health boards on the same boundaries as county councils, unitary councils and London boroughs, ensuring local accountability.

That's the kind of integration we want.

So while the Lansley Act is being belatedly and partially dismantled, let's not miss what could be a chance to press for our alternative.

Local MPs back Hands Off HRI campaigners

On Wednesday 6th March 2019, campaigners from Huddersfield Hands Off HRI travelled to the Houses of Parliament to meet up with the four local MPs for Huddersfield and Kirklees, namely Tracy Brabin, Barry Sheerman, Paula Sherriff and Thelma Walker.

The purpose of the meeting was to relaunch and refocus the local campaign to maintain all local hospital services in Huddersfield. The campaigners were also joined by Dr Tony O'Sullivan from the Save Lewisham Hospital Campaign who has continued to offer valuable advice and support to the group.

All acute care transferred

Following the decision of the local Trust to lift the planned closure of HRI and A&E, a new plan has emerged which will see ALL acute and emergency care transferred to Halifax. This will mean having hospital care in name only without the staffing and care required to provide a full and comprehensive service.

The Chair of the campaign group, Mike Forster, explained the next major focus of the campaign:

"The removal of acute and emergency care from HRI will mean the "A&E" is reduced to a walk in centre and our hospital to a rehabilitation unit.

"They plan to expand Calderdale Hospital with the extra government money they have been offered and downgrade local hospital provision.

"Our MPs confirmed they are totally opposed to these plans and we drew up a campaign approach to begin to challenge the Hospital Trust.

"We intend to launch a People's Commission locally which will be like a full scale public enquiry into local health provision, but one that we oversee and organise. We intend to call witnesses and expert evidence to show why we must maintain ALL hospital services.

Massive undertaking

"This is a massive undertaking and cannot be solely organised by our campaign. The MPs all confirmed they will do all in their power to support us. They were all inspired by the Lewisham model which was a hugely successful event which attracted a crowd of 500 and helped win their Judicial Review."

The campaign is drawing together a small group of health professionals who will scrutinise the new plans and prepare an alternative critique of the proposed downgrade.

"All of these plans will help us draw together the evidence we need to bring a second legal challenge if that is what is required," says Mike.

"We are now into our fourth year of campaigning and have already achieved a great deal by saving our hospital and A&E. The next and final stage will be to ensure we have the full skilled staff group to meet all our health needs."

Thelma Walker, MP for Colne Valley, who convened the meeting added: "It was great to meet with my Kirklees MP colleagues and Hands Off HRI campaigners to plan future strategy for the campaign to fight for our hospital and primary care services".

Since the meeting with the local MPs, Hands Off HRI has successfully lobbied Kirklees Council which has committed to meet the campaign group to explore ways in which they can assist with a Peoples' Commission."

Nottingham City council beats an unexplained retreat on ICS

Nottingham City Labour group voted to lift its 6 month suspension from involvement in the Greater Nottingham "Integrated Care System" on March 18.

Campaigners learnt this was on the agenda only hours before and briefed a couple of the prospective councillors attending who took along KONP leaflets to hand out to group members.

They were surprised that a decision was to be taken now as it assumed this would be left to the new council after the May elections (it is not yet 6 months since the Council took the decision to suspend its involvement).

Campaigners were told that the basis for the suspension had been "lack of elected member involvement", with only officers involved. However this situation has not changed, so it's hard to see why Labour has changed tack.

The only saving grace was that group members voted unanimously on an amendment "calling for unanimous votes if there was threat of privatisation or outsourcing".

Review: Banner Theatre Company 'Free for All' – Nottingham

Dr Des Powe, Unite Nottinghamshire Health Branch

An inspiring evening of music, video footage and commentary was sponsored and hosted by Unite Nottinghamshire Health Branch at the Nottingham Arts Theatre, 28th February.

Celebrating the NHS and increasing awareness for the need to protect it, Birmingham-based Banner Theatre's production 'Free For All' played to an audience of almost 200.

Recounting how access to medical treatment was governed by ability to pay pre-NHS, audio and video testimonials painfully described the devastation this wreaked on individuals and families. Using an inimitable mix of humour and satirical original songs, the cast skilfully weaved through NHS history, covering its birth, growth and more recently, assaults that threaten its very existence.

Over several decades, a predominantly Tory-led initiative has engineered a blue-print for fragmenting and running down the NHS, putting in place legislation to achieve their ideological aim of NHS privatisation.

The destructiveness and high economic cost inflicted by internal marketisation, accounting bureaucracy, and Private Finance Initiatives (PFI) have left an under-resourced NHS. Banner's take- home message is that,

despite sustained attack and inflicted damage, the NHS survives because of its dedicated (but demoralised) staff and strong community-based campaigns.

People can make a difference to outcomes. This was well evidenced by a selection of guest speakers who spoke of their involvement in local campaigns to oppose cutbacks and failing services.

Last year, Rachel Bannister received national media coverage when she directly challenged the then health minister, Jeremy Hunt, to explain why her daughter could not obtain the essential mental health services she so desperately needed, at a local level.

Though based in Beeston, her daughter had to travel 300 miles for treatment in Edinburgh, resulting in deterioration of Rachel's own health and a tremendous strain on all her family.

Another local campaigner, Tom Hunt, described the successful campaign opposing closure of the neurological rehabilitation Chatsworth Ward at Mansfield Community Hospital.

Jon Dale (Secretary, Unite Nottinghamshire Health Branch) and Richard Buckwell (Keep Our NHS Public) spoke about the need to organise, collaborate and challenge privatisation as was the case in highlighting failures by the private outsourcing of Estates, cleaning and patient catering services at NUH before bringing back in house from the now defunct company Carillion.

Pressure from trade unions and Keep Our NHS Public's well-publicised campaign pressured Nottingham University Hospitals Trust to terminate the contract – a year before the company went bust.

The final message was – get ready for whenever the next assault comes. We'll need to organise together to defeat that too!

Unhealthy Profits

Lifting the lid on PFI and its consequences

Richard Bourne

John Lister's excellent book on PFI combines very well his journalism and analysis skills.

The level of detail is astonishing and this allows real strength to the demolition of the various bogus arguments put to justify and to defend PFI.

In part it also movingly tells a compelling story of the long and frustrating journey of those who campaigned for a new hospital but fought against it being funded through PFI – a journey over many years well described.

John forgoes the tendency to advance conspiracy theories and actually sheds at least some light on why so many generally intelligent and honest people make what looks like seriously bad decisions.

Having so much of the context and knowing the various players and their interests is fascinating if dispiriting.

Work like this hopefully ensures that PFI will no longer get any serious consideration.

It supplies hard evidence and much ammunition to those who have campaigned against PFI and will do so again if it raises its ugly head!

I have been studying PFI for over 20 years and been involved in a number of real schemes including cancelling a major PFI.

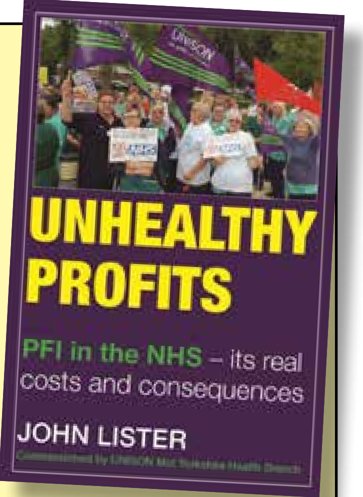
Over the years I have observed that much of what gets said is repetitive based on anecdote and poorly researched; ideologically driven positioning.

John's book is new and refreshing in that it is dealing with the issues of today with some suggested solutions within a proper framework of evidence and real experience.

I would strongly recommend it to anyone interested in the topic.

■ *Unhealthy Profits* is self-published by Mid Yorkshire Hospitals UNISON.

The story of PFI ... up to date



Ebook (£7.50) and 280-page paperback version (£9.99) both now available via Amazon

Unhealthy Profits by **John Lister** charts the story of PFI in the NHS from its beginnings in 1992 through to Philip Hammond's announcement that no more PFI contracts will be signed.

It also follows the story of PFI in one hospital trust - Mid Yorkshire Hospitals – and the battles that have been fought there by the UNISON branch, which has fought PFI from the outset and commissioned and published the book.

A chapter discusses what to do about PFI: and a postscript looks at the growth -- and costs -- of PFI world-wide.

For single copies order via Amazon. For discount on orders of 10 and above contact *midyorksunison@aol.co.uk*

NHSE plan: drop targets to match performance

A&E waits in England have reached their worst level since the four-hour target was introduced in 2004. In January nearly 330,000 patients waited longer than they should, with hospitals reporting significant problems finding beds for those needing to be kept in.

Yet NHS England has made clear their main focus is on seeking to shift the goalposts, change the targets for maximum waiting times in Accident and Emergency units and for elective operations, and end any comparisons with previous years.

With a budgets effectively frozen in real terms since 2010 and rising pressures from a growing population, the NHS has not consistently achieved the target for 95% of the most serious "Type 1" A&E patients to be treated or admitted within 4 hours since 2011, and not achieved it at all since 2012.

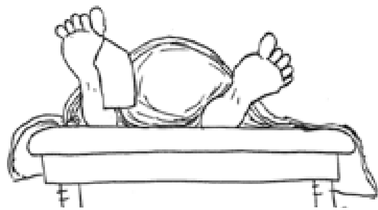
Now ***The Times*** has revealed that NHS England is pushing to change the system:

"New targets that focus on patients who need a hospital bed will be tested in the spring before a full switch from October. Under the proposed system, people with sprains and other minor injuries are likely to be discouraged from going to A&E."

However the worst and most worrying delays are precisely in the treatment of these patients with more serious health needs: those with more minor problems are treated more quickly.

It's not clear how changing the targets will solve this problem.

The ***HSJ*** reports that there are also plans to axe the 18 week standard for referral to treatment times for elective care, which has not been hit since 2016, with average waits now 22.7 weeks, and 4.15 million people waiting.



The plan is to move to an "average" target waiting time. But again if capacity is inadequate this average can only grow.

President of the Royal College of Emergency Medicine, Dr Taj Hassan urged ministers and NHS England to focus on addressing the core of the problem:

"Staff continue to work doggedly in difficult conditions and must continue to focus on patient safety.

"We absolutely must not lose sight of the people behind these numbers; both patients experiencing undignified conditions, and staff working at the limits of their abilities."

"We fear that these figures will give impetus to move away from meaningful measurement of flow and system performance, which if not managed carefully runs the risk of hiding problems."

Hospitals plunge to their worst-ever A&E performance

The number of patients waiting over 4 hours in A&E for a bed increased five-fold from 2012 (129,835) to 2018 (641,963).

But the pressures have continued to increase, and the final "sitrep" report for the 2018-19 winter shows only **20** out of **131** acute trusts managed to contain bed occupancy below 90% on March 3.

36 trusts were running on or above 97%, well above the already increased NHS England target level. **Five were running completely full, at 100%.** Of 13,400 patients brought by ambulance, 1,000 (7.5%) were kept waiting for over 30 minutes, and 129 over an hour to even get into the hospital.

The A&Es with most ambulance delays are Medway, Norwich, Newcastle, Tameside, Pennine Acute, Dudley, Grimsby, Worcester, Birmingham and Lincoln.

The *Health Service Journal* has reported that waiting time performance for major emergency admissions at one London trust has deteriorated by 29 percentage points in the last two years, while 17 trusts reported a deterioration of 10 percentage points or more on their four-hour performance for the most serious Type 1 patients, between January 2017 and January 2019.

Croydon Health Services Trust's 29 percentage point slide – to just 49.1% type 1 performance in January 2019 was the biggest drop, and the worst in the NHS, 27 points behind the 76.1 per cent average.

More big declines in performance were reported at United Lincolnshire Hospitals Trust (20.2%), Plymouth Hospitals Trust (19.8%), and Barking, Havering and Redbridge University Hospitals Trust (19.1%).

A number of trusts did make big improvements over the last two years but they included Weston Area Health Trust (up by 18.7%), which has closed its A&E at night and could lose more services, and previously struggling London North West Healthcare Trust (16.4%), although this only brought it up to 67%.

National data reveals the NHS hit a record low in January on both the overall A&E performance and for the type 1 category for major emergency admissions.

A&E performance was 84.4 per cent compared to 85.1% in January 2017, and 85.3% last January. Type 1 performance overall fell from 77.6% in January 2017, to 76.1% in 2019.

Poorest performers on Type 1 A&E within 4 hours

Trust	%
Croydon Health Services Trust	49.2%
United Lincolnshire Hospitals Trust	55.5%
Plymouth Hospitals Trust	59.1%
Barking, Havering and Redbridge UHT	55.2%
Wrightington, Wigan & Leigh FT	60.2%
Lancashire Teaching Hospitals Trust	57.8%
Nottingham University Hospitals Trust	60.9%
Norfolk & Norwich UH FT	60.6%
Warrington & Halton Hospitals FT	64.9%
University Hospitals Birmingham FT	60.9%
Blackpool Teaching Hospitals NHS FT	52.5%

Unions, campaigners, join us!

HEALTH CAMPAIGNS TOGETHER is an **alliance** of organisations. We ask organisations that want to support us to make a financial contribution to facilitate the future development of joint campaigning.

WE WELCOME SUPPORT FROM:

- **TRADE UNION** organisations – whether they representing workers in or outside the NHS – at national, regional or local level
- local 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 102 Corve Street Ludlow SY8 1EB.

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 <u>PER ISSUE</u> (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. If possible please order online.

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