HEALTH CAMPAIGNS TOGETHER #our NHS

NHS NOT FOR SALE

Keep our NHS public

A Rescue Plan

2020 vision for a post-Covid NHS

A draft for discussion and action

Contents

Background: the Covid disaster

The Covid-19 pandemic continues to take a cruel toll of tens of thousands of lives ended prematurely, including over 540 health and social care workers – a disproportionately large number of them of Black, Asian and Ethnic Minorities background.

From almost any point of view the British government, and specifically ministers in England, have handled the pandemic worse than any comparable European country.

The official death toll of over 45,554 confirmed Covid-19 deaths (July 23) and if the additional thousands of excess deaths are taken into account (the Financial Times estimates the true total of Covid-linked deaths at 64,000) the UK has the fourth highest of all death rates in the world.

New estimates (July 10) suggest almost a third of those dying of Covid-19 in the UK have been in care homes, to where thousands of patients were abruptly discharged from hospitals without testing to free up beds, but where supplies of PPE and medical support have been grossly inadequate.

This is not only the biggest crisis to hit the NHS since its formation 72 years ago: it's the biggest peacetime crisis to confront the British economy for 100 years.

But if our NHS is to be geared up to cope with a continued additional need to treat Covid-19 patients as well as resuming 'normal' elective, emergency and mental health services, a bold plan is needed.

These are our proposals as campaigners: we will be arguing for them in the months ahead, hoping to establish a common starting point.

We therefore invite comments and amendments, and welcome support from trade unions, campaigning organisations and politicians committed to the values and principles of the NHS.

This Rescue Plan is put forward by Health Campaigns Together and Keep Our NHS Public as a basis for discussion on how best to protect and develop the National Health Service in England in the new period opened up by the Covid-19 pandemic.

The background is explained and the proposals advocated as a basis for action by **politicians of all parties.**

We aim to ensure our NHS, which so many have recently applauded so warmly, is equipped, resourced and organised to re-establish routine and emergency care alongside continued care for Covid-19 patients.

- **Rebuild and properly fund the NHS for the post-Covid world**
- **Reintegrate our NHS – revoke the 2012 Health and Social Care Act**
- **Proper pay and respect for all NHS staff – end outsourcing**
- **Health care for all – scrap all charges and obstacles to care**
- **Keep the NHS out of all trade deals**
- **No digital exclusion – no sale of data**
- **Rebuild and strengthen public health provision and networks and implement WHO recommendations**
- **Go further: a radical reform of social care**
- **Investment – for the next 70 years**

Prematurely easing lockdown

On June 11 as political pressure mounted for a further, swifter, relaxation of the lockdown, the daily confirmed Covid-19 death toll had only just dipped below 200 – more than all of the rest of Europe combined, and equivalent to a daily crash of a commercial airliner.

There were over 1,300 confirmed new infections, and ONS estimates from antibody tests suggest 2.8 million people had been infected by mid July. In several regions the reinfection rate R has been at or above 0.9.

Hospitals are preparing for a second peak of Covid-19 infections as the lockdown is wound down in the hopes of reviving the economy – but the expensively privatised system of test and trace has shown itself to be neither a robust nor reliable.

Instead of the failed centralised systems it has become more important to develop local Outbreak Control Plans delivered by public health networks in each local authority.

There are no reliable statistics on the actual numbers of people tested or the numbers of valid tests completed. Ministers are also proceeding without the promised and much-hyped app to help track the spread of the virus.

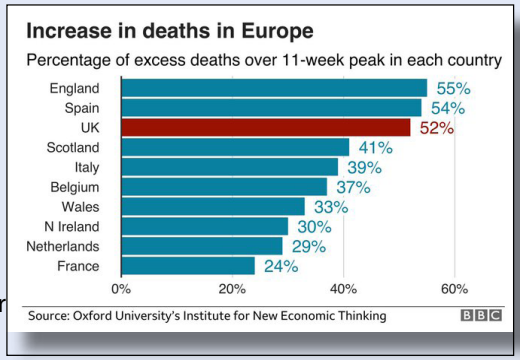
And the deficient track and trace system is staffed by poorly trained people recruited on near minimum wage by private contractors – who admit the system will not be fit for purpose until the autumn, well after lockdown is lifted.

Refusal to admit or learn from mistakes

When ministers finally recognised the need to test and trace, they again ignored the expertise and networks in local government, and insisted on bringing in a private company to develop a brand new "NHS app" for contact tracing – declared not fit for purpose and abandoned 18 June after spending £11.8m – rather than using or adapting apps already available in other countries.

On 10 May Boris Johnson announ-ced a 5-level alert system – only to ignore it in the rush to lift the lockdown while the alert level remains at 4.

Scientists and the chief nurse who refused to join Johnson's defence of the actions of his advisor Dominic Cummings in breaching the lockdown have now been excluded from press briefings, and the government has explicitly shifted from claims to be "following the science" to now being "guided" by the scientists they choose to listen to.



Even into July it's clear the government is unwilling to publish or face up to the evidence of the disproportionate toll of BAME staff dying from Covid-19, or commit to action to address this.

BAME staff

The government has shown itself reluctant to face up to the evidence of the disproportionate toll of BAME staff dying from Covid-19, or publish proposals and commit to action to address this.

Despite the empty words and promises to do better, by June 26, fully two months after NHS England chief executive Sir Simon Stevens wrote to all trusts telling them Black Asian and Minority Ethnic staff are at greater risk,

Sky News revealed only 23% of hospital trusts have risk-assessed their BAME staff: more than three quarters of trusts responding had still not taken this basic step.

Governments elsewhere, such as Justin Trudeau in Canada have been willing to apologise for mistaken policies that have failed to protect care home residents: the British government and NHS England have instead tried to blame care homes for the numbers of deaths. Ministers should follow the Canadian example and initiate an immediate comprehensive review of the policies in place, drawing on appropriate scientific advice from public health experts and epidemiologists.

Wrong priorities, flawed decisions

Why we need a public inquiry

It's important to recognise and learn from the succession of wrong decisions taken by government which have exacerbated the scale and impact of the epidemic, if we are to ensure that any future peaks of infection can be tackled differently.

To minimise future false starts and misguided decisions a full public inquiry needs to begin without delay to draw out the full facts and propose changes where necessary.

From the outset the government has repeatedly bypassed and ignored clear advice from the WHO, not least by clinging on to a "herd immunity" strategy, even when this clearly entailed hundreds of thousands of deaths.

Despite early warnings in January that the new, deadly virus was on its way, the British government did nothing in February, and failed to prepare or take any action until too late.

There were complacent assurances in mid-March about preparations and supplies of PPE which swiftly proved to be false: there were neither adequate supplies nor a viable supply chain, and shortages reached crisis levels throughout the NHS and care sector – putting the lives of health professionals, care staff, patients and residents at risk.

Lockdown came later than other countries. It is now clear that by delaying the lockdown for even just one week after they were first advised to do so on March 12, the Government caused upwards of 20,000 avoidable deaths. For months after that there were no controls on entry via airports and ports or quarantine, allowing the virus free movement.

Community testing, which had begun early, was abandoned in March, rather than making any plans for community testing at scale. When mass testing did eventually begin, existing public sector expertise and resources were ignored: testing was contracted out to unreliable private companies – often without competitive procurement – and the processing of samples bypassed the existing network of local NHS labs, instead setting up three ad hoc "super labs" to cover the UK.

NHS Birthday weekend 2020: Downing Street vigil remembers the hundreds of NHS staff who have lost their lives to Covid-19

Taking stock of a damaged NHS

It's increasingly urgent to take stock of the damage that has been done in the last few months to what was an already overstretched NHS, under-funded and understaffed after 10 years of austerity funding.

The focus on Covid – includes the rapid building and equipping of a network of Nightingale field hospitals at a cost of £346m for three months, regardless of the lack of sufficient staff to run these extra beds in addition to expanded NHS intensive care facilities – has brought a widespread collapse in levels of care for other NHS patients.

Almost all elective treatment – even for cancer patients – was halted at the end of March, and in many areas this has only begun to reopen in July. Some outpatient clinics saw a reduction of 80% of patients attending.

The waiting list, which had risen to an unhealthy at 4.5 million when the Covid crisis hit, was thought to be rising at 1.6m per month, and to potentially reach 10 million by the end of the year: the Royal College of Surgeons estimated that to clear the backlog of operations could take five years.

However urgent and emergency services have also been running well below previous levels.

Urgent cancer referrals for April reduced by an average of 60% (78% for breast cancer) compared with April 2019, with a 20% drop in starts of cancer treatment.

Attendances at Accident & Emergency services in May also ran 42% below last year's levels, with emergency admissions down 27%, although these numbers have since risen. Numbers seeking urgent treatment for suspected heart attacks fell by 50%, with big reductions in numbers accessing stroke services.

There have been fears that up to 10,000 people needing regular treatment for eye problems could lose their sight. Tens of thousands of people in chronic pain have been unable to access elective surgery for joint replacements or other problems.

Outsourcing and privatisation of services – bypassing public sector resources

There is widespread concern at the eagerness of ministers to bring in management consultants to run services and private companies – often without even a competitive tender, even where companies lack any relevant experience – to take on vital jobs that should properly be done by the NHS or by public health and local government, including supplies of PPE.

Perhaps the most blatant example was the decision in April to award a £108m contract for procurement of PPE to PestFix, a family-run pest control company with just 16 employees and assets of £18,000.

The *Times* has also highlighted the award of a £2m contract to Double Dragon, a small company with a phone number that does not work and business premises on a residential street in Ilford, which describes itself as a wholesaler of coffee, tea, cocoa and spices, but is now claiming to be a certified supplier to the NHS of medical-grade equipment.

Contracts to set up Covid-19 testing sites have been awarded to city analysts Deloittes, and sub-contracted to Serco, Sodexo, G4S, Mitie and others.

And the contract of up to £90m for setting up and running the vital track and trace system has also been entrusted to Serco: the results so far are unimpressive, with no hope of a fully functioning system until the autumn. *Private Eye* points out that public teams have been 50 times more effective, per person employed, in tracing contacts.

Profitable contracts also have been handed out to develop the unproven track and trace app abandoned on 18 June, and even more questionable contracts have handed over or opened up NHS data to other tech companies including Palantir, Faculty, Amazon, Google and Microsoft.

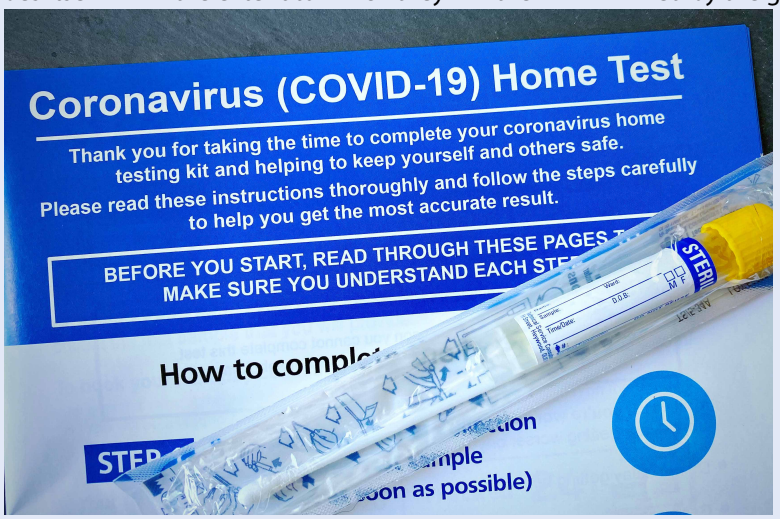
In each of these cases there are serious questions to be asked about the reliability of the companies, the extent to which they will be accountable for what they do, the quality and value for money of services they can offer, and the extent to which they will then link properly with relevant NHS, social care and local government services.

As We Own It campaigners point out in a letter demanding the publication of the contracts:

"According to the Treasury, £10 billion of public money has been allocated for spending on the Test and Trace system in England, yet only £300 million additional funding has been offered to local authorities across England to support the system.

"This leaves over £9 billion of funding unaccounted for, of which some will be spent on contracts to Serco, Sitel and Capita. However, the value for money and effectiveness of these contracts is not known. McKinsey is reported to have been asked to review the contact tracing service."

The whole process seems to be led by the government's ideological preference for any private provider compared with any public sector provider – which has proved over the years to be an expensive and ineffective way to develop coherent services.



Meanwhile NHS England and Matt Hancock see continued long term block booking of private hospital beds as central to their plans for the NHS to resume limited provision of elective treatment.

Empty NHS beds & staff shortages

Official (but undisclosed) NHS England figures revealed by the Health Service Journal showed up to 40% of NHS elective care beds (37,500) were unoccupied by mid-April, after over 33,000 patients were swiftly discharged to make space for Covid-19 patients. The current picture is less clear, since NHS England refuses to publish any update on the leaked statistics, while the July 5 COVID-19 daily situation report shows almost 92,000 NHS beds occupied in England, including 2,088 occupied by patients with confirmed COVID-19.

This is slightly HIGHER than the average of just over 90,000 general and acute beds occupied in the three months January to March 2020 – before the pandemic struck, and including the peak winter months of January and February, when the occupancy rate was 88%. However the figures do not show how many of the currently occupied beds are in private hospitals.

NHS England has acknowledged that until and unless an effective vaccine and more effective, quick and reliable testing become available, hospitals will have to reorganise the way their buildings are configured, to separate out "red" areas dealing with Covid-19 infection, and "green" areas which are free of the infection.

In many cases this will mean a major change of policy: reversing years of efforts to concentrate larger numbers of services and patients together; halting closures and instead reopening and refurbishing "surplus" buildings; and limiting the maximum capacity of hospitals to 60% of pre-Covid levels.

This threatens to further add to the delays for treatment.

Staff shortages – with 100,000 vacant posts – were a major

problem going in to the epidemic, and despite the 5,000 recently retired or departed staff who have returned to assist in the fight to deal with the virus, staff shortages remain a key impediment to any significant expansion of services to bring waiting lists and waiting times back under control.

The recruitment of overseas staff has also been made much more difficult by government proposals for restrictions on immigration which would also limit the numbers of EU-trained staff from next year, even though after intense public pressure the government has (at least temporarily) exempted some health workers from the increased £625 per person per year "immigration health surcharge".

However ministers appear to have excluded care workers and staff working for NHS contractors from their 'health and care visa' while draconian salary thresholds also mean many NHS cleaners, porters and support staff won't qualify. The GMB has described the government's new immigration rules as an 'embarrassing shambles'.

Mental health, learning disability and autism

Mental health services, already struggling to meet demand before the pandemic, have also been hard hit, with some trusts needing to open more psychiatric intensive care beds and others reporting bed shortages, made worse by the design and configuration of many older units with dormitory style wards and limited scope for social distancing.

Many mental health patients have found their level of care reduced to less effective telephone or virtual consultations, and in some areas hundreds of patients had their ongoing treatment wrongly ended.

The CQC has also reported that between 10 April and 15 May this year, 386 people with a learning disability, some of whom may also be autistic, died while receiving care and support, a 134% increase on the 165 people with similar needs in the same period last year.

More than half of the 2020 deaths (206) were as a result of suspected and/or confirmed COVID-19. The CQC argues that this data should be considered when decisions are being made about the prioritisation of testing at a national and local level.

A growing number of people – not least frontline medical staff dealing with the pandemic – are facing symptoms of post traumatic stress.

As many as
90%
of those who experienced the trauma of ITU treatment will have PTSD symptoms

Many of these people will have felt overwhelmed by the dramatically increased levels of patient suffering and deaths, as well as at risk of becoming infected and carrying infection home to families as a result of inadequate PPE.

There is also an increased risk of patients who have spent time in intensive care developing PTSD: up to 90% of those who experienced the trauma of ITU treatment will have PTS symptoms including feeling edgy or constantly on guard, sleeplessness, irritability and acute anxiousness in the first few weeks after treatment.

Many will have much more serious and potentially long-lasting PTS symptoms, and require support from mental health services that were inadequately provided even before Covid-19.

Extra funds needed to restart services

It's increasingly obvious to all that to restart the NHS as a comprehensive service providing emergency, elective, community and mental health care, GP and primary care as well as treatment for Covid patients will require a substantial injection of additional resources.

As a 'once in a century' event, the pandemic will require extraordinary measures to restart and re-equip the NHS.

This means that there has to be a complete rethink on the Long Term Plan as well as local plans to reconfigure hospital services and build new hospitals.

We also need increased and sustained effort by government and NHS to develop and implement a workforce transformation plan, going well beyond the limited efforts of NHS England's Interim People Plan published last summer.

This is vital to enable and resource the NHS to improve the terms and conditions of existing staff, retain as many as possible of those who have returned to work in the NHS, and invest in a programme to recruit and train thousands more nurses and health professionals.

Scrap fees, bring back the bursary

Fees for student nurses and health professionals and for medical students need to be abolished and an attractive bursary system reinstated to attract and support a new expanded intake of trainees.

None of this can be done within the constraints of the government's 5-year settlement – promised back in in 2018, and now written into law – that would increase the NHS budget by just £33.9 billion in cash terms by 2024, equivalent according to the government's own figures to just £20.5 billion in real terms after inflation and additional known costs.

This would be a 3.1% annual increase, and is much less than the pre-2010 average of annual increases in spending, and far less than the 4.1% called for by the BMA and leading think tanks.

To rebuild and improve our NHS and build better will need ministers to fully reimburse trusts for all of the additional revenue and capital costs of tackling the Covid epidemic (including the costs of fresh stockpiles of PPE and equipment (and regular re-stocking where items have limited life), and adapting buildings for the new post-Covid reality), plus a sustained additional annual injection of revenue and capital until services and performance levels are restored.

It's not at all clear from recent reports that this level of support will in fact be forthcoming.

We also need an even more ambitious equivalent to the ten-year investment programme from 2000-2010 which reduced the waiting list and waiting times and improved NHS performance on all fronts.

A new challenge for a new generation

72 years ago the NHS was established in a war-ravaged Britain, in an economy wracked by shortages and rationing: the disorganised and unplanned networks of municipal, private and charitable hospitals, along with the major teaching hospitals were on the verge of bankruptcy.

Bevan's bold stroke of nationalising the hospitals and establishing a new tax-funded health service, in which access to all services was free of charge and based on clinical need rather than insurance status or ability to pay, created the basis for a health care system that broke free from the shackles of a dysfunctional market – and created a model of equitable care that became the envy of the world.

The nationalisation ensured that neighbouring hospitals that had previously functioned completely separately were brought into a single system, and could begin to collaborate and share expertise; it made possible the development of a national training programme for nurses and doctors; and it made it possible for the first time to plan and allocate services to meet local needs.

The generations that made this historic breakthrough and went on to build the foundations of today's NHS now need its support, and a new, supportive system of social care.

A new generation has to fight to protect and restore its founding values and vision and rebuild a new NHS, capable of dealing not only with the long term costs and pressures of Covid-19 but also restoring the peak performance levels of delivery of emergency care, elective treatment, mental health care, community services and primary care – all of which were already deteriorating before the pandemic hit.

After weekly displays of huge support in popular applause, an outpouring of generosity of donations of food and support to health staff, and an astounding 750,000 volunteers offering help, there is no doubt of the country's affection for Our NHS, and the wish to see it fully revived and improved.

But while it has been welcome, applause was never enough. We need bold policies to be implemented NOW to rebuild our NHS to deal with the "new normal" of a post-Covid world.

That's why as campaigners, health workers and trade unionists, we are putting forward policies that ought to unite us, and urging politicians of ALL PARTIES to grasp the need for bold and decisive action to put our NHS not just back on its feet, but to build back a better service that can meet the needs and win back the trust of ALL patients, rather than only Covid patients and emergencies.

Rebuild and properly fund the NHS for the post-Covid world

This means no return to the austerity and real terms frozen funding of 2010-2019 – and no moves by the Chancellor to recoup the additional funding promised to NHS trusts to cover the additional costs of the Covid pandemic.

The Department of Health and Social Care initially said the NHS will get "whatever funding it needs to respond to the coronavirus outbreak:" this is to be welcomed, but the need for funds to treat patients suffering from Covid-19 and its after-effects, as well as to restore other services, will last for years after the outbreak itself is contained – and there are still doubts over how much additional funding will be made available to cover costs already incurred..

A massive rehabilitation programme will be needed to support thousands of patients who have survived a serious illness with Covid-19 but continue to suffer serious physical after-effects, as well as the large numbers who will have recurrent PTSD after ICU treatment.

We need to revisit the funding settlement that the Government has just enshrined in law, and recognise that a much more generous increase is required. We need another decade of substantial above inflation annual increases in revenue funding, plus £6 billion to tackle backlog maintenance and refurbishment of existing buildings.

We need a halt to the sale of "surplus" land and building assets – but also a halt to any building of the promised "new hospitals" on the basis of pre-Covid plans and assumptions lacking substance, until a full strategic post-Covid review has been completed.

Plans for any further centralisation of NHS services and any cutbacks and closures in local services should be scrapped. NHS England has now declared its ambition to achieve permanent increases in staffing and bed capacity – and until a vaccine is available, social distancing should mean rejecting any plans that rely upon increased bed occupancy levels.

As was shown in the 2000s, waiting lists and waiting times currently out of control can be brought down, but only by sustained and substantial investment, coupled with an energetic workforce strategy.

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Our 2020 Rescue Plan – to rebuild the NHS and go further

Reintegrate our NHS

The NHS in 1948 brought together a chaotic jumble of private, charitable and municipal services, and forged a new relationship with GPs to create the basis of an integrated, planned system.

But since 1989 successive governments have begun to unpick that integration, separating purchasers from providers, replacing collaboration with competition and the trappings of a market, and slicing off chunks from the public sector budget to create openings for private contractors and private hospitals.

This fragmented system, institutionalised by the 2012 Health & Social Care Act, has proved itself a liability in the current situation.

To enable a coordinated response that can cope with the Covid crisis, NHS England has had to effectively bypass almost the whole of the 2012 Act, which further fragmented the NHS and prioritised competition over collaboration.

The 2012 Act established Clinical Commissioning Groups as local bodies allocating funds to commission services for their population – but also required them to carve up an increasingly wide range of clinical services into contracts to be put to competitive tender.

Now local CCGs have been bypassed by crisis measures centralising control in the hands of NHS England; contracting has been suspended, along with the so-called "payment by results" system of cost per case payment – with a return to the previous system of block contracts that existed up to the mid 2000s.

Any return to payment by results, under conditions where NHS trusts are obliged to severely limit the capacity of hospitals to deal with Covid and social distancing, would trigger a new, substantial wave of trust deficits.

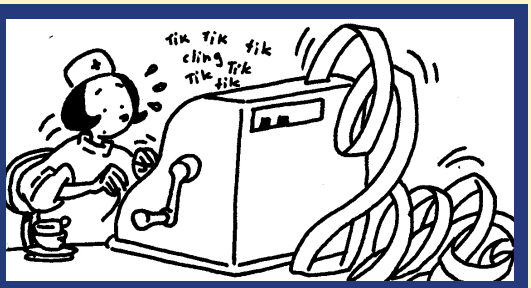
Unpayable loans

This comes just months after £13.4bn of trusts' cumulative, unpayable loans (which had been taken out in the past few years to help balance the books) were claimed to have been 'written off'.

In fact they were simply converted into Public Dividend Capital, which requires trusts to pay 3.5% of the net value each year to the government.

It's also clear that despite the Act ending the direct duty of the Secretary of State to provide comprehensive health care (one of numerous fundamental problems with the legislation),

Prioritise reopening NHS beds: no subsidies for private hospitals



As the process of remobilising the NHS eventually gets under way, the priority should be the reopening of closed NHS services and beds, and where necessary refurbishing and remodelling older buildings to make the fullest and most effective use possible of the NHS's own resources.

Any resort to using private hospitals, which are too small, too concentrated in big cities and more prosperous areas (often at some distance from NHS hospitals), and lacking in facilities and equipment necessary for much of the daily work of NHS general hospitals, needs to be on the most minimal possible scale – and purely as an interim measure for a defined period of time to bridge gaps in NHS facilities.

There must be no long-term reliance on private hospitals, which train no staff, and can only expand their provision of services at the expense of reducing the staffing of NHS front line services.

Matt Hancock, like Jeremy Hunt before him, has effectively acted as if he were still responsible and in charge of the NHS.

Meanwhile NHS England continues to drive measures that seek to get NHS trusts to collaborate, and share waiting lists, rather than compete with each other as required by the 2012 Act.

As a result questions are increasingly being asked about what need there is for CCGs and the system of commissioning, as well as the other aspects of the Act and its associated regulations – especially since it obviously gets in the way of a coordinated response to a major challenge like Covid-19.

Fragmentation

However none of the changes so far have halted the continued fragmentation of the NHS through outsourcing – now accelerated by billions allocated at national level to private providers of testing, tracing and private hospitals. The proliferation of private providers, many of them delivering less reliable and inferior quality services, is still undermining our NHS as an integrated public service.

The government has hinted in that it is planning legislation to roll back some elements of the 2012 Act – although subsequent reports suggest any proposals to assert greater central control over NHS England could be postponed until 2021.

In any case there is little or nothing to suggest that local accountability, let alone influence of local public and a powerful voice for patients play any part in the government's approach.

Rather than revert to the discredited Act, the government must recognise the widely recognised need to repeal it, reverse the fragmentation that has flowed from it, scrap the regulations that continue to carve up local services into piecemeal contracts, and begin to bring outsourced and privately provided services back in-house.

Commissioning as it has developed since the "internal market" was established in 1990 needs to be abolished.

Instead the function of planning, allocating resources and provision of services should be brought together in unified local health boards, which should be established as accountable local public bodies based on local government boundaries, and working closely with local borough, unitary and county councils.

Reopen closed services

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Our NHS will need more, not less local accountability

Clinical Commissioning Groups (CCGs) are already ceasing to be the local bodies envisaged in the 2012 Act. In April 2020 74 CCGs merged to establish 18 new ones, reducing the total number of CCGs from 191 to 135.

Several merged CCGs now cover large geographical areas and populations of well over 1 million.

NHS England is also pressing for providers and commissioners to ignore the divisions established by the 2012 Act – and link up with local government in new "Integrated Care Systems (ICSs)."

According to the Long Term Plan published in January 2019, 42 of these ICSs are supposed to cover the whole of England by 2021 – despite the fact that they still lack any statutory powers or legal status

In May this year four more ICSs were set up, bringing the total to 18. On May 11 NHS England declared it was beginning to "lock in" the changes that had been pushed through as part of emergency measures to cope with coronavirus.

This type of' integration' without proper account-ability or legitimacy could open the door to privatisation, or large scale loss of local services.

The reintegration of our NHS as a public service should run alongside measures to democratise it as a service accountable at local level to, and organised by staff, patients and wider community groups.

Health care for all: **end discriminatory checks and charges**

As a notifiable disease, coronavirus is exempt from charging and immigration checks. But a new report by Medact and others has revealed that migrants are frightened to access healthcare during the pandemic, intimidated by the government's 'Hostile Environment' policy.

People have learned to be afraid of the imposition of charges to access NHS treatment and being reported to the Home Office. Many migrants are still being asked to show their passports for Covid-related treatment. Many are not seeking treatment – with fatal consequence.

Any policy that excludes or deters any potentially vulnerable group from accessing health care is not only morally wrong – it is opposed as such by many professional bodies. It also risks public health and interferes with test and trace, resulting in people possibly spreading infection, and increasing the risk to the public overall.

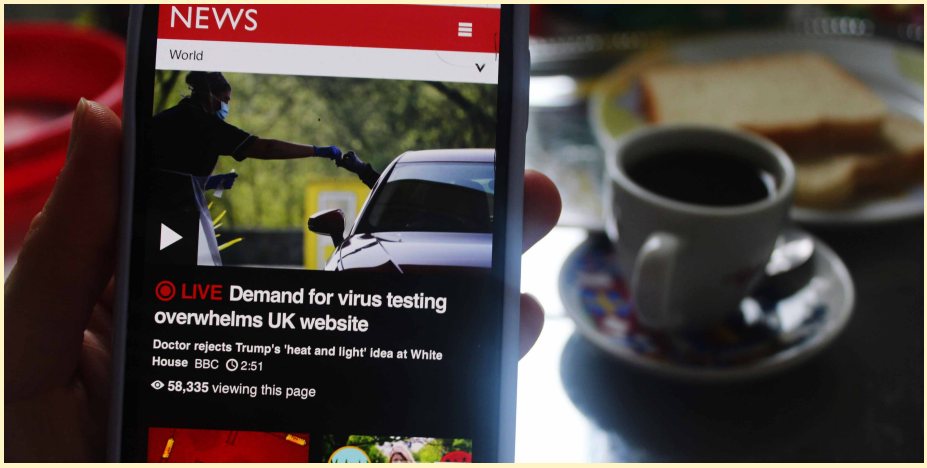
The NHS needs to be restored as a universal service, free to all at point of use: the cost of lifting these charges is insignificant in the context of the NHS budget.

Ministers remain committed to increasing the "immigration health surcharge", even after they were forced to scrap the charge for 'frontline' NHS and care staff.

This is an additional tax to be paid up front by often low-paid migrants working here and their families, in addition to their regular tax and national insurance payments – in effect, imposing a double payment.

This charge too undermines the principles of the NHS, deters migrant workers who are needed to sustain social care and other vital services, and is part of the oppressive machinery of increased, discriminatory system of checks that should be scrapped.

Rebuild and strengthen public health provision



The Public Health system should have been in place in every area to inform and strengthen the response to Covid-19, and lead the establishment of testing along with a thorough and effective 'find, test, track, isolate and support' system, as the WHO urged.

But it has been undermined in England by five years of cuts in budget allocation totalling £850m that has inflicted a 25% real terms cut since 2015.

And as the Marmot review has shown, any concerted drive to improve public health has also been undermined by a decade of relentless austerity, growing social inequalities, increasing shortages of affordable housing, and the cutbacks imposed on local government and other public services.

The cutbacks have had the biggest impact on the more vulnerable communities in the more deprived areas, where healthy life expectancy is no longer improving but beginning to roll backwards.

By 2016 more than 20 local councils were scaling back their community contraceptive and sexual health services, and some councils ended GP referrals to weight loss and exercise services.

Budgets cut back

Alcohol and obesity services have had their budgets cut by over 10% and stop smoking services have been cut by over 20%, with less than 10% of councils commissioning smoking cessation in April 2019.

A population weakened by poor underlying health, and living in poorer housing, more crowded conditions, working in more exposed, less protected low wage jobs, is obviously at greater risk of contracting and spreading the coronavirus.

It will also potentially make far greater demands on the NHS and benefits system.

An urgent programme of investment to enable local authorities to rebuild and expand public health provision and preventative services to improve the health of the poorest is essential to protect our NHS.

Proper pay and respect for all NHS staff – end outsourcing

NHS and care staff have gone the extra miles, and many have put their lives on the line to care for their patients and clients. They are crucial to any rebuilding and expansion of the NHS: but their commitment has not been matched by their income.

NHS pay has deteriorated since 2010. Staff now face years in the stressful, frustrating and exhausting conditions dictated by the Covid pandemic, donning and doffing PPE.

To show respect for and to value and retain the staff, they should receive a significant pay rise – which would help recruit the extra staff need to fill those vacancies in the NHS and care services.

But staff also need reliable and timely access to appropriate PPE: it is estimated that 89% of Covid-19 infections among healthcare workers may have been caught in hospital.

By April, over 60% of health worker deaths (and 90% of deaths amongst doctors) were black, Asian and minority ethnic (BAME) staff. Surveys by the BMA and RCN have found that BAME doctors and nurses had much poorer access to appropriate and sufficient PPE than white colleagues, and BAME staff are disproportionately represented among lower-graded frontline staff likely to be at greater risk.

A review by Public Health England has also found that mortality risk from Covid-19 is higher among BAME people, amongst whom diagnosis of Covid-19 is also greater. There is a greater mortality in lower paid and more exposed jobs: nursing assistants and care workers have experienced bigger increase in deaths than other occupations.

According to the Institute for Fiscal studies, Pakistani, Indian and black African men are respectively 90%, 150% and 310% more likely to work in healthcare than white British men.

Yet despite promises many of these staff have yet to be risk assessed, and many trusts are unable to systematically test staff or patients for Covid-19.

As reports have begun to show, this failure to properly support or value the large numbers of BAME staff within the NHS is the latest example of continued long-standing institutionalised racism within an NHS in which there are far too few BAME senior managers, directors and clinicians.

Outsourcing NHS support services has for 35 years been a costly failure that has undermined standards and quality of care

Reports for Public Health England and the Welsh First Minister have begun to outline recommendations on how management in health care – and wider government policy – must change to address this inequality.

There is also a health risk to staff and patients from private contractors delivering outsourced support services in hospitals: they employ thousands of staff on inferior terms and conditions – many are still denied the 2018 increase paid to NHS support staff and only receive statutory sick pay.

This combination of low basic income and inadequate sick pay potentially puts staff under pressure to work on while sick, endangering themselves, their work colleagues and patients.

Outsourcing support services has for 35 years been a costly failure that has undermined standards and quality of care. It has fragmented what once was, and should be once again, a united NHS team committed to NHS care.

A new, reintegrated NHS must bring an end to outsourcing of support services, clinical care and so-called 'back office' services at the earliest opportunity, to bring contractors' staff in-house as part of a single NHS team, working for patient care rather than private profit. An NHS contract for all employees.

Digital dangers – and benefits

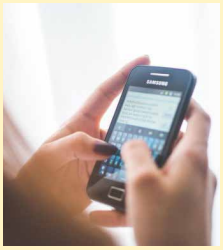
Last year, it was clear the government intended to expand the digital role of companies, from electronic patient records to medicines management, care co-ordination and system planning, demand management and capacity planning.

Now, the pandemic is being used to justify the massive expansion of digital healthcare, which will increase the influence of the private sector over the NHS.

Plans being drawn up at local and national level of the post-Covid remobilisation of the NHS seek to take full advantage of the dramatic increased use of digital technology.

New data-driven models of treatments have the potential to revolutionise healthcare and deliver immense benefit to patients and help make our health system more efficient and effective at providing healthcare services to the population.

But they must be introduced ethically, to the most rigorous standards – and developed and implemented for the benefit of NHS patients and staff – not to enrich private-sector organisations.



Risk

If the NHS is going to shoulder much of the risk and provide the infrastructure and data required to drive a healthtech boom then the NHS should control the intellectual property and profits produced by developing these new models of care to help fund itself.

City analysts EY estimate that the commercial value of the health data sets the NHS has built up over years of providing health services to the general public could be as much as £9.8bn per annum: this should not be given away to profit-seeking companies.

The NHS must retain control of personal health data – this is the patient's data held in trust by the NHS and must not be given over to major tech and AI companies. The NHS must also retain its operational data.

To win and hold the public's confidence, there must be cast iron guarantees that personal health data will be kept firmly and securely under the control of the NHS, and not made available for use for other purposes – including actuarial use by the insurance industry or targeted advertising.

NHS England paying U.S. tech firm Palantir just £1 for a contract to use its Foundry data management software – and Google offering "technical, advisory and other support" for free – can mean only one thing: Palantir and similar companies are salivating at the riches to be made from virtually free access to the largest health database in the world, securing access to private personal data of millions of British citizens. Already some system suppliers are using their web portals to sell targeted adverts for medicine to users.

Private companies must not be allowed to monopolise critical parts of NHS IT infrastructure, holding back new models of care and NHS operational efficiency while extracting hundreds of millions of pounds from its operational budget and providing little value. It is not possible to have a competitive market in IT solutions that are hugely expensive and damaging to 'rip and replace'.

The Covid-19 pandemic has clearly shown benefits of IT solutions to maintain contact between isolated individuals and to deliver health advice in virtual settings.

But while the NHS will want to retain many of these new ways of working, this cannot and must not be seen as a replacement for personal and face-to-face contact.

There are vulnerable sections of society (those in mental distress, with learning disability or dementia, sensory impairment, children, the elderly and a large "digitally excluded" population without access to or expertise in using IT and the internet) who must have face to face contact available.

Any move towards more remote clinical appointments must be carefully planned with risk assessment and safeguards.

Go further: a radical reform of social care

The Guardian reports that the government is considering steps to incorporate the social care system into the NHS: but this would only shift responsibility for funding, leaving care homes and home care in private hands.

Given the current level of crisis in social care, we are urging bold government action to take ownership of the care homes and domiciliary care providers.

This would lift the financial burden from managers and proprietors of the majority of smaller companies and homes and end the flow of public funds to the offshore companies running the larger chains.

Soaring costs of PPE – estimated to cost care homes more than £4 billion between April and September – and additional staffing (well over £1 billion) far outstrip the additional £1.3 billion passed on from local councils from the £3.2 billion allocated from central government to cover Covid.

But in addition, loss of income in care homes where growing numbers of beds are left empty after residents have died is a major problem in the smaller homes which run on a minimal profit margin based on full occupancy: even the larger chains are based on an assumed 90% occupancy level. Some care homes are increasing costs to self-funding residents by up to 15%.

The present system has few defenders, and could only be preserved by hefty and continuing government subsidies.

A national, publicly funded service is also needed for personal social care and to support independent living.

Delivered locally, this could ensure additional resources are used to improve the terms and conditions and training of care staff, few of whom have any more than statutory sick pay and holiday entitlements – making jobs in the care sector much more attractive in an effort to fill the 120,000 vacant posts and improve services to clients.

A national service, funded from general taxation, could work to establish national standards as well as lift the burden of hefty charges from many who have no choice but long-term care, and who currently find themselves paying their own bills.

Keep the NHS out of all Trade Deals

Due in part to the 2012 Health and Social Care Act, the NHS has for years already been opened up, with contracts being put out to tender not just to UK companies, but also to European and American corporations.

The NHS is even more at risk from the post-Brexit deals that the UK wants to make with the US, the EU and other countries and trading blocks. Opening up the NHS like this is likely to escalate privatisation of back room data-based and IT services such as commissioning support and population health management as well as services themselves.

On July 21 the government whipped its MPs to vote down amendments to the Trade Bill that would have protected the NHS from future trade deals. During Bill's Report Stage, the final step before the Bill is submitted to the House of Lords, MPs had the opportunity to back two key amendments that would have helped keep our NHS safe.

However an amendment from Caroline Lucas and Labour which would have protected the NHS and publicly funded health and care services in other parts of the UK from any form of control from outside the UK was voted down by 340 to 251 votes.

Another amendment from Jonathan Djanogly, which would have given MPs and peers a say on any new agreement signed by the government, was also defeated by his fellow Conservative MPs, with 263 votes in favour to 326 against.

This leaves our NHS exposed, and MPs without a final say on future deals. The government promised to 'take back control' and keep the NHS off the table, but they have done the opposite. The Trade Bill will now go through the House of Lords, so it's time to call on the Lords to support the parliamentary scrutiny of future trade deals which is key to keeping Trump's hands off our NHS.

Additional dangers include:

Lowering regulatory standards on goods and services, endangering quality and safety and public health generally – as appears to have been already conceded on food standards.

Existing privatisation could be locked in by investment protection measures such as the Investor State Dispute Settlement (ISDS) which would allow transnational corporations to use an international trade tribunal to sue the government for massive compensation if new policies or laws threaten company profits

Measures that undermine data privacy and allow the sale of confidential health data

The extension of intellectual property rights, so decreasing our use of and control over pricing of drugs and medical equipment.

Action to save General Practice

Even before the Covid 19 epidemic General Practice in the UK was in crisis: underfunded, understaffed and with an ever increasing workload. This was experienced by patients as great difficulties getting appointments and by staff as stressful working conditions leading to recruitment and retention problems.

As a result of the Covid 19 epidemic the need for infection control measures will limit how patients and staff can interact, while GPs need to manage the continuing health problems of millions of people on extended waiting lists for secondary care. The crisis can only deepen.

Patients in many areas are unable to get appointments to see a GP for weeks, and are even less likely to see a GP that they know, and who knows them personally.

In other words General Practice is collapsing in many areas and on the brink of collapse in many others.

How to rescue General Practice

Increased funding is urgently needed for General Practice – the current package is not nearly enough. Financial and non financial support for all practices, including small and medium sized practices, is needed to ensure their survival, and prevent practice closures – as well as more determined and intensive efforts to recruit and retain GPs and other practice staff such as practice nurses.

We need to invest in improving GP and primary care premises, to ensure they are adequate for the needs of wider primary care teams.

Adequate funding is also needed to widen the range of primary health care practitioners such as clinical pharmacists, and increase pay for all practice staff, as well as a concerted effort to bring outsourced community practitioners such as school nurses and health visitors back into NHS employment.

It is vital to preserve the values and forms of General Practice that deliver what patients want and that have proved their worth: high quality, personal, continuing, community based care. Corporate models that undermine those values must be opposed, and efforts must be made to restore traditional general practice when existing corporate contracts come to an end.

Patients and the public must be involved and given a powerful voice in any decisions locally or nationally around plans to fundamentally change the nature of General Practice including local decisions about mergers, practice closures and "new ways of working".

Investment – to safeguard the NHS for the next 70 years

There is no denying that the costs of rescuing and remobilising our NHS and social care services will be considerable: but they are part and parcel of the historic challenge of reconstructing the economy after its most major peacetime challenge in a century. Society requires a healthy, educated and secure population.

In 2007-2009 Gordon Brown's government spent £137 billion, and extended guarantees of up to £1 trillion to rescue the economy from the aftermath of the banking crash.

But the Covid-19 lockdown that has brought a massive 20% drop in GDP for April has been a different and unique type of crisis, and has required different measures, including furlough schemes and support to the self-employed to limit the growth of mass unemployment and retain the possibility of reviving the economy.

Austerity

Little if any of that money could or should be reclaimed, since it would undermine what has been achieved and trigger a new round of austerity and falling incomes.

Indeed, more huge sums of money are required to ensure the UK can emerge safely from the Covid pandemic: some of that money needs to be spent on the NHS as our most universal public service.

Since the banking crash, billions have been pumped in at various points by the Bank of England through "Quantitative Easing" to prop up and revive the economy.

Similarly, creative measures will need to be adopted on an even wider scale to ensure that sufficient investment can be provided to rescue the NHS and social care.

Profits

Giant corporations that have continued to scoop up profits during the lockdown should of course be obliged to pay their fair share of tax – perhaps through a turnover tax: and the speculation that continues in the City of London could also usefully be subjected to a transaction tax (Robin Hood tax) that could generate large sums without damaging the underlying economy or living standards.

And if ministers insist that additional investment needs to be borrowed, money can currently be borrowed at historically low levels of interest.

The Japanese are attempting once again to kick start their economy on this basis.

Whichever combination of measures are used, the key factor is that our NHS needs to be rescued from its current state, the whole economy needs a massive bail-out, and various options exist to pay for this without further screwing down the already depressed living standards of working class families or indeed the poorest 90% of the population.

HEALTH CAMPAIGNS #our NHS TOGETHER

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