HEALTH CAMPAIGNS TOGETHER #OUR NHS

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Misconduct in public office – damning verdict of Covid Inquiry - p6-7

SOS NHS

New campaign to save health and care

From best to worst since 2010

In 2010, after a decade of investment, our NHS was delivering its best-ever performance: by 2021 after more than a decade of austerity – despite heroic efforts by staff to keep services afloat – it has sunk to the worst-ever.

The problems were growing before the Covid pandemic, but have been deepened by the sudden and contuinued loss of capacity and continued high level of Covid infections.

- **Waiting lists** at a record high – close to 6 million and rising.
- Record delays in **emergency care** – patients dying in ambulances queuing outside A&E, or waiting hours in pain for ambulances to arrive
- Record delays in **cancer care** – performance targets missed for 5 years and getting worse
- Record gaps in **mental health**, with 1.4 million people needing treatment and not getting it
- **100,000 vacancies** and staff burnt out and demoralised by years of relentless pressures and year after year of falling real terms pay, and increasingly frustrated that the quality of care they want to provide is being compromised.
- A **"tsunami of unmet need" in social care –** over a million people not getting the care they need.

More decades of decline?

Ministers keep arguing that spending is at "record levels": but it's clear to all that the NHS lacks staff, beds and resources – as a result of **ten years of frozen funding** while the population has grown by 5 million.

The level of 'record spending' is still not enough to restore 2010 performance or meet demand.

The recent Spending Review locked in the freeze on funding to 2025, and gives no extra capital to repair and remodel hospitals to reopen lost capacity.

This threatens us with another deadly decade of declining

Continued back page

Trust bosses overwhelmingly fear the worst

NHS Providers' latest State of the provider sector report shows that, while COVID-19 cases are well below their January 2021 peak, with 5,800 Covid patients in English hospital beds on December 3, trusts are "beyond full stretch" as they deal with current pressures and prepare for winter.

Trust leaders are particularly concerned about the scale of pressure they are already under before the NHS has reached its traditional peak of winter demand which usually runs from mid-November to end-February, with pressure often greatest in January.

- 87% said they are extremely concerned about the impact of winter on their trust and local area, (compared with 56% when asked the same question last year, ahead of what proved to be one of the toughest winters in the history of the NHS.)
- 84% are very worried/ worried about their trusts having the capacity to meet demand for services.
- 85% are very worried/ worried that insufficient investment was being made in social care in their area.
- 94% are extremely/moderately concerned about staff burnout.

The trust bosses want the government to provide emergency help to enable the social care sector to keep its existing workforce in place over the next few months.

Retention bonus

Chris Hopson, chief executive of NHS Providers, said:

"If we want to keep hold of the staff that we've got, the government should seriously consider introducing some kind of emergency support for the social care workforce.

"One option is a retention bonus of a minimum of £500 each for the 1.5 million social care staff in England, similar to the schemes now operating in Scotland and Wales.

" This would add up to a £750m bill, most of which would have to be a draw on the government reserve."

Over half (57%) of trust leaders were very worried or worried about whether sufficient investment is being made in public health and prevention in their local area.

Hopson's blog concludes:

"Longer term, trust leaders are clear that this is a completely unsustainable position for the NHS and social care to be in and we have to address the underlying causes – a broken workforce model, insufficient capacity to match growing demand, inadequate funding and a social care system in crisis – which COVID-19 has significantly exacerbated."

Deadly toll of A&E delays and overcrowding

A damning report on delays in handing over emergency patients to the care of hospitals published last month by the Association of Ambulance Chief Executives (AACE) has found "unacceptable levels of preventable harm are being caused to patients".

Up to 160,000 patients are experiencing harm every year in England as a result of being stuck in the back of ambulances that have rushed them across town to hospitals under blue lights.

80% of those whose handover took longer than 60 minutes were assessed as potentially suffering some harm, and almost one in 10 of these patients could potentially suffer severe harm, such as a cardiac arrest, loss of a limb or brain damage.

The post-Covid lockdown situation is more dangerous for patients than the period prior to Covid. Safety incidents reported to NHS England by ambulance trusts have jumped 26 per cent so far in 2021 compared to the whole 12 months of 2019. Deaths as a result of safety incidents in ambulance trusts are up 13 per cent compared to 2019.

The scale and spread of the problem is underlined by a new report from the Royal College of Emergency Medicine, which warns that nearly two thirds of A&Es across the UK had ambulances waiting to transfer patients every day in the past week.

The NHS mandates that ambulance handovers ought to be reliably completed within 15 minutes of arrival, but 61% of Emergency Departments in the survey were struggling to meet this standard every day.

The RCEM survey also found that for lack of adequate numbers of beds for admission of emergency patients over half of Emergency Departments had provided care to patients in non-designated areas such as corridors every day in the previous week.

The problems are not over when the patient finally gets into the Emergency Department, where a new set of delays and problems of overcrowding again puts them at risk.

Deaths from crowding

A separate report by the Royal College of Emergency Medicine, 'Crowding and its Consequences', found that at least 4,519 patients have died as a result of dangerous crowding in Emergency Departments in England in 2020-2021.

The Royal College's survey also found:

- 14% of respondents stated that the longest stay they had had in their Emergency Department was between 48 and 72 hours
- 36% of respondents stated the longest stay in their Emergency Department was 24 to 48 hours
- 39% of respondents stated the longest stay in their Emergency Department was 12 to 24 hours
- 50% of respondents stated that Same Day Emergency Care had limited availability, less than 12 hours a day or weekdays only in their Emergency Department
- 71% of respondents stated that they had been unable to maintain social distancing for patients in their Emergency Department in the past week.

The RCEM blames the deadly combination of shortages of appropriately trained staff – and the dire shortage of available acute beds for emergency admissions:

"Across the UK there is a shortfall of 2,000-2,500 WTE Emergency Medicine consultants, and crucially, there are also widespread shortages of Emergency Medicine nurses and both junior and supporting staff.

"At the same time capacity is severely depleted across the UK.

"The government must restore bed capacity to pre-pandemic levels, this requires an additional 7,170 beds across the UK."

What investment we need to fix our struggling NHS

£8bn needed now to rebuild crumbling infrastructure

There is no capital to invest in re-modelling hospital buildings, refurbishing and where necessary rebuilding to enable the hospitals to reopen the thousands of beds that have been closed or left unoccupied since March 2020. **Rishi Sunak has to be told to make a fund of up to £3bn immediately available for this work to be done – and end the need to ship NHS patients off to costly and inefficient private hospitals.**

The bill for backlog maintenance to repair crumbling buildings and replace clapped-out equipment has soared to £9.2 billion – double the £4.5bn capital allocation to NHS England. **The lack of maintenance causes thousands of incidents each year that interfere with clinical care and put patients at risk.**

£6bn needed to rebuild the collapsing hospitals

A dozen or so hospitals built in the 1970s using reinforced autoclaved aerated concrete planks are in serious danger of collapse. **West Suffolk NHS Foundation Trust** is so concerned over the threat that it has hired a law firm to assess the risk of being charged with corporate manslaughter should any hospital collapse and kill patients, staff, or visitors.

Several of these hospitals are in such a dire state that it could be cheaper to knock them down and rebuild – but there is no capital to do so. Rishi Sunak has to be forced to make the necessary funding availableto completely rebuild the hospitals that put patients and staff at risk – this could easily add up to £6bn.

£18bn+ needed to ensure 'new hospitals' can be built as planned

The £2.7bn allocated to build six, and then eight prioritised 'new hospitals' was completely unrealistic to begin with.

But it's even less plausible now that the New Hospitals Programme insists the same pathetic pot of cash has to stretch to cover costs of eight previously existing schemes – including two long-delayed PFI hospitals.

The New Hospitals Programme itself, which during the summer instructed all of the priority schemes to submit new plans costing no more than £400m – implying drastic cutbacks – has now been dropped to a "red rating" by the government's infrastructure watchdog the Infrastructure and Projects Authority.

This is defined as meaning: "Successful delivery of the project appears to be unachievable…".

Estimates in 2019 suggested the full cost of 40 new hospitals could be as high as £24 billion, and not less than £18bn.

To get any projects started Rishi Sunak needs to be told to make the necessary funds available as soon as clinically viable plans have received planning approval.

Hubs and mental health

There is also need for NHS capital to build its own community diagnostic hubs and its own elective surgical hubs to streamline efforts to reduce the waiting list. And capital and revenue funding are also needed for investment in mental health services, which have been promised more staff and parity of esteem for years on end with no extra resources to match.

Eight more hospitals – and rebuild public health

Meanwhile, as *The Lowdown* has reported, the government has invited trusts to bid to be one of eight additional hospital projects to be funded, bringing the total schemes to 48 – but so far has allocated no additional capital.

A clutch of schemes have been published, adding up to a total cost between £3.4bn and £5.1bn.

More investment is also needed at local level to rebuild public health services that have been foolishly cut back and are now straining to support the fight against Covid.

Discharged – but not assessed or supported

Serious questions are being raised over the care of older people after they leave hospital, as the Health and Care Bill proposes to remove the entitlement to an assessment of needs prior to discharge.

A report by Healthwatch published last month, based on a survey of 590 patients, notes the huge proportion of patients who had not been assessed:

While the discharge to assess model "rests on the principle that people should have their recovery and longer-term support needs assessed in the community at a follow-up visit, **" 82% of respondents did not receive these visits,** and nearly **one in five of these (18%)** reported having unmet needs."

No contact details

More than one in three did not receive contact details of a health professional they could get in touch with if they required further support or advice after leaving hospital.

Some patients felt that their discharge from hospital was rushed; approximately **one in five (19%) people** felt they were not properly prepared to leave.

Almost two thirds of the respondents (61%) did not receive information about the new discharge process, and family members encountered difficulties being kept up to date.

Nearly one in ten (8%) survey respondents were **discharged at night** (after 8pm) with approximately **two thirds (64%) of those** not being asked if they needed transport support.

Healthwatch notes that the findings "have also led us to question the assumptions implicit in the policy about who should receive follow-up assessments and support."

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Splashing cash – to crooks and cronies

Before Rishi Sunak bleats that the extra levels of funding we are calling for from SOS NHS are unaffordable, we need to remember the huge sums of money he threw at the private sector during Covid.

Vast amounts of this money were stolen, wasted – or squandered on overpriced or useless PPE and equipment.

£48bn was shelled out on 'bounce back loans' alone, with minimal checks on the credentials of the companies claiming the cash: no less than £26billion of that has been lost to fraudsters and borrowers who cannot repay, according to the NAO.

£37 billion was famously allocated over 2 years to the disastrous privatised test and trace system, blowing over £1m per day on Deloitte consultants, with no proper value for money checks or consideration of an NHS and public health-led scheme.

The money wasted on these two things alone would have been more than enough to put the NHS back on track. if it can be raised to waste, it can be raised to invest.

Sunak has also ditched plans to increase capital gains tax to the levels of income tax, which could have raised another £17bn per year from the wealthiest people, and given scope to invest further in health and social care.

Mental health services face growing crisis

Mental health services remain under increasing strain after the peak of the Covid pandemic: NHS crisis services have seen a 74% increase in referrals post-pandemic. The latest data (Quarter 1 2021/22) shows that crisis lines were managing around 180,000 – 200,000 calls per month.

NHS England's latest estimate is that at least 1.4 million people have been accepted for, or are eligible for mental health care but are yet to receive it, with an additional eight million who would benefit from care, if access barriers were reduced.

Increased acuity of patients attending is causing pressures on the urgent and emergency care pathway and inpatient beds, and adult acute bed occupancy remains above the recommended safe levels of 85%, in a system that is currently operating with reduced bed capacity and that is entering a period of seasonal winter pressures.

Above the safe levels, surge demand cannot be met, the likelihood of safety incidents increases, as does reliance on Out of Area Placements.

A&E waits over 12 hours are worsening, and NHS Digital have estimated a 4.5% increase of detentions under the Mental Health Act (1983) between 2019/20 and 2020/21.

In November the Independent revealed one instance of a mental health patient who had waited 36 hours for a bed in a mental health hospital, having to spend the night on a mattress on the floor in Bolton Hospital for lack of beds.

The proportion of children and young people (CYP) aged 5-16 years with a probable mental disorder has risen by more than half from 11% in 2017 to 17% in 2021, and CYP mental health services have faced an unprecedented surge in urgent eating disorder cases.

The HSJ reports national clinical director Professor Tim Kendall telling NHS England that in 2016 teams were seeing only around one in four children with mental health problems: while that measure has now been boosted to around 40 per cent, it was nowhere near good enough.

"If you said you were only seeing 40 per cent of people with cancer, we'd get lynched, and understandably," he said. "It just wouldn't be tolerable."

NHS England's November board meeting heard that "new capital and workforce solutions are required to enable systems to provide care closer to home."

One constraint on service expansion is staffing: the latest available data show an increase of more than 18,000 mental health staff since 2016, with an expectation that delivery of HEE's "Stepping Forward" will be achieved by December 2021.

However expanding the workforce remains critical to delivering the long term plan and coping with the additional post-pandemic pressures; the LTP alone is estimated to require an additional 27,000 WTE by 2023/24,

NHS England admits that expansion also requires capital investment to 'house' growing community services.

Meanwhile the Royal College of Psychiatrists' latest census reveals a shortage, with one in ten posts unfilled and almost a quarter of staff effectively acting as locums without a substantive post, meaning that they cannot offer continuity to patients or feel secure in their own jobs.

The RCP's Dean, Professor Subodh Dave told the HSJ current workforce gaps are having a "knock-on effect," with "inevitable rationing" of patient care to keep services running.

'Extra' £700m was first announced in September

"£700 million to support NHS this winter" was the catchy headline of the Department of Health and Social Care Press Release on December 3, picked up and relayed as a lazy good news story by LBC and many local and national newspapers.

But the money is not new or extra: part way though the press release it states that it is "part of the £5.4bn already announced" … back in September.

The only new factor is the breakdown of how the money is to be carved up – into a staggering 785 schemes across 187 hospital trusts.

The six largest schemes add up to £51m, leaving an average of just £800,000 for each of the other schemes, some of which are much smaller than that.

Handing out such limited sums in the first few days of December seems most unlikely to make any significant difference to capacity or waiting lists this winter, and more aimed at reinforcing the complacent view that "record" funding of the NHS is enough to address the unprecedented crisis it has been plunged into by austerity policies since 2010.

Waiting list to hit at least 7m by 2025 – NAO

With England's waiting lists now estimated at 5.98 million by the IFS, there is a grim warning in the latest National Audit Office report on backlogs and waiting lists:

"If 50% of missing referrals return to the NHS and activity grows only in line with pre-pandemic plans, the waiting list would reach 12 million by March 2025.

"If 50% of missing referrals return and the NHS can increase activity by 10% more than was planned, the waiting list will still be seven million in March 2025.

"The challenge is how to prioritise and manage long waiting lists in the immediate future."

Doubts over recruitment as HEE abolished & merged with NHSE

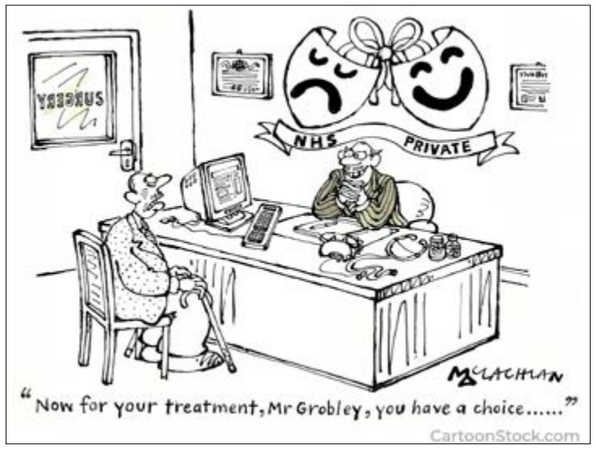
Health Education England, which is the body responsible for recruitment and training of NHS professional staff, is to be 'merged' into NHS England by April 2023, according to leaked reports to the *HSJ*.

The decision to axe the independent body follows arguments with the Treasury over funding, and an unsuccessful bid to increase HEE's £3.96bn annual budget to enable it to increase staff supply.

While HEE has been far from perfect, once the dedicated body focused on staffing has been scrapped, the battle to get NHS England to prioritise workforce planning will have to be waged internally in a sprawling organisation that is also planning to merge NHSX, NHS Digital and NHS Improvement into one all-embracing bureaucracy.

There are also fears that an HEE budget for an overseas recruitment campaign could be lost in the process of the merger, further undermining hopes of filling the growing and dangerous gaps in front-line staffing.

The Tory Party logo on the advert announcing Sajid Javid's latest effort to lure back retired NHS staff seems unlikely to trigger an increased response.



More patients turn to "self-pay"

Data from the Private Healthcare Information Network (PHIN) shows the significant increase in numbers of patients paying up front to use private hospitals to escape growing NHS waiting lists since the Covid pandemic.

65,000 patients resorted to self-pay operations between April and June 2021, up 30% from the same period in 2019.

And for cataract surgery and hip replacements more patients are now paying up front for private care than covered by insurance.

The PHIN is also thrilled by a YouGov poll showing that over a fifth of those responding said they were more likely to consider using private healthcare than before the pandemic, most of them citing concerns over the NHS waiting list.

A new PHIN report admits that 600 patients had to be transferred from private hospitals to NHS acute beds for emergency treatment in the year to June 2021 – underlining the limited facilities and staffing in private hospitals.

NHS funding has been kept unsustainably low – says FT

"We must accept higher taxes to fund health and social care" is the headline on an important Opinion piece by veteran Financial Times journalist Martin Wolf on November 29.

It quotes the Institute for Fiscal Studies' comment in its recent Green Budget that "between 2009–10 and 2019–20 UK government health spending grew at an average real-terms rate of 1.6 per cent per year — lower than any previous decade in NHS history."

Fewer doctors, beds and scanners

It also notes that "The waiting list for elective treatment had grown by 50 per cent from 2015. The NHS entered the pandemic with fewer doctors, hospital beds and CAT scanners per person than in most similar countries.

"The system was creaking. Then came the pandemic. Rescue funding had become vital."

Wolf goes on to cite the Office for Budget Responsibility analysis showing the most recent increase in spending on health and social care as around £15bn a year, but notes that:

"Given the ageing of the population, new treatments, growing demand and the inescapable rise in costs of labour-intensive services, the share of spending on health in national income will continue to rise."

Looking at ways of responding to rising costs of health and social care, Wolf dismisses austerity, which in the end "blows up," and hypothecated tax.

He also dismisses the claim that an insurance based system is any solution: "quite apart from the upheaval, compulsory insurance is just another tax."

He attacks the levy on national insurance payments as "a disgrace" and "unjustifiable," and the new "cap" on social care costs as massively penalising those with small wealth in favour of those with much more.

And the conclusion? "The country has still not recognised the long-term need to accept rising taxation in order to deliver the services people will demand. There is no realistic alternative."

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Misconduct in public office

Tony O'Sullivan, co-chair KONP

The report into the handling of the coronavirus pandemic was published on Wednesday 1 December, two years on from the emergence of the novel virus and COVID-19, the deadly disease that has killed over 5.2 million people – 167,000 of them in Britain. Keep Our NHS Public organised the inquiry which has filled the deafening silence from Government.

The Prime Minister had steadfastly refused to organise an inquiry even when it was obvious to all that a rapid-learning inquiry was needed to save lives and halt the tragic repetition of government mistakes and misjudgements.

In the absence of a formal public inquiry into the pandemic, The People's Covid Inquiry began in February 2021 and concluded its hearings in the summer.

The purpose was in the title: 'Learn lessons – save lives'. It covered all aspects of the Government's handling of the pandemic and heard testimony from a wide range of individuals and organisations.

These included previous government advisors and key academics, as well as frontline workers and bereaved family members.

The Inquiry was chaired by world renowned human rights barrister Michael Mansfield QC who, together with a panel of experts, has now delivered their findings and recommendations on all main aspects of the pandemic to date:

"This Inquiry performed a much-needed and urgent public service when the nation was hit by a catastrophic pandemic coincident with an unprecedented period of democratic deficiency.

"It afforded an opportunity for the beleaguered citizen to be heard; for the victims to be addressed; for the frontline workers to be recognised; and for independent experts to be respected.

"When it mattered most and when lives could have been saved, the various postures adopted by government could not sustain scrutiny."

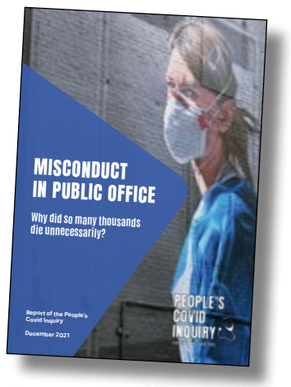
(Above) Inquiry chair Michael Mansfield. (Right) Prof Neena Modi and KONP co-chair Tony O'Sullivan

'A theme of behaviour amounting to gross negligence by the Government'

The findings and recommendations of the People's Covid Inquiry

The findings are damning – the recommendations are urgent and potentially life-saving. But the reasons behind why the 6th richest nation in the world, with a proud NHS and public health reputation, has the 27th worst death rate of 190 nations and the worst economic impact of the OECD countries are shocking.

The joint Health & Social Care and Science & Technology Commons Select Committees' report in October declared the handling of coronavirus to be the worst public health failure. Our report exposes the failings of the UK response to be the worst political failure. There is a case to answer of gross negligence and misconduct in public office.



In his damning assessment of the Government's pandemic handling, Michael Mansfield argued the case for the charge of 'misconduct in a public office' by government ministers:

"This People's Covid Inquiry report is unequivocal – [there has been a] dismal failure in the face of manifestly obvious risks … It was plain to …[the organisers of the Inquiry] that Government words were bloated hot air, hoping to delay and obfuscate. Within this narrative lies a theme of behaviour amounting to gross negligence by the Government, whether examined singularly or collectively. There were lives lost and lives devastated, which was foreseeable and preventable. From lack of preparation and coherent policy, unconscionable delay, through to preferred and wasteful procurement, to ministers themselves breaking the rules, the misconduct is earth-shattering."

Testimony

The Inquiry heard the sadness and the questions from bereaved families demanding justice.

It heard the pride of NHS, care and other frontline staff and we heard about their pain, exhaustion and their moral injury.

The Panel listened to vital expert testimony on failings in public health, on workplace safety, on the impact of inequalities, on the running down of the NHS.

There was disastrous policy and behaviour in public office at every stage

Pre-pandemic, 10 years of austerity policy left the NHS exposed and social care in danger of collapse. Pandemic planning exercises, including Exercise Alice in 2016 based on a coronavirus pandemic, gave clear warnings which were ignored – on exactly the dangers exposed: insufficient stocks and qualities of PPE, insufficient hospital beds, ventilators and staff, a lack of capacity and data systems to test, contact trace and isolate, and to regulate borders.

Delayed response

Government responses to the pandemic spread, despite the experience of China in December -January and Italy in February-March 2020, were unforgivably delayed. The 2-3 week delay before lockdown in the UK when cases were doubling every 3-4 days caused at least 20-30,000 avoidable deaths. Two further lockdowns were delayed in the face of scientists' urging action and a tens more thousands of deaths resulted in January-March 2021.

Running through this whole time from pre-pandemic to initial response and across three lockdowns has been the refusal to accept WHO basic public health policy: 'test, test, test'; 'go hard go early'; the essential need for rigorous case finding, testing and tracing, isolation and quarantine with support for those who need it. Never has our Government put this FTTIS system in place.

The heightened inequalities of the past decade led to brutally discriminate impact on the low-paid, unemployed, women, disabled people (six in every 10 deaths) and on Black, Asian and ethnically diverse communities. People in multi-generational households, more crowded accommodation, working zero-hours and low-paid jobs all were exceptionally at risk.

We learned to redefine the meaning of 'key worker' as frontline staff across sectors went to work unprotected by PPE or any semblance of Health & Safety Executive activity. 1500 health and care workers died. In London alone, dozens of bus drivers died.

It was unions like the GMB, NEU and ASLEF who were actively protecting their members at work, not Government, not employers. The inquiry heard how employers let down their staff exposing them to avoidable risk.

Public servants were ignored across the NHS, public health, primary care, care homes, local authorities and schools. Teachers were accused of not caring for children when staff demanded safety in schools. Government redefined and downgraded PPE requirements when supplies were running out, to avoid being accused of breaching employees' safety, and blamed NHS and care staff for abusing PPE.

Private contracting was the preferred route to procure supplies and services, from NHS Test and Trace at a cost of £37 billion wasted (run by Serco, Sitel and Deloitte) to setting up private, often unaccredited laboratories, instead of urgently boosting NHS capacity.

The private hospital sector's costs were underwritten and no more than 30% of their capacity was used. The level of government cronyism and resultant profiteering has been blatant and in plain sight.

Breach of public trust

The Government had no time for a public inquiry but time to rearrange the NHS mid-pandemic, with its dangerous Health and Care Bill. Government treated bereaved families with disrespect and ignored their questions for over a year.

If and when the Government's judicial-led public inquiry convenes (no chair or terms of reference at the time of writing), Jo Goodman, Co-Founder of Covid-19 Bereaved Families for Justice (who contributed to the Inquiry) argues:

"It's vital that bereaved families are at the heart of the forthcoming inquiry and listened to at every turn, and this report evidences exactly why. The loss of our loved ones should be used to learn lessons and save lives - something the Government should be entirely focused on and dedicated to."

Lessons to save lives

The Inquiry set out to learn the lessons that could save lives in this and future pandemics. The Panel has been shocked at the avoidable loss of tens of thousands of lives through the neglect of pandemic planning, the run-down of the NHS, and the intense inequality in this country and the wider impact this has had.

All this has left the NHS and Care sectors at existential risk of collapse. Equally shocking has been the breach of all the Nolan Principles of behaviour in public office, including lack of candour, honesty and integrity.

The overall conclusion of the Inquiry is that there has been misconduct in public office. This has to be addressed: if it is ignored, the country cannot learn the lessons from today to face the challenges of tomorrow.

If the NHS, Care and support services and inequalities are not addressed the future for the population is bleak. Keep Our NHS Public believes that these findings are an important contribution to what must change and change now.

The report will be submitted to government and the future public inquiry in the hope that its contents may help inform future policy.

■ **Watch the report launch here:** https://youtu.be/S56rrfgFWFg
■ **Download the report at** https://www.peoplescovidinquiry.com/

Photos by Jim Aindow

Private hospitals coining in cash from NHS and self pay

The staggering £2.15 billion paid out by the NHS to private hospitals since the Covid pandemic, to cover their costs and ensure capacity would be available, have been broken down by ***Private Eye*** (issue 1561).

It found £468m (boosting its revenue by more than 50%) had been paid to the largest hospital chain Circle Health Holdings, with 54 hospitals and over 2500 beds, which has now been acquired by grasping US health corporation Centene. The NHS payments effectively trebled the value of the company.

£430m was paid out to Spire, with 39 hospitals and 1,870 beds, helping to almost double the company's share price.

And Australian-owned Ramsay Health Care UK picked up a cool £385m (equivalent to 76% of its revenue) in the first 13 months of the pandemic for providing capacity in its 29 hospitals with 892 beds.

Both Spire and Ramsay have bragged that the increased NHS waiting list offers them even more lucrative possibilities with self-pay patients. Spire's 2020 Report notes that they were able to keep back beds from the NHS deal to ensure they could continue to treat private patients, and that some of this was exceptionally profitable:

"Q4 saw exceptionally strong growth in self-pay revenue with priority given to more clinically urgent complex cases, which carry a greater average revenue per case."

Spire's Strategic Report notes:

"our self-pay admissions were broadly in line with the same period in 2019. This wave of activity, following the pause between March and August, was largely due to pent up demand and a desire by people to avoid a lengthy wait for treatment in the NHS at a time of increasing NHS waiting lists and times;"

NHS England's eagerness to strengthen its ties with Ramsay was underlined in October when NHS England's Director of Clinical Improvement turned up to cut the ceremonial ribbon, opening a new Ramsay Hospital in Chorley – where the future of NHS acute services remains uncertain.

National Director of Clinical Improvement for NHS England Professor Tim Briggs opens Ramsay Health Care UK's new Buckshaw Hospital in Chorley

The private hospitals have obviously been happy to accept NHS subsidies to cover their costs during the Covid lockdown, and to fill their otherwise under-used beds with NHS patients as part of the 4-year £10bn "framework" deal announced last autumn.

But it's clear that, despite the lavish payments, nowhere near the full 8,000 private sector acute beds have been made available to the NHS, and fewer still have been used.

If they can choose, the hospitals themselves would clearly rather treat their more profitable self-pay and privately insured patients than fill beds with NHS patients at the lower NHS tariff cost.

But even utilising ALL of the private acute beds would still leave the NHS still facing a drastic loss of capacity in four years time, compared with 2019 – and leave the capacity gap unresolved, with the NHS more chronically dependent on the private sector.

As private hospitals increase their caseload, they poach more staff from the same limited pool of NHS-trained staff – increasing the pressures on front-line NHS services – with NHS teams split up and vital staff redirected to work away from main sites in small private hospitals.

Any benefit in access to additional beds for elective work would be offset by the greater problems maintaining adequate staffing of emergency services.

North Tynesiders still livid as Livi gains new contract

Jude Letham (Co-ordinator), Keep Our NHS Public North East

Most North Tyneside residents knew nothing of Livi before they received a leaflet in August 2020. North Tyneside CCG (NTCCG) commissioned this private, Swedish company to provide 21,000 on-line GP video appointments on a 12-month pilot scheme, in addition to standard primary care services.

The NTCCG website implies that Livi was brought in to help with the pandemic:

"At the start of the Covid-19 pandemic the CCG recognised that a different complementary digital solution with additional GP capacity may help to improve access across 7 days a week, and release time for practices to focus on patients who need face to face appointments."

However, minutes from a Patient Forum meeting on 14th November 2019, record that funding for the Livi pilot had already been approved.

Rather than improving access to GPs, Keep Our NHS Public North East (KONPNE) see the Livi service as exclusive. Patients require access to and proficiency in the use of smart phones/laptops, as well as adequate data and broadband.

Awry

Privatisation

Not surprisingly, KONPNE's main objection is that this is privatisation of the NHS. A private company should not be used to address shortfalls in GP provision and the fundamental problem that must be addressed is the underfunding of primary care services.

North Tyneside Council have made clear their opposition to NHS privatisation. Councillor Margaret Hall (Chair of the North Tyneside Health & Well-Being Board) stated in a North Tyneside Council Meeting on 26th November 2020 that, *"North Tyneside Council is 100% opposed to any privatisation of the NHS."*

Perhaps this is why the NTCCG did not consult with the local authority scrutiny committee before commissioning Livi.

They claim, on their website, that consultation was not necessary because: *"This is an additional new service."*

In our experience the vast majority of the public are also opposed to this private contract. People queued in the street to sign our petition opposing Livi and the service has not been widely used.

Only 45% of the commissioned appointments were taken up. Indeed, Livi resorted to hiring advertising billboard vans to drive around North Tyneside to promote their service.

Figures provided by NTCCG indicate that, on average, the uptake of Livi appointments is one per day, per practice (N.B. not per GP).

However despite the lack of enthusiasm from the public and the lack of evidence that one-to-one GP appointments are now easier to book, NTCCG produced an evaluation report with gushing praise for Livi.

They have decided to extend the pilot while a new 5 year contract is procured.

■ ***More details on this, and other campaigns by KONP North East at https://konpnortheast.com/***

MPs nod through Bill with few changes – fight starts in the Lords

Tory MPs have rubber stamped a deeply flawed Health and Care Bill with no opposition amendments passed and minimal changes conceded by ministers, and the focus for opposition to it has shifted to the House of Lords.

Continuing to fight over the controversial issues is important, both to expose as widely as possible (and warn a wider public and the NHS staff) what new problems are coming down the line, and to make it absolutely clear that each and every negative consequence that flows from the Bill is down to ministers and the Tory MPs that vote it through, and nobody else.

According to a document leaked to the HSJ, it appears that NHS England is concerned that the tight schedule to launch Integrated Care Boards by April next year, when legislation may not have been finalised until late February or March could force a delayed launch of the new system.

But even if this happens, at the end of the process a government with a majority of 80 will get the core elements of its Bill through.

So whatever is passed we will have to find ways to fight on to repair and restore our battered NHS – just as we had to do back in 1991 as John Major's government first broke the NHS into an "internal market" of purchasers and providers, and in 2012 after Andrew Lansley's wide-ranging and fundamental Health and Social Care Act was forced through by the Tories, propped up only by the spineless LibDems.

Entrenched privatisation

That legislation set out to entrench privatisation and outsourcing, a competitive market system in which local commissioning groups were forced to put an ever-growing range of clinical services out to competitive tender. Lansley's fundamentalist neoliberal supporters gleefully hailed it as the start of the "denationalisation" of the NHS. Happily they were subsequently disappointed.

The 2012 Act ended the direct accountability of the Secretary of State for the promotion and provision of health services in England, which was transferred to an 'arm's length' body, NHS England – although in practice Health Secretaries have continued to behave as if they were still in charge.

The Bill means more powers for him – and less local voice than ever

The new Bill does end the requirement for some tendering (for clinical services (of which only an estimated 2 percent have been going through with tender processes anyway). But it does not roll back any existing contracts and pulls up well short of abolishing outsourcing and privatisation, or making the NHS the default provider, as proposed by the unions.

An amendment reinserting regulations to limit the danger of a new round of shameless crony contracts has been rejected.

New powers

Numerous controversial proposals would extend and add new powers of the Secretary of State on a wide range of issues, including intervention in local hospital closures and reconfiguration of services.

The Bill scraps the legal right in the Care Act (suspended last year during the Covid peak) for vulnerable patients to have their needs fully assessed before they are discharged from hospital, posing real dangers of patients being left stranded at home by inadequate social care, community and primary care services.

Ministers have responded to criticism that the Bill is a 'corporate takeover bill' by tabling an amendment to prohibit anyone "involved with the private sector or otherwise" from taking a seat on an Integrated Care Board if this could be "reasonably regarded as undermining the independence of the health service".

But the private sector voice remains strong at every level, and an amendment to similarly keep private sector representation out of all ICB decision-making bodies has been rejected, and an amendment to exclude GP employees of private corporations also failed.

Less accountable

With just 42 ICBs as "local" bodies, some spanning large areas and populations as large as 3 million, and no explicit requirement to establish more local "place based" structures, England's NHS will be less locally accountable and less open to scrutiny than it has been since the early 1970s.

The Bill reorganises the NHS – but it does not fundamentally change the system established in 2012.

It does not "sell off" the NHS, although many services will still be contracted out, not least where capital investment is required to develop new centres or services. Private hospitals and contractors do not seek to own, but feed off and profit from the NHS.

The fight goes on, through the Lords – and beyond. There's still a lot of NHS to defend – and far too much to lose if we don't.

Unite lists key topics for amendment

Unite has written to all Peers urging them to oppose the Health and Care Bill, which had its second reading in the House of Lords on December 7.

The letter focuses on the issues of privatisation, accountability and transparency, and concludes by advocating that "Amendments to address some of the worst aspects of the Bill should be pursued, but nonetheless the Bill should be opposed in its entirety."

It adds a commendably brief list of issues on which Unite would welcome and support amendments:

1. Ensure NHS suppliers/ providers are default providers of NHS services
2. Ensure ICBs and ICPs are made up wholly of representatives of public sector organisations, with the exception of GPs
3. Ensure ICBs can only delegate functions to statutory NHS bodies
4. Ensure NHS professions cannot be removed from regulation and that regulatory bodies cannot be abolished
5. Ensure people receive their social care needs assessments before they leave hospital
6. Address the regressive impact of the social care cap
7. Ensure people in England can receive treatment in any part of the country, ensuring no postcode lottery and that any suggestions of A&Es turning people away because they live in the 'wrong' postcode are removed
8. Ensure this Bill does not undermine the scope of national collective bargaining and health workers' access to Agenda for Change rates of pay, T&Cs and NHS Pensions.

Trust bosses: no confidence in ICSs

Confidence in the new system being legislated through the Health and Care Bill is strikingly lacking amongst trust bosses according to the latest NHS Providers' survey.

It shows that

● **Less than half (43%) of trust leaders were confident or very confident that plans to embed system working, via statutory ICSs, will support better collaboration between local partners and improve mutual aid,**

● **Even fewer (41%) were confident or very confident that these plans will support better outcomes for patients.**

And amid all of the rhetoric of "Integrated Care Systems" **just 22% of trust leaders** were confident or very confident that support and infrastructure is in place locally to enable a more integrated service between primary care and secondary care.

US doctors fight to stop attack on Medicare

Campaigning US doctors, members of Physicians for a National Health Program, are fighting moves by the Biden administration that would effectively put profit-seeking private companies in charge of most of the publicly-funded Medicare system that covers senior citizens.

Most seniors are enrolled in Traditional Medicare, which gives them free choice of any doctor or hospital and reimburses providers directly at a set rate. Because of its simplicity, it spends 98% of its funds on patient care, with only 2% spent on administration.

In contrast, Medicare Advantage (MA) is run mainly by commercial insurers for profit. Medicare pays MA insurers a set amount per enrollee per month; then, MA insurers pay providers for enrollees' care – and keep what they don't spend on care.

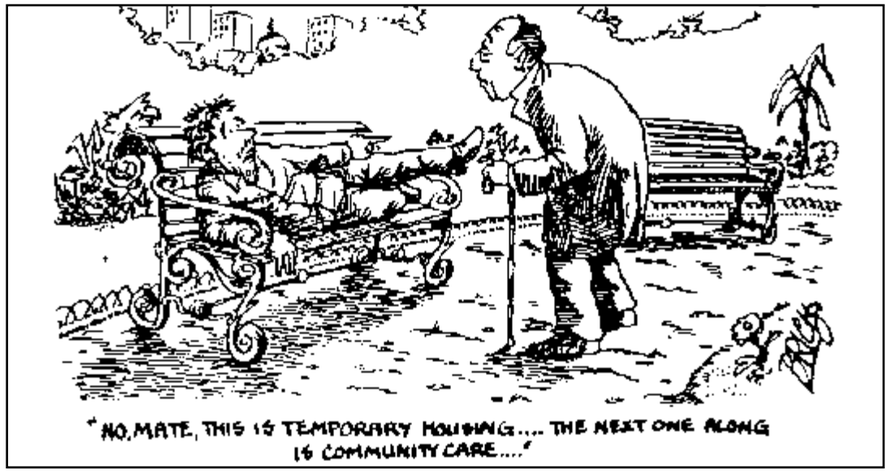
In 2020, MA plans spent just 82% of their revenues on care, keeping 18% as overhead and profit.

The Centre for Medicare and Medicaid Services (CMS) recently announced a plan to move everyone enrolled in Traditional Medicare into a "care relationship" with a third party "Direct Contracting Entity" (DCE), as initially proposed by the Trump administration – effectively replicating the flawed MA system, and opening the prospect of increased fraud and denial of care.

Virtually any type of company can apply to be a DCE, including commercial insurers and venture capital investors. DCEs are profitable because Medicare pays them more money for sicker patients, giving DCEs a strong incentive to engage in a type of fraud called "upcoding," meaning they exaggerate — or falsify — seniors' diagnoses, as happens widely in Medicare Advantage.

DCEs are also allowed to keep as profit and overhead what they don't pay for in health services, a dangerous financial incentive for them to restrict seniors' care.

The plan is being driven through without seniors' knowledge or consent, and without Congressional oversight. Campaigners have launched a petition calling on Department of Health and Human Services Secretary Xavier Becerra to halt the DC program, provide real oversight and accountability, and protect traditional Medicare.



Adult social care White Paper

Still kicking the can down the road

Abridged and adapted from an article by Martin Shelley in The Lowdown, December 3

The long-awaited White Paper on adult social care unveiled in the House of Commons this week proved to be a damp squib.

It's little more than a 100-page 'holding' statement of intent or stopgap measure while the government worked on the more awkward question of health and social care integration – the latter now the focus of a follow-up paper with no release date known as yet.

Rehash

The policies talked up by care minister Gillian Keegan do little more than rehash and re-present elements of the new Health and Care Bill and its 'build back better' plan for a "once in a generation" transformation of adult social care.

This was unveiled by the government only last week and which introduced a cap on social care costs, a mere seven years after the enabling legislation made its way onto the statute books.

And just like the care cap legislation, the adult social care paper (snappily titled 'People at the Heart of Care') was greeted with little enthusiasm by leading stakeholders.

The Association of Directors of Adult Social Services (ADASS), Carers UK and the National Care Forum were lukewarm in their responses, and even Jeremy Hunt, the chair of the Commons Health And Social Care Select Committee, attacked the paper, calling it "three steps forward and two steps back", and saying it would do nothing to ease pressures on hospital wards or help older people get the care they need.

A snap survey, undertaken last month by ADASS, shows that:

- almost 400,000 people are now waiting for an assessment of their needs or for service provision
- more than 1.5m hours of commissioned home care could not be provided between August and October because of a lack of staff, despite record growth in provision
- one in two councils has had to respond to a care home closure or bankruptcy over the past six months
- more than 40,000 people have been waiting longer than six months for an initial assessment

The Nuffield Trust has warned of a "deepening crisis" as it unveiled its own research showing that the social care workforce shrank by up to 70,000 between April and October this year.

Low pay

Low pay levels in social care are a major recruitment obstacle – skilled carers can earn more working in supermarkets or Amazon warehouses – but an estimated 32,000 staff may also soon leave the sector because they don't want to be double-vaccinated.

Governments have long been reluctant to invest in social care. The press release for this new plan makes sparse reference to extra funding for the sector, which the Health Foundation estimates is facing a shortfall of between £6bn and £14bn.

Spending on adult social care was more than four per cent lower in 2018/19 than in 2009/10, despite a 17 per cent growth in the size of the population aged 80+ over the same period.

Privatisation

It's difficult not to conclude that the crisis in the adult social care sector stems largely from the creeping privatisation of health and local government services that has been part of the Tory project.

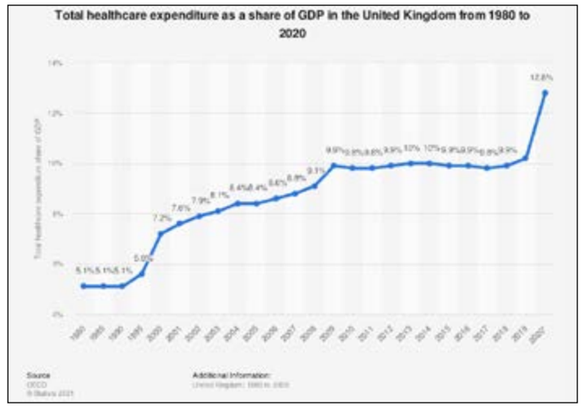
When Margaret Thatcher swept to power in 1979 the proportion of residential and nursing care services provided by the state was 64 per cent, but by 2012 this had fallen to just 6 per cent.

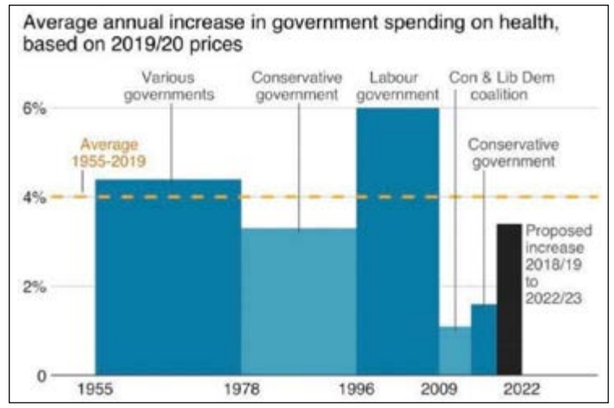
And the private sector provided just 5 per cent of state-funded domiciliary care services in 1993, a figure that had risen to almost 90 per cent by 2012.

That privatisation and fragmentation is at the root of today's crisis: and it's why a publicly run National Care and Support Service is the necessary solution, not another evasive White Paper.

NEXT ISSUE

Our next issue of the news bulletin will be in January 2022.* Please get any articles, photos, tip-offs or information to us no later than JANUARY 1. Seasonal Greetings to all readers and supporters – and a militant new year!





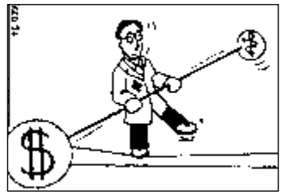
Dodgy figures wheeled out to attack NHS

Right wing publications are unreliable sources of most information: but Boris Johnson's old employer *The Spectator* has gone into overdrive this month, with its editor joining forces with a contributor from the obscurely-funded Institute for Economic Affairs to falsify figures and blame the NHS itself for the crisis created by over a decade of under-funding.

Kate Andrews' article picks up on the massive Covid-driven increase in 'health spending' in 2019-20 (most of which did not come anywhere near the NHS, and was squandered on private contractors and consultants) to claim that the NHS is awash with cash ("The UK now spends almost 13 per cent of its economic output on healthcare — the highest in Europe").

She goes on, apparently unaware of the virtual real terms standstill in health spending as a share of GDP from 2010 to 2019 (see graph) along with a 5 million increase in population, to argue "between 2010 and 2025, the health budget will have increased by 42 per cent — squeezing cash spent elsewhere in government".

Andrews claims "The government will soon be pouring almost half of day-to-day public



service spending into a system which is falling short of what patients (and tax-payers) deserve."

In fact the most recent Red Book on government spending shows the Department of Health and Social Care **receiving just a third of the total** of Departmental Budgets by 2025 – a lower share than in 2019.

From this dishonest and deceptive starting point Andrews goes on to ask: "how much respect does the system deserve, given that it is currently preventing the treatment of the sick…?"

The article's opening paragraph, describes a recent "surprisingly frank conversation" in Boris Johnson's cabinet on the "many shortcomings" of the NHS as argued by Rishi Sunak, Jacob Rees Mogg, Cabinet Secretary Steve Barclay and Business Secretary Kwasi Kwarteng. All apparently agreed it is failing.

But Andrews does not divulge what alternative system these right wing luminaries would prefer, or spell out any clear alternatives herself. Before discarding the NHS as a model it surely makes sense to look at the cost and disadvantages of any alternatives.

Instead she suggests a vaguely described shift to a "private and charity sector" system to "work in tandem with the state" to ensure the best outcomes for patients. Clearly Ms Andrews, (an American who is canny enough to distance herself from the ruinously expensive basket case of the US health care system) is arguing for far greater use of market forces and private provision.

But the examples of 'failure' that she quotes are not areas where the private sector has any contribution to offer – or indeed any private insurance or self-pay system could fill in the gaps.

She attacks poor performance in NHS emergency hospital and ambulance services – which anyone with any sense long ago connected directly to the disastrous decade of frozen real terms funding since 2010.

But the private sector does not offer emergency hospital care in Britain – and everywhere avoids involvement in it wherever possible.

She bizarrely blames GPs having limited face to face appointments (a policy imposed upon them by NHS England and by Covid precautions) for patients waiting hours on trolleys in emergency departments – as if all primary care patients need immediate admission to hospital.

Andrews (and Spectator editor Fraser Nelson, who rallied to her defence on Twitter) seem unaware of the loss of 10,349 front line general and acute beds (almost 10% of capacity) since 2010, or the impact of almost 6,000 Covid patients currently occupying front line beds plus an additional 4,500 beds remaining unoccupied compared with 2019 – a further capacity reduction of over 10% for non Covid-patients.

Instead they offer partial and inappropriate comparisons with the performance of other systems in which private insurance and private provision play a significant part.

For example **Belgium** which spends more than **3.6% more per head** on health than the UK and has more than twice as many hospital beds per 1,000 population.

Germany is mentioned, too, of course, which **spends almost 28% more** per head on health than the UK, and has more than three times as many beds available as the UK, and six times more acute beds per head than England.

Andrews goes on to bring in another of her favourites, **Switzerland**, the highest-spending health care system other than the US, which **spends over 35% more** than the UK on health, and has almost double the UK provision of beds.

Sweden, Denmark, Norway Italy and Ireland are also thrown in for good measure: Sweden **spends 9.2% more per head** than the UK, Denmark **10% more**, Norway **28% more** and Ireland – whose system is a notorious horror story with extensive private profiteering, spends **6% more**: only Italy somehow spends less. And all of these countries except Sweden, which has long had integration of health and social care, also have **more beds per head** than the UK.

Andrews' examples shoot down her own argument: how can the NHS be over-funded, when all her preferred models are more expensive? Why does she never mention user fees and supplementary insurance costs of these systems?

And why have none of them been ranked as more accessible and equal than the NHS? Because they are quite the opposite.

The IEA won't say who funds them, and won't say what system they really favour: all we know is they really hate the relatively cheap, fair and efficient NHS because it's not privatised enough.

And it seems Johnson's cabinet agree.

Country	Hospital beds per 1,000 population	Latest spending per head (US$)	Extra spending compared with UK (%)	Doctors per 1,000 population
UK	2.4	5268	na	3.0
Sweden	2.1	5754	9.2	4.3
Denmark	2.6	5849	10.0	4.2
Ireland	2.9	5604	6.0	3.3
Italy	3.2	3819	-27.6	4.1
Norway	3.5	6748	28.0	5.0
Switzerland	4.6	7138	35.5	4.4
Belgium	5.5	5458	3.6	3.2
France	5.8	5564	5.6	3.2
Germany	7.9	6731	27.7	4.4

Spending figures from https://data.oecd.org/healthres/health-spending.htm
Bed numbers from https://data.oecd.org/healtheqt/hospital-beds.htm
Doctor figures from https://stat.link/3pasve

SOS NHS

From front page

NHS – and soaring private sector profits, both as contractors to the NHS, and as private providers of elective care to desperate self-pay patients facing agonising waiting times for NHS care.

The Health and Care Bill addresses none of these problems, but reduces any local scrutiny and accountability: it will not put an end to contracts going to the private sector, draining resources from the NHS.

No solutions without more money

If all this is not to go from bad to worse we need a massive public campaign now, to make Rishi Sunak see sense, and force the government to make a major U-turn, to review and revise the Spending Review:

- No more wasted billions on private contracts: **invest in our NHS**
- **Restore and expand NHS capacity**, to eliminate private providers
- **Build back bigger:** repair or rebuild crumbing hospitals and reopen the unused NHS beds
- **Invest in staff**, with new targets for recruitment, training, and levels of pay that would prevent the service losing experienced staff
- Build a properly resourced, publicly run **national care and support service**
- Invest in **public health** and policies to close the health divide

STOP THE ROT!

Act now to save health and care

This government has shown it won't change course without pressure from below: but U-turns have occurred.

That's why Health Campaigns Together has linked up in a powerful new **SOS NHS** campaign with Keep Our NHS Public, NHS Support Federation, the major health unions and other campaigners.

The campaign will lift off in the next few days, and run into the new year with social media messaging, a major online rally and local and regional events to pile maximum and broadest-possible pressure on MPs.

It's a campaign in solidarity with all NHS staff battling to keep services afloat, to give them hope: join us in this fight.

More details, info and resources as the campaign develops from **SOS NHS** web pages at *sosnhs.uk.*

HEALTH CAMPAIGNS TOGETHER #our NHS

New owners seek big profits from Virgin Care

Peter Marshall / Alamy Stock Photo

Virgin Care no longer exists: Richard Branson's company which set out from 2008 to compete for NHS and social care contracts all over the country, especially in primary care, community health care, children's services, sexual health and urgent care, has been handed over to venture capitalists Twenty20 Capital, and rebranded as HCRG Care Group.

Virgin Care at one point seemed to be one of the most successful private firms in scooping up contracts after the 2012 Health & Social Care Act, and won £2 billion of contracts in five years from 2013-2018. It even felt bold enough to sue and win £2m in damages from a group of Surrey NHS commissioners who had dared to terminate a contract.

Virgin Care is Twenty20 Capital's seventh transaction in 2021, and its fourth acquisition in the health and social services sector. The company's website boasts that it looks for "significant returns in 2-5 years."

Not all of Virgin Care's contracts will necessarily be transferred to Twenty20. Bath and North East Somerset council and CCG, for example, awarded Virgin a 7-year £54m per year contract for health and care services in 2017 – and controversially agreed last month to extend it for another five years.

Virgin Care's local managing director had as a result of this contract even more controversially been listed as a member of the 'Partnership Board' running the 'Integrated Care System' that will be in charge of the NHS across Bath, North East Somerset, Swindon and Wiltshire from next April.

But now council leader Kevin Guy has warned that the November deal has not been fully signed off, and might not be: the impending sale of Virgin Care to a firm of venture capitalists was not disclosed to council officers during the negotiations.

Virgin Care's boss Dr Vivienne McVey, staying on as chief executive under HCRG, insists only the owner and name of the company have changed, and "everything else remains the same." But it's not clear how many commissioners will accept health and care services being taken over by Twenty20 Capital.

AFFILIATE now for 2022
Unions, campaigners, join us!

HEALTH CAMPAIGNS TOGETHER is an alliance of organisations, launched at the end of 2015 that has mobilised conferences, and events including the massive demonstration in March 2017.

We are now working with Keep Our NHS Public, NHS Support Federation, trade unions and others to initiate the even wider SOS NHS campaign .

During the 2020 lockdown we replaced our quarterly printed tabloid newspaper with a monthly online news bulletin to keep campaigners informed. But we have no big money sponsors, and rely on affiliations and donations to support our work.

So we are asking all the organisations that support what we are doing to affiliate (or re-affiliate) for 2022 to facilitate the future development of joint campaigning. Our Constitution can be viewed at *https://healthcampaignstogether.com/aboutus.php*

WE WELCOME SUPPORT FROM:

- **TRADE UNION organisations – whether they represent workers in or outside the NHS – at national, regional or local level**
- **local & national NHS CAMPAIGNS opposing cuts & privatisation**
- **PRESSURE GROUPS defending specific services and the NHS,**
- **PENSIONERS' organisations**
- **POLITICAL PARTIES – national, regional or local**

The guideline scale of annual contributions we are seeking is:

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

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

SIGN UP ONLINE, and pay by card, bank transfer or cheque – check it all details at *https://healthcampaignstogether.com/joinus.php*