HEALTH CAMPAIGNS TOGETHER #OurNHS

MONTHLY ONLINE NEWS BULLETIN #11 September2021

Fighting Health & Care Bill

The Health and Care Bill, a new, major top-down reorganisation of the NHS, is now going through the committee stage in the Commons, with the government set on pushing through the most contentious Part 1 of the Bill in the next two weeks.

The Bill repeals section 75 of the 2012 Health and Social Care Act, the section requiring services to be put out to competitive tender, which was hotly contested by campaigners and trade unions.

But while its repeal is seen in itself as positive by trade unions, it falls far short of a halt to privatisation, and the repeal does not extent to vital non-clinical services.

There are also many concerns about the new regime that will take the place of Section 75 and its regulations, not least fears of reduced scrutiny over contracts awarded without competition – as happened with so many 'crony contracts' during the peak of the pandemic.

Health Campaigns Together has been discussing with trade unions, with other campaigners and with the Labour team fighting the Bill to develop the broadest possible campaign that also seeks to promote amendments that can minimise the damage it might do to local accountability.

That fight is urgent now – but will need to continue as the Bill goes forward to the House of Lords.

SEE INSIDE pages 6,7 and 8

Justin Madders MP – Fighting the Bill clause by clause – p7

Why £36bn is not enough

Extracted from The Lowdown, September 8

After a decade of austerity, the whirlwind efforts by the Johnson government to push through a £36 billion 3-year package of tax increases on the lowest-paid workers to spend more on the NHS and social care appears to represent a major change of policy from Chancellor Rishi Sunak, who since January has warned colleagues that Covid-19 handouts "can't go on forever"

But while any extra money is welcome, the problem created since 2010, with real terms NHS funding in England each year falling further behind inflationary costs and the needs of a growing population, £36bn still nowhere near enough to do all the things ministers claim it will do.

Health bosses have spoken up. Matthew Taylor, CEO of the NHS Confederation and Saffron Cordery, deputy chief executive of NHS Providers, said:

"No one should be in any doubt that this extra funding is welcome.

"But the government promised to give the NHS whatever it needed to deal with the pandemic, and, while it makes a start on tackling backlogs, this announcement unfortunately hasn't gone nearly far enough.

"Health and care leaders are now faced with an impossible set of choices about where and how to prioritise care for patients."

£36bn over 3 years is divided between:
£6bn Devolved governments
£15.6bn NHS England
£9bn Department of Health & Social Care
£5.4bn social care

Successive governments have been digging and deepening a black hole for the NHS and social care – and are now belatedly trying to escape the blame for the consequences, with the increased costs falling on the poorest workers.

With over 7,000 hospital beds in England still occupied by Covid patients, infection levels still high, and 14,000 front line beds that were occupied in 2019 now closed or lying empty as a result of the Covid pandemic, the pressure on the NHS and its stressed-out staff is enormous.

But the extra allocation to NHS England equates to £15.6bn spread over three years.

This falls well short of the £10bn extra for 2022-3 called for by NHS Providers and the NHS Confederation to cover ongoing COVID-19 costs (£4.6 billion); recover care backlogs

Continued inside, p 2

INSIDE THIS ISSUE

Alamy

The "extra" social care cash will not go to improve rock bottom staff pay or help support younger disabled people

National Insurance – worst way to raise money

Updated from The Lowdown

The 1.25% increase in national Insurance breaks yet another of its manifesto promise.

The promise to build 40 new hospitals is already almost certain to be broken, as is the triple lock on pensions – keeping British pensions among the lowest in Europe.

This is wrong on so many levels. Not only is the amount be raised pathetically inadequate but national insurance is the most regressive way to raise tax income.

Rather than raise capital gains tax, corporation tax, or taxing private wealth, financial speculation or tax-dodging corporations like Amazon, Google etc., this tax targets the poorest workers.

Tax expert Richard Murphy has pointed out that the government's own table of rates, allowances and reliefs shows how the tax lands most heavily on those on lower pay, starting on levels of income below the income tax threshold – but proportionally falling drastically on income above £50,000 a year.

Indeed many of the wealthiest people are exempt from it. NIC is not paid at all on unearned income, whether from interest, rents, trusts or other sources.

Retired people, however well off, do not pay it unless they are also working – as many poor pensioners are obliged to do.

And many wealthier self-employed people with their own companies can avoid significant NIC liability.

So, this is a tax on those in paid employment, and those least likely to be able to afford a tax increase, including people on very low incomes who are already suffering cuts in Universal Credit and facing increased fuel poverty.

Worsening their plight is likely to undermine their health and increase pressure on the NHS.

As the Independent report points out: "it is likely to disproportionately hit millions of working-age younger people, many of whom are unable to buy a home, in order to pay for a scheme designed to ensure that non-working elderly people are not forced to sell their homes."

Lib Dem spokesperson Munira Wilson, rejecting a possible 2% NI increase as "unfair and unjust" responded to Sky News:

"Has it really taken all this time to make a decision to rip-off the people who can least afford to shoulder the burden of social care?"

Why £36bn is still not enough . . .

from front page

(£3.5-4.5bn); and compensate for lost 'efficiency savings'.

The Health Foundation estimates an extra £17bn is needed by 2024 just to shrink waiting times to 18-week target levels.

In social care, where the funding cuts have been even more severe, 95% of providers told ITV news they are unable to take on all the new clients in need of their help, while many more are unable fulfil their contracts for lack of staff.

Yet just **£5.4 billio**n (£1.8bn per year) is allocated to social care over 3 years, supposedly to solve the chronic problems of the fragmented, privatised and dysfunctional social care system, where staff shortages are estimated by the GMB to rise as high as 170,000.

This is clearly nowhere near enough to address all of the problems – nor does a new formula for means testing charges for social care and capping personal spending at the eye-watering level of £86,000 address any of the issues that need reform.

Meanwhile a new report from the Association of Directors of Adult Social Services indicates a rapid worsening of the situation, with nearly 300,000 people awaiting social care assessments, care and support or reviews, up by just over a quarter (26%) over the last three months: 11,000 of them have been waiting for more than six months, up by over 50% in 3 months.

■ **A petition has been launched by We Own It to highlight the need to focus on reducing the NHS 5.5 million waiting list – and ensuring any new money is spent expanding the NHS, not lining private pockets.**

Sign it at ***https://weownit.org.uk/act-now/nhs-waiting-lists.***

£1.8bn extra funding is nothing like a proper plan to fix social care!

The long-promised Johnson "plan" to deal with the crisis in social care, which he claimed to have had ready-made in the summer of 2019 has been pushed back to the end of the year, while much more limited proposals to "cap" the total costs payable have been published and forced through Parliament within a few days.

It will not be a great surprise to our readers to find that the "cap" is not all it claims to be (see page 3) – and that most people, especially the poorest who lack savings and a home to sell – will feel no benefit from it at all

Brexit

The problems of the increasingly dysfunctional, largely privatised social care system have been significantly worsened since Covid and Brexit, with an exodus of staff and increased problems in recruiting to low-paid stressful jobs often at unsocial hours.

A survey for ITV News report on September 2 found 78% of providers who responded said recruiting carers is the hardest it has ever been.

Because of the staffing crisis, 95% of providers said they are unable to take on all the new clients in need of their help, while 30% of the 843 providers surveyed said they are handing back some, or all, of their care to local authorities because they can no longer fulfil their contracts.

3-month wait

ITV News reported having seen lists of people who are waiting more than three months to have a provider assigned to them.

So while the Health and Care Bill seeks to remove the legal requirement to assess vulnerable patients' needs prior to discharge, the lack of functional social care is likely to block any more rapid discharge of patients.

Tackling part of the problem, and denying the scale and complexity of the issues that have arisen from a decade of under-funding and rounds of ill-conceived legislation limiting international recruitment, still leaves a health and care system deep in crisis.

Weasel words mean £86,000 'cap' will leave most paying full cost of social care

The Johnson plan for England's social care sounds simple - from 2023 no-one will pay more than £86,000 for 'personal care'. People would be protected from "catastrophic" costs – although for most people £86,000 is pretty catastrophic.

This exclusive focus on the issue of wealthier pensioners completely ignores the people of working age with disabilities who account for half of the depleted social care budget.

However it does not actually protect the wealthier either. The government has confirmed to BBC News the daily living costs in a care home - those associated with food, energy bills and the accommodation - will not count towards the cap.

In discussion of a possible 'cap' following the 2014 Care Act it was suggested people's contribution to these accommodation costs should be fixed at £12,000 a year. Today's figure would certainly be higher.

BBC's Nick Triggle calculates based on the average care home cost of £36,000 a year - that deducting ever £12,000 for daily living costs would mean only £24,000 of the spending would count towards the cap: so it would take the average care home resident more than three and a half years to reach the £86,000 cap.

Sorry, but that's the bill, sir

"But the problem is not many people live that long once they move into a care home. Half die in little over a year, with three-quarters not making it past three years."

Home care

And while costs of home care do count towards the cap, this tends to cost much less, so "people would normally need to be in receipt of that care for many, many years to hit the cap." Again, most don't live that long.

Indeed most are not deemed frail enough to qualify for any support at all from social service departments that have been slashed back year after by local government cuts. The County Councils Network, whose members cover 47% of England's population warn that:

"Last year, some 58% of all requests from people for social care services in county areas were not eligible for council-arranged care, due to insufficient funding for councils leading to a very high eligibility bar for individuals to access services.

"A cap on care and extended means-test will not address this – and unless further funding is announced in the Spending Review, councils will not have the means to increase the level and quality of services provided for care users already within the system and those who needs are currently going unmet, including working-age adults."

A further possible catch that could yet appear in the fine print of the "cap" has been highlighted in a blog by legal expert Lisa Morgan warning from previous experience that:

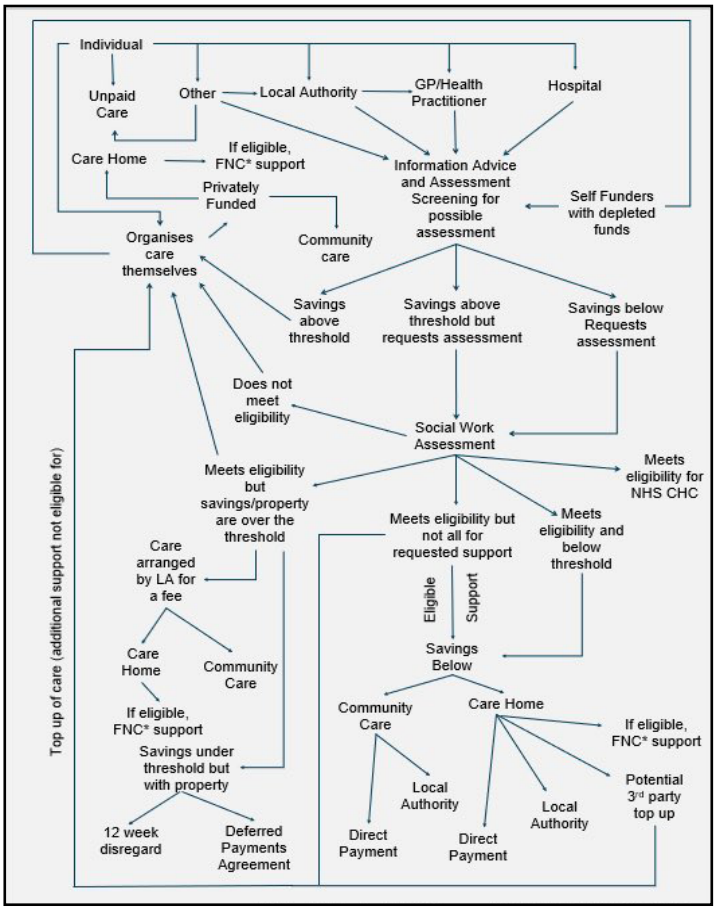
"In the 2014 Care Act, which was later abandoned, the cap was due to be £72,000. However, this was not as it first seemed.

"… when the cap was reached depended upon the rate of care fees that a local authority was prepared to pay. For example, if a local council was willing to pay £500 a week for care then, for individuals falling within that local authority's responsibility, the £72,000 cap would not be reached until 144 weeks of care had been paid for. This was true even if, in reality, an individual was paying £720 a week for their care."

No protection

So the harsh reality is that the regressive rise in National Insurance is not only getting the poorest of the workforce who can never afford a house to fork out extra to protect people much better off than them – it will not even provide any protection to the vast majority of richer people.

It only seems designed to protect Johnson and ministers from legitimate complaints from families caught in an unfair, dysfunctional privatised system.



It's as simple as that: ONS map of England's social care system

Chronic underfunding caused current NHS crisis

For an understanding of the underlying financial issues in the NHS it's worth reading the recent update from Nuffield Trust's Sally Gainsbury Checking the NHS's reality - the true state of the health service's finances. In a closely argued comment contrasting the "parallel reality" of Treasury, NHS England and commissioners' assumptions with the actual situation facing NHS providers.

While noting the additional costs faced by the NHS (£2 billion a year to even start to fix the elective waiting list, and perhaps a further £6.6 billion needed from October onwards to deal with ongoing Covid admissions to hospitals) Gainsbury also highlights the £2bn shortfall of funding that has been a feature of NHS plans every year since the 2015 Spending Review:

"The same reality gap is present each time: activity assumptions understating the cost pressures brought by increasing patient numbers by around £1 billion each year, accompanied by a further £1 billion or so over-optimism on the scale of costs that could be permanently (i.e recurrently) removed from providers' cost bases."

She goes on to calculate what how the underlying income and cost base of providers would have changed by now had it not been for the pandemic, estimating that the current funding gap has widened to £5 billion.

The gaps and deficits are no accident: they are a result of deliberate policy decisions – and patching up the NHS and social care is now so costly even £12bn a year falls well short of what is needed.

Waiting lists up again as winter approaches

January 2021 at King's Mill Hospital, Mansfield

Latest NHS England figures show 1.4 million more patients are waiting for procedures such as a hip or knee replacement or cataract removal than when the pandemic struck in March 2020, forcing the suspension of much NHS care such as diagnostic tests and surgery.

The figure of 5.61 million people waiting to start routine NHS hospital treatment is the highest since records began in August 2007, and up from 5.45m in July.

Almost one third of them (1.8 million) who were waiting for care in July had already waited at least 18 weeks. That is more than double the 860,309 people who were in that situation in March 2020.

Almost 8,000 patients have been waiting for more than two years for treatment– up 39% from 5,727 such cases in July. This growing group includes people waiting for joint replacements, general surgery and ear, nose and throat treatment.

NHS Providers and the NHS Confederation, which represent the 213 health service trusts in England, have warned it could take up to seven years to clear the backlog.

Staff shortages

Professional bodies – pointing to chronic staff shortages – have questioned the viability of Boris Johnson's promise to increase hospital capacity by 10% and enable 9m more appointments, scans and operations to take place by 2024-25.

It is clear that NHS trusts have been working hard to pull services back together after the disruption and lost capacity during the pandemic.

Even though the waiting list is growing at around 180,000 per month, average waiting times have almost halved from 19.6 weeks last July to 10.9 weeks in July 2021.

However accident and emergency performance has fallen to its lowest level since records began, with just 77% of patients treated or discharged within 4 hours in August, compared with a target of 95% and 86% in August 2019.

The position for the most serious Type 1 emergencies was even worse, with just 66% seen within 4 hours.

The HSJ has pointed out five trusts saw less than 50% of patients attending their main type one A&E unit within four hours. These were: Barking, Havering and Redbridge University Hospitals Trust; Royal Cornwall Hospitals Trust; North West Anglia Foundation Trust; Blackpool Teaching Hospitals FT; and Torbay and South Devon FT.

Overall, 96,000 patients needing emergency admissions waited more than 4 hours for a bed – compared with 56,000 in August 2019.

Soaring waiting list brings private sector boom

Private hospital firms are rubbing their hands with glee as waiting lists grow and increase demand for self-pay surgery for anything from hip replacements to heart operations has soared since the start of the pandemic

Increasing numbers of patients are now choosing to go private 'as a last resort' after waiting for months, with some considering taking out loans, or help from family members. Others are using money they might otherwise have spent on costly holidays if not for Covid.

Britain's largest private hospital group, HCA, told the Daily Mail last month there had been an increase in 'higher acuity care' since the start of the pandemic – including a 20 per cent increase in 'self-funded cardiothoracic inpatient procedures' costing upwards of £17,500.

There has also been a 30 per cent increase in self-funded neuroscience procedures, such as those on the spinal cord and brain.

Desperate patients facing ling delays to access NHS treatment are also paying privately for urology, which covers treatment of the prostate, bladder and kidneys, gastroenterology – and increasingly willing to pay for cancer care.

Nuffield Health, with 31 private hospitals, reported rising demand from self-paying patients: so did the largest private hospital chain, BMI Hospitals, with most requests for hip and knee replacements.

Private sector analysts LaingBuisson's research confirms that NHS delays were the biggest driver for patients choosing to pay for treatment.

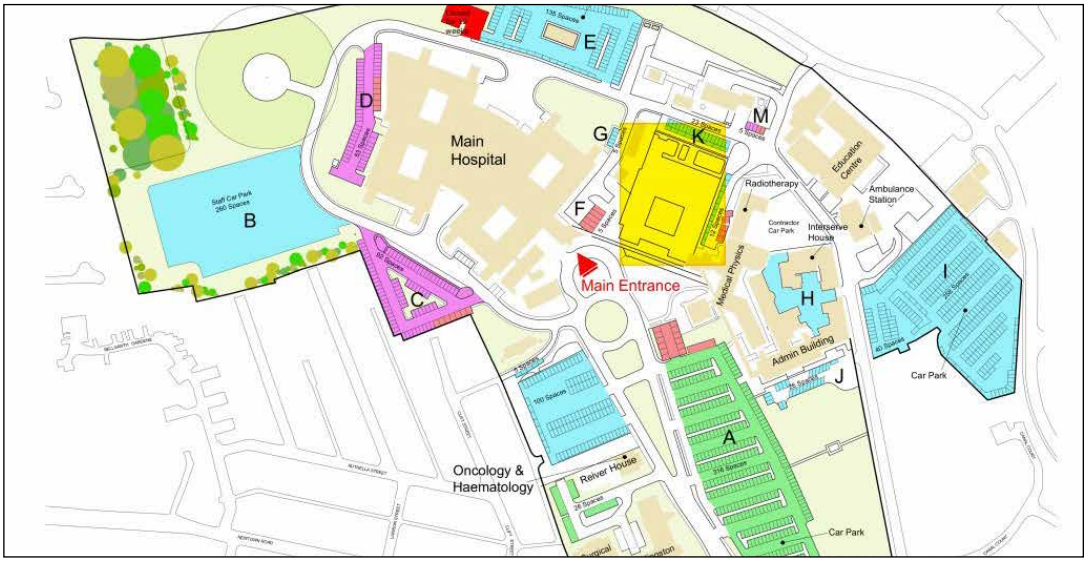
Siva Anandaciva, chief analyst of the King's Fund think-tank, told the Daily Mail: 'It's worth remembering the vast majority of private healthcare providers rely on staff who also work in the NHS – the same staff who already have full time workloads and are at risk of burnout after 18 months working in the pandemic.'

Jonathan Ashworth, Shadow health secretary, told The ***Independent*** that for seven out of 15 diagnostic tests, waiting lists are now at record levels.

These included 275,436 people waiting for magnetic resonance imaging (MRI) scans, up 35% since the end of 2019, and 447,993 waiting for a non-obstetric ultrasound, up 30% in the same period. 163,265 are waiting for CT scans too, up 20% since the end of 2019, while there has been a 69% leap in numbers waiting for echocardiography tests.

Some patients were going into debt taking out loans to pay for private treatment to escape "unacceptable" pain, argues Ashworth:

"Thanks to years of Tory underfunding, staff shortages and cuts, a two-tier health service is opening up, eroding the founding principles of the NHS as a universal service for all. A rescue plan for the NHS is now more urgent than ever".



The shaded yellow patch shows how small the new "hospital" is on the Cumberland Infirmary site, Carlisle

"New Hospitals" – NHS issues a Liar's Playbook

By John Lister, adapted from The Lowdown

Leaders of two professional bodies seeking to uphold standards in public relations have criticised the convoluted "Playbook" from comms chiefs in the DHSC's New Hospital Programme, which insists new wings and refurbishments of existing buildings had to be described as "new hospitals".

Indeed the Playbook completely rewrites the history of the commitment to "48 new hospitals" and constructs a tissue of lies and deception: why the desperation?

The answer lies in the crisis of the prioritised six, and more recently eight "pathfinder schemes," (Whipps Cross, Epsom & St Helier, West Herts, Princess Alexandra, Leicester, Leeds, and later Hillingdon and North Manchester) which are at a standstill or going backwards, with costs soaring and plans having to be revised.

Boris Johnson made building 40 new hospitals a prominent election pledge. The list was only inflated to 40 by lumping in two PFI-funded hospitals in Liverpool and Birmingham (still unfinished after the collapse of Carillion) along with other projects that were already "in build," like the Carlisle cancer centre, plus a dozen tiny community hospitals in Dorset – and relabelling new units as 'hospitals'.

Only six of the promised '40 new hospitals by 2030' were allocated immediate funding. The rest got only token "seed funding" to work up projects that could not go ahead until at least 2025.

The increase from 40 to 48 projects came last October with the announcement of a vague 'competition' for "8 further hospitals including new Mental Health Hospitals," with results next spring.

The six pathfinders were promised a share of £2.8bn. The most advanced, Epsom and Leicester, pressed ahead with consultations and "Decision Making Business Cases".

But the pool of cash was not increased when the two additional pathfinders were added – and all the plans have had to be revised in the light of Covid and new policy guidance.

In early July the leader of the New Hospital Programme, Natalie Forrest, admitted to a conference that the 'brakes had come on' for some of the pathfinder projects, most notably Princess Alexandra, and that several were unlikely to start before 2023-24. The concerns were said to focus on the capacity of the construction industry – but the unwillingness of the Treasury to finance the schemes is the key factor.

Three weeks later the New Hospital Programme team wrote to all eight "pathfinder" trusts calling for them to draw up cheaper plans, and submit three sets of plans for evaluation – an option costing no more than £400m; their preferred scheme, and options to build the project in phases.

Phasing the building programmes, as happened in the 1970s, would threaten years of disruption and run the risk of the full scheme not being completed at all.

All of the five schemes that have published estimated costs are over £400m. Indeed Epsom & St Helier and University Hospitals Leicester had already admitted that their allocated funding would not be sufficient to complete the plans on which they consulted the public – and hoped more funding would avoid cutting back their schemes.

So behind the Playbook spin NO new hospitals are yet being built, and plans are being hacked back – while older hospitals not prioritised for funding, like QEH Kings Lynn, James Paget and Hinchingbrooke are actually falling down.

Matt Hancock's secret visit to crumbling QEH Hospital where NHS England Comms chiefs fear demonstrators

CEO slammed for speaking out as QEH crumbles

A telling Briefing Note from the Comms team which is clearly critical of a chief executive for speaking out over major structural problems with a hospital that is literally falling down has been revealed through a request under the Freedom of Information Act by the Eastern Daily Press.

The newspaper, which has publicised the state of the crumbling Queen Elizabeth Hospital in King's Lynn and supported the campaign for a new hospital, had been left off the invitation list for a visit to it by then Health Secretary Matt Hancock.

The note warned there had been recent protests over the state of the hospital, which is propped up by 200 steel posts to prevent the roof collapsing, and noted that:

"The trust isn't part of the new hospital programme, and we cannot guarantee the hospital will receive the funding required to upgrade it."

It went on to criticise what DHSC bureaucrats view as 'sensationalist' comments of the hospital's CEO Caroline Shaw: "Their CEO has been very vocal about the state of the hospital's roof in recent months, and the NHS England media team has been concerned with the sensationalist tone they've been taking in the media."

Ms Shaw has been warning since 2019 that "minor fixes and repairs" were no longer sufficient and said there had been "little investment to allow the scale of modernisation and upgrades required"

Back in March the QEH had to evacuate its critical care unit to ensure the safety of patients and staff. The Trust's own risk register says: "There is a direct risk to life and safety of patients, visitors and staff of the trust due to the potential of catastrophic failure of the roof structure."

But the Comms team clearly believe such embarrassing details should not be allowed to disturb the illusions of the local public, whose lives could potentially be put at risk.

Key concerns as Bill pushed forward

Issues that we oppose in the Bill and on which we support amendments include:

Competition Procurement and Privatisation

Establish the NHS as the default provider when existing NHS or out-sourced contracts come to an end.

Require that no contract can be awarded to a private company unless there has been a process as least as thorough as the Public Contracts Regulations that currently apply.

Tighter rules to prevent cronyism and make all NHS business and decision-making fully open and transparent, with full declaration of conflicts of interest, and no commercial confidentiality exceptions – as well as a tough regime requiring ICBs to justify the award of any actual contracts outside NHS.

All private contracts to be be subject to strong contract management, and with no competition on price.

Eliminating corporatisation of primary care by preventing the abuse of Alternative Provider (APMS) contracts. As these expire, GPs should be brought back onto standard contracts, closing a gateway through which private firms like Virgin and Centene have been able to buy in to primary care.

Secretary of State

Those who campaigned against the Lansley Bill will be in favour of the Secretary of State being held directly responsible for the NHS, as was clear before 2012. But not all of the many new powers proposed in the Bill are appropriate, and there must be proper parliamentary oversight of their use.

For example, making every NHS organisation inform the Secretary of State every time they think about changing a service would create a bureaucratic nightmare, and new powers for him to intervene on reconfigurations runs the risk of politically-driven decisions being imposed on local services.

Nor are the new Secretary of State powers coupled with the restoration of the pre-2012 **duties** of the Secretary of State. An amendment will be moved that would reverse this aspect of the 2012 Act, and return to the original wording, and apply the same duties to NHS England and ICBs.

Loss of local accountability

The Bill will leave England with just 42 ICBs – the fewest "local" bodies since NHS reforms began almost 50 years ago.

The reduced number of decision-making bodies significantly reduces local accountability and local voice on future policy, while extending central powers of the Secretary of State.

Chairs of the 42 ICBs would be appointed by NHS England, subject to approval by the Secretary of State – but could only be removed if the Secretary of State agrees.

What powers should he have?

This means they would be accountable only upwards, but not at all to local councils, communities and constituencies. Amendments will propose ICB chairs to be ELECTED in a system analogous to Mayors or Police and Crime Commissioners.

Amendments will seek to explicitly rule out people associated with the interests of private companies having seats on ICBs and Integrated Care Partnerships.

All other ICB non-executives needs to be appointed not by the chair but under a fair process, with respect for diversity and independent overview.

Amendments also address the narrow composition of ICBs, which with no voice to patients, creates the danger that strong vested interests such as a large Foundation Trust could dominate – and services such as mental health or community health could be pushed to the side lines.

The single local government seat on ICBs covering wide geographical areas would leave no real voice for the local authorities they cover.

Amendments are also required to ensure that each ICS should be based on the principle of "primacy of place", with all matters devolved to local level, unless there is a compelling reason (agreed by the ICS Partnership Board) for an ICS level decision.

Local access to the full range of NHS services should be guaranteed to all communities, and any change to local services must be subject to oversight by each council's Health Scrutiny function. Local authority powers to refer contested changes to the Secretary of State must be preserved.

Discharge to assess

The Bill also proposes to change the law to remove the legal requirement to assess patients prior to discharge from hospital. Amendments will require stringent safeguards before any such changes, and protect patient rights.

Trusts and Foundation Trusts

Foundation Trusts (FTs) are left outside of any "integration" process and not subject to direction by the ICBs or by NHS England.

The highly controversial 2012 Act provision remains in place, allowing FTs to expand their private patient and non-NHS income up to half of the FT's total revenue without any proper scrutiny.

Amendments to the 2012 Act seek to make FTs subject to direction in the same way as NHS trusts, reimpose the cap on non-NHS income, and require both FTs and NHS Trusts to publish income AND EXPENDITURE details of any private patient activity – to expose the real cost to the NHS.

Professional regulation

New powers over professional regulation should not be given to the SOS unless the Bill imposes some stronger oversight by parliament and some test to apply as to the overall value of any change.

Main issues summed up

- The Bill does not end or reverse privatisation – or even competitive tendering, **but could allow private health companies to sit on the new ICBs;**
- It gives the Secretary of State sweeping new powers – but does not reinstate the duties to promote comprehensive service that were swept away back in 2012.
- The reduced number of ICSs, many covering wide areas and populations from 1-4 million drastically reduces local voice and accountability on cuts and closures for councils, communities, and constituencies;
- Chairs of the ICBs, with extensive powers, would be appointed from above, with no local accountability and could only be removed by agreement of the Secretary of State
- The Bill leaves Foundation Trusts free to ignore local plans – and to maximise private patient income – as some are trying to do.
- It gives no voice on ICBs to patients, or to mental health, or to public health, or to health workers or trade unionists.
- The proposed new payment scheme could lead to a postcode lottery on the level of funding for specific services
- and new powers to deregulate professions could undermine quality and safety of care.

Fighting the Bill – clause by clause

Sajid Javid, with NHSE boss Amanda Pritchard in Milton Keynes Hospital

By Justin Madders, MP for Ellesmere Port and Neston, leading for Labour on the Bill Committee

As the media focus on the long awaited social care reforms, the more immediate and far reaching changes that will impact on the NHS and social care can be found in the Health and Care Bill which is now winding its way through what is known as the Committee Stage in the House of Commons.

This is where the provisions in the Bill can be examined in detail and amendments submitted.

Despite constituting yet another reorganisation of the NHS the Bill does not address the most challenging issues it faces; the impact of chronic underfunding, the unprecedented waiting list and the persistent staffing crisis. It is far from clear what benefits the Bill will bring for patients, carers, families or communities.

When the NHS is dealing with the continuing impact of the pandemic and the consequences of it, particularly in terms of record waiting lists and staff burnout, another set of reforms would seem to be the last thing it needs. For these reasons Labour has already voted against the Bill on its Second Reading.

The Bill creates 42 Integrated Care Boards across England which will be responsible for running the NHS in those areas.

Private sector

We will seek to remove any possibility that representatives of private companies can have any role in the Boards of the new organisations; as we have already seen in the South West, Virgin Care have been given a seat on one of the shadow boards and there is a risk that unless this Bill spells it out very clearly, more and more private companies will not only be running parts of the NHS but also actually having a say in where resources go.

That would only lead to a further acceleration of the already massive increases we have seen in spending on private healthcare in the NHS over the last decade.

The Bill has a huge hole where accountability ought to lie. We will seek to require all the parts of our NHS to meet in public, publish the papers, be genuinely inclusive and not to hide behind some myth of commercial confidentiality.

We will ensure all Board members are properly appointed and we will explore having elected Chairs to give some genuine representation and accountability. Some of the bigger ICSs will have budgets that are greater than every council in the area they cover, so having greater democratic accountability is key, particularly if, as is feared, the ICSs become a vehicle for passporting central Government cuts.

Adequate funding

The greatest problem facing the care system is the lack of funding. If the new bodies are not adequately funded then they may not be able to deliver the volume or quality of services required and then get the blame. Only by having plans properly subject to independent evaluation of affordability can this risk be addressed.

Default provider

We want the NHS itself clearly defined as the default provider both of clinical and other near patient services like cleaning, catering and porters. Only where the NHS is unable to provide what is needed should there be any possibility of outsourcing through contracts.

We want to see greater investment in the NHS instead of having to buy in from outside. Any contracts must be awarded by an open and transparent process not by giving it to friends and family. Contracts have to be properly managed – no more crony contracts.

The Secretary of State intends in this Bill to give himself wide ranging powers to interfere in the everyday running of the NHS, overriding local medical opinion.

Where the Bill brings in the need for a greater role for local authorities and others to build better place based approaches to wellbeing and reducing inequality we will seek to make these effective so that influence is genuine and meaningful.

There has to be far more and far better ways to involve the patients, the public and staff in all aspects of decision making.

Why Tory MPs should want to amend Health and Care Bill

Since splitting some Tory votes is key to defeating the worst bits of the Bill, John Lister offers some ideas for how campaigners can most effectively argue for their local Tory MPs to press for amendments to address key issues.

The government's Health and Care Bill has been left so late it has left too little time to properly establish the new Integrated Care Boards. It seems certain to create disruption and divert management time and resources for years on end – at a time the NHS needs to focus on recovery after Covid.

But for all the problems arising from the Bill, many MPs see there are no compensating benefits.

It says virtually nothing about the key issue of the workforce, barely mentions social care, and does not address any of the major problems confronting the health and care systems after a decade of austerity funding. It won't clear a single patient from the waiting list, ease the burden on a single A&E, or halt the crisis and decline of social care.

Health Secretary's concerns

Many NHS leaders and professionals, MPs, and even the Health and Social Care Secretary himself (in moving the Bill at the behest of Downing Street rather than delaying and amending it) appear unhappy at the substantial array of new powers for the Secretary of State that were written in to the Bill by Matt Hancock.

These and many other flaws in the Bill will be hotly contested both in the Commons and in the Lords, potentially delaying its progress – and quite possibly resulting in concessions on the most controversial issues in order to get it through in time.

Many of the most contentious parts of the Bill are those that go beyond the repeal of section 75 of Andrew Lansley's 2012 Health and Social Care Act and associated regulations.

Boundaries and Boards

Many Conservative councillors and MPs have already expressed legitimate concerns about the boundaries of ICSs covering their constituencies, but perhaps most controversial for MPs must be the reduction from 100+ Clinical Commissioning Groups (already reduced from 207 established by the 2012 Act) to just 42 Integrated Care Systems.

This is the fewest 'local' bodies since NHS reforms began 50 years ago, bringing an unprecedented loss of local voice and accountability for communities, councils and constituencies.

To make matters worse, ICB chairs will be imposed from above by NHS England and the Secretary of State, giving no downward accountability. This role, with extensive powers, and at least as significant as Police and Crime Commissioners or Mayors, should be an elected post.

Failure on the NHS ensures protests against the government in charge

Fewer 'local' bodies taking decisions means less local voice for communities and c

The Bill gives no voice to patients on ICBs, but could potentially allow people associated with the interests of private companies to sit on ICBs and Integrated Care Partnerships. This threat of increased influence of private providers on NHS decision making – which will inevitably reinforce public concerns over potential privatisation of the NHS – must be explicitly ruled out.

No delegation to 'place'

NHS England's promises that decision-making within each ICS would wherever possible be devolved to more local 'place' (borough, county or unitary authority) level are not matched by any equivalent provision in the Bill – which makes no reference to place.

The Bill states that ICB would set its own constitution, opening up a new post code lottery of varying levels of local influence. Amendments are needed to ensure that each ICS should be based on the principle of "primacy of place", with all matters devolved to place-based decision-making, unless there is a compelling reason (agreed by the ICS Partnership Board) for aggregating responsibility at the ICS level.

Amendments are also needed to guarantee continued local access for all communities to the full range of NHS services, and ensuring any change to local services is subject to oversight by each council's Health Scrutiny function. Local authority powers to refer contested changes to the Secretary of State must be preserved.

The Bill's repeal of the 2015 Public Contracts Regulations would leave little or no protection against more contracts awarded without proper oversight – as happened too often during the peak of the Covid pandemic.

Bureaucracy

To wipe out pointless bureaucracy and fragmentation, reintegrate the NHS, and prevent scarce NHS resources flowing out to private providers while the government takes the blame for waiting lists and failing services, the Bill needs amendments to go further.

The repeal of Section 75 should also extend to important non-clinical services which should be delivered by NHS staff – cleaners, porters, caterers and others. It should establish the NHS as the default provider when existing contracts come to an end, and prevent more trusts – or ICBs – setting up subsidiary companies to dodge taxes, evade scrutiny or undermine terms and conditions of staff.

Another amendment is needed to require that no contract can be awarded to a private company unless there has been a process as least as thorough as the Public Contracts Regulations that currently apply.

Foundation trusts

The Bill curbs some of the freedoms of Foundation Trusts (FTs) – but it leaves FTs outside of any "integration" process, and not subject to direction by the ICBs or by NHS England.

It also leaves intact the highly controversial 2012 Act provision for FTs to expand their private patient and non-NHS income up to half of the FT's total revenue without any proper scrutiny.

This is an obstacle to any

constituencies facing changes

integration of services, since it leaves FTs free to go their own way and focus on non-NHS activity at a time when NHS resources are stretched to the maximum. Some FTs, like Oxford University and Royal Marsden are already doing so.

Amendments to the 2012 Act should put FTs on equal status with NHS trusts (a level playing field), make them subject to direction in the same way, reimpose the cap on non-NHS income, and require both FTs and NHS Trusts to publish income AND EXPENDITURE details of any private patient activity – to expose the real cost to the NHS.

Discharge to assess

The Bill also proposes to change the law to remove the legal requirement to assess patients prior to discharge from hospital.

Some pilot schemes have deployed additional resources to facilitate "discharge to assess" – and of course there were specific reasons for suspending the law during the pandemic.

However the general picture outside hospitals is one of big gaps in community and primary care and social care services, raising a real risk in many areas of patients discharged in this way merely being dumped without support – with the government clearly taking the blame for the change of policy and its potentially dangerous consequences.

Amendments must require stringent safeguards before any such changes, and protect patient rights.

Boris Johnson's decision to press through the tax rises to increase funding indicates how sensitive an issue the state of the NHS is for Conservative voters. Pressing through a half-baked Bill littered with problems would again undermine the party's credibility.

Mental health care gaps exposed

Extracted from The Lowdown SEPTEMBER 6, 2021

Around 8 million people in England are denied access to mental health services because they do not have severe enough symptoms to get put onto a waiting list, according to NHS leaders.

The 8 million figure is based on the known prevalence of mental health conditions and the thresholds dictating who gets access to treatment; NHS England considers it an accurate figure for the number of people who are missing out on care because services are not adequate.

NHS Providers, which represents the NHS trusts, warns that any progress that has been made in improving mental health services over the past few months to help those who actually reached the waiting lists will also be lost without an adequate increase in funding.

Demand now significantly outstrips supply despite the fact that services are treating more patients than ever before.

Extra funding

In 2020 when it became obvious what a devastating effect the pandemic was having on the nation's mental health, there were calls for extra funding. In the November 2020 spending review, the Chancellor gave an extra £670 million.

This fell some way short of estimates that due to increased demand mental health services will require more than £1bn a year for the next three years, to deal with the long term fall out of the pandemic.

Under 18s

Services for under-18s in particular have seen a dramatic increase in demand since the pandemic began.

The recent NHS Confederation report – Reaching the tipping point: children and young people's mental health – notes that as many as 1.5 million children and young people may need new or additional mental health support as a result of the pandemic, but this is likely to be an underestimate.

The official waiting list contains just 374,000 under-18s.

The area of eating disorders has been singled out as one that has seen a particularly high increase in demand.

Waiting list

In August a new analysis by the Royal College of Psychiatrists found that at the end of the first quarter (April, May and June) of 2021/22, 207 patients were waiting for urgent treatment, up from 56 at the same time last year.

A further 1,832 patients were waiting for routine treatment, up from 441 at the same time last year. And 852 patients received urgent treatment, compared with 328 in the first quarter of 2020/21.

However, in May 2021, an NHS Providers survey found 85% of trust leaders said they could not meet demand for children and young people's eating disorder services.

Although the problems within mental health services have been exacerbated by the pandemic, a decade of underfunding by Conservative governments has resulted in bed cuts, falling staff numbers, an infrastructure that is no longer fit for purpose, and A&E being used as the first port of call for patients in crisis, due to a lack of any other option.

NHS Providers note that services need "critical capital investment to tackle the most immediate challenges facing the mental health estate" plus "significantly more funding."

Skilled staff

This is needed to "recruit enough staff with the right skills, expand community services to avoid inpatient admissions where possible, increase bed numbers to bring care closer to home and to tackle the ever growing backlog of care caused by the pandemic."

A survey conducted by the British Medical Association (BMA) just before the pandemic began found 63% of mental health staff worked in a setting with rota gaps, and 69% of these said such gaps occurred either most or all of the time.

According to The Health Foundation the number of mental health nurses dropped by 8% in the 10 years to June 2020, and there was a 39% fall in learning disability nurses.

GOS domestics back inhouse

Great Ormond Street NHS Foundation Trust brought back all domestic service staff, until then employed by external companies (most recently by OCS) into direct NHS employment on August 1, in a deal negotiated with UNISON, Unite and other unions.

All 312 new employees will have access to the NHS pension scheme and the same sick pay entitlement as all other NHS staff. Two additional improvements to their terms and conditions:

- pairing up every staff member's sickness entitlement will be paired up to their full length of service working on the GOSH site on transfer, to ensure all staff, regardless of which cleaning service outsourcing companies they have worked for at GOSH.
- and, in direct response to their feedback, and as we welcome them to our team, from 1 August 2021, the Trust will remove the clocking in / clocking out system, which has been in place historically.

All domestic services staff are to be paid the London Living Wage of £10.85 per hour and will receive the same sick pay entitlement as all NHS staff.

Negotiations are continuing on other aspects of Agenda for Change.

Derriford Hospital -- a site full of contractors and franchises

Trust to bring outsourced surgery back in-house

University Hospitals Plymouth Trust is seeking to resume much of the 200 monthly elective orthopaedic operations which it outsourced three years ago to Care UK as part of plans to create a "hot/cold" services split.

The trust told HSJ the change would mainly be for high-complexity patients, with Care UK continuing to treat low-complexity patients.

However the HSJ report queries how the trust could restart orthopaedic work at Derriford Hospital, "which is struggling with emergency care demand and is currently among the worst-performing hospitals in England for ambulance handover delays."

Kent confusion

Mixed messages in Kent, with plans revealed last month to upgrade the A&E department in William Harvey Hospital in Ashford, as trust bosses admit the site no longer has sufficient capacity to cope with growing patient numbers.

But only a few months ago images were released to show what a new 'super' hospital in Canterbury could look like – if there was any money to build it.

If built, it would bring the closure of William Harvey's A&E.

However Ashford residents can breathe easily for a while yet -- the new hospital is not on the list of 40 'new hospitals,' and many not make it onto the longer list of 48.

So no new hospital until the 2030s. If then!

'Stop using poor quality private hospitals' – council report

A Tory council-commissioned report has called for the Law Commission to review the current legal position of private companies providing services for adults with learning disabilities and autism, after yet another major failure of a private hospital that led to the deaths of three adults with learning disabilities.

Norfolk Safeguarding Adults Board found significant failures in the care of the patients at Jeesal Cawston Park, Norfolk, and concluded such hospitals should "cease to receive public money".

"Unless this hospital and similar units cease to receive public money, such lethal outcomes will persist," said report author Margaret Flynn, who carried out a previous review into the Winterbourne View scandal in 2011.

She found failings including:

"Excessive" use of restraint and seclusion by unqualified staff

Concerns over "unsafe grouping" of patients

Overmedication of patients

High levels of inactivity and days of "abject boredom"

The hospital's operator, Jeesal Akman Care Corporation, which has apologised for the failings, went into liquidation in June, owing almost £4m.

Under-resourced NHS plunges down the league tables

Martin Shelly, The Lowdown, August 10

The Commonwealth Fund's latest Mirror, Mirror report – which analyses how healthcare in the US compares with services in other rich countries – has downgraded the NHS from top spot to fourth position in its global rankings, citing increased patient delays post-covid and lack of investment as the main reasons for the change.

The NHS achieved top place in the Washington-based thinktank's two previous reports, but now ranks behind Norway, the Netherlands and Australia.

The Commonwealth Fund report looked at the performance of healthcare systems in 11 countries. It found that the UK scored lower on three main criteria – access to care, care processes and the ability to obtain healthcare regardless of income – than in previous years, and most crucially ranked just ninth this year for health outcomes such as infant mortality and cancer survivability.

For access to specialist mental health services, the NHS was the second-worst performer.

These findings will come as no surprise to some. Similarly negative findings emerged three years ago in How good is the NHS? – a joint report from the Health Foundation, the Institute for Fiscal Studies, the King's Fund and the Nuffield Trust – which compared the NHS to healthcare services in 18 other countries.

Child mortality

This found that the UK had high rates of child mortality around childbirth, and that mortality rates for patients treated for cancer, heart attacks and strokes were also higher than average.

It also noted – despite the NHS doing better than health systems in comparable countries at protecting people from heavy financial costs when they're ill – that healthcare spending was actually lower than the average, and that the UK had fewer doctors, nurses, CT scanners (8 per million population compared to an EU average of 21.4) and MRI machines (6.1 per million compared to an EU average of 15.4) than the other countries in the report.

Pressures on staffing and resources continue, made worse by the pandemic and helping to explain the downgrading of the NHS in the Commonwealth Fund's latest report.

Just this week NHS Confederation policy director Dr Layla McCay told LBC there were 76,000 unfilled vacancies in England alone, while Cancer Centre London clinical oncologist Professor Angus Dalgleish told the same radio programme that the NHS was short of 40,000 doctors, with no funding in place to pay for them.

Delays handing over patients at over-stretched hospitals ads to the stress on staff

Call for support to stressed ambulance staff

UNISON has written to ambulance service chiefs calling for urgent support for staff as services face unprecedented 999 call volumes and unsustainable demand from the public.

The letter says employers must act now to limit the impact on the wellbeing and morale of staff, especially those working in control rooms.

In the letter, UNISON says 'missed meal breaks, late finishes, queuing outside hospitals and increasing levels of sickness absence have become widespread'.

The letter continues: "This is all having a terrible impact on morale, as well on the health and wellbeing of ambulance staff.

"Ambulance staff have been at the forefront of the Covid response, working under levels of pressure never seen before."

Major issues that are being reported to UNISON by staff across the country include:

- An ambulance service employee having to attend jobs for an extra five hours and travel over 100 miles after their shift officially ended.
- Timewasting 999 calls from the public including requests for crews to attend a property where someone couldn't reach their TV remote control and another where the person was too hot because they couldn't turn their heating off.
- Staff at ambulance stations crying at the end of their shifts because of stress, low morale and lack of breaks. Some are spending hours queuing in A&E department corridors waiting to hand over patients on stretchers to hospital staff.
- Significant delays in responding to patients because of the overwhelming number of emergency calls.

One service had 400 calls outstanding and had worried people ringing back asking when an ambulance would arrive.

- Emergency call handlers starting shifts with ambulances needed at over 100 incidents. In some cases, there's been a 24-hour wait for ambulances to arrive.
- Ambulance services regularly reaching the highest possible alert level (REAP 4) because they're under such extreme pressure.

UNISON is urging employers to ensure employees get their legal entitlement of rest periods, minimise missed meal breaks and shift overruns, and check staff are not working excessive hours because of overtime or extra shifts.

Peter Fisher and Kailash Chand

Campaigners have suffered a double loss this summer with the deaths of two stalwart defenders of the NHS.

Dr Peter Fisher, one of the founding members of the NHS Consultants' Association in 1976, going on to become its chair and later President for Life, died last month, aged 88.

The NHSCA was formed to speak up for doctors who felt the British Medical Association (BMA) was putting too much emphasis on private practice and not enough on building up the NHS: in 2014 its became Doctors for the NHS.

Peter was also was also a founder member at local level of Banbury Health Emergency in 1990 – and at national level played a leading role in founding Keep Our NHS Public in 2005.

In late July another energetic and principled campaigner, Prof Kailash Chand Malhotra, the first Asian elected as deputy chair of the BMA, and a fellow of the Royal College of GPs, who had remained active role in local and national medical politics and a prolific writer, died aged 73.

Greater Manchester's mayor Andy Burnham praised him in a video message, echoing the feelings of many when he said he was 'reeling' from the news of his death.

His death is the more tragic because his son, Aseem Malhotra, a heart specialist, is convinced that his father's death could have been prevented if an ambulance had arrived more quickly.

Kailash Chand had complained of chest discomfort before asking for help from neighbours, who were also doctors, who called an ambulance because they believed Prof Chand had had a cardiac arrest, and tried to resuscitate him. The ambulance took over 30 minutes to arrive, but by the time they got there he was dead.

Covid levels remain high

6300 NHS beds in England were occupied by Covid patients on September 8, and rising.

The most recent figures as this bulletin is completed shows a 7-day UK-wide average of 39,000 daily new infections, and a 7-day average of 132 deaths per day or 924 per week – equivalent to 4 major air crashes.

Research in North East London shows that 90% of patients in ICU beds with Covid were unvaccinated or had only one jab.

999 delays increase

Patients needing ambulances for life-threatening calls are often waiting longer than they should, latest NHS England figures show.

The average ambulance response time for life-threatening calls slightly shorter, on average, in August than in July. But they were still more than one minute longer than the 7-minute target for responding to the most urgent calls – for people who are struggling to breathe or have had a cardiac arrest.

The average response time for an ambulance that can take a patient to hospital was close to the worst on record in August at 11 minutes 10 seconds.

And for category 2 emergency calls - which cover heart attacks, seizures and road traffic accidents - the average wait was 38 minutes, against a target of 18 minutes.

Once patients arrive at hospitals there are often further delays. Just 66.2% of Type 1 emergencies arriving at hospital-based A&Es in August were seen within four hours, the lowest level ever – the target is 95%.

NEXT ISSUE

Our next issue of the news bulletin will be in October. Please get any articles, photos, tip-offs or information to us no later than OCTOBER 1.

HEALTH CAMPAIGNS TOGETHER #our NHS

NHS England fuels media campaign against GPs

Extracted from The Lowdown, September 6

Flu vaccine and blood test tube shortages – along with a 'new' access improvement programme* – look set to further stress a primary care network already hamstrung by workload and recruitment issues, abuse from patients, attacks by the media and mixed messaging from NHS England.

GP appointments are now actually up 31 per cent compared with pre-pandemic levels, and more than 50 per cent of appointments have been delivered face-to-face throughout the pandemic, according to figures from NHS Digital.

But a survey taken last October by the Medical Protection Society (MPS) revealed that more than one in three doctors had been the victim of verbal and physical abuse by patients or their relatives in the preceding six months after the first lockdown began. Most of the hostility linked to false assumptions GP surgeries were closed.

Similar research, undertaken by the MPS last month, showed that staff at three quarters of surgeries had experienced verbal abuse.

A BMA survey of 2,400 doctors last month found more than a third of doctors had experienced verbal abuse and threats – as well as violent assault – with GPs the most likely to be targeted.

Nearly 70 per cent of GPs interviewed said such abuse had worsened over the past 12 months.

And according to a report in the Independent, again last month, some surgeries have received bomb threats, others have been daubed with graffiti, while staff at one practice fell victim to anti-vaxx hate mail and were sent text messages describing them as 'Nazi b******s'.

Much of the abuse suffered by GPs and surgery support staff stems from the false perception among many patients that practices are closed and appointments are unavailable.

It's a perception that's been widely promoted by several right-wing media outlets – and subsequently amplified on social media sites like Mumsnet – since the pandemic began. And it is gaining momentum.

Two ***Daily Mail*** articles chimed in in the past few days, the first a 'special report' seeming to suggest GPs might be "obstinate and idle," second a comment piece by Janet Street-Porter headlined, "A betrayal of the NHS".

Three pieces similar pieces in the ***Telegraph*** chimed in with the ***Mail*** stories, featuring such headlines as: "Are GPs who refuse face-to-face appointments breaking the law?", "Time to turn the heat up on GPs who won't see us face to face" and "Vets serve pets better than GPs do [the] public".

The fact is that NHS England actually instructed GPs to move to 'total triage' in March last year – a move dependent on remote rather than face-to-face consultations, and described at the time by former health secretary Matt Hancock as "remote by default".

And last week NHSE again instructed primary care providers across England to maintain covid infection protection and control procedures – despite them being relaxed across most other settings last month – in a move that is said to have led to thousands of appointments being cancelled through no fault of GPs.

Misrepresentation of GPs' performance has gained traction since the pandemic began.

An analysis by ***Pulse*** earlier this year found that nearly half of the articles in 2020 suggested practices were either shut or providing poor access to appointments, and claimed GPs were 'refusing' to work or should be 'back at work'.

NHSE has adopted a fairly docile, almost ambivalent stance on media attacks aimed at GPs.

Last September it seemed to echo the stance of the Mail and Telegraph, writing to all practices to 'remind' them that patients must be offered face-to-face appointments when they need them.

Four days later surgeries reported that practice staff were being abused by patients following publication of incorrect media stories about a lack of appointments, leading the BMA's GP committee to demand NHSE issues a correction to counter the negative coverage.

Two months after that, in November, former RCGP chair Professor Dame Clare Gerada suggested NHSE shouldn't leave it to GPs to correct misinformation, and should instead set up a rapid rebuttal unit.

NHSE primary care medical director Dr Nikki Kanani pledged that the organisation "can and will do more" to explain to the public that GP practices are actually open.

But in May this year NHSE was again writing to GPs saying they must offer face-to-face appointments, and so the negative stories continued, prompting RCGP chair professor Martin Marshall to write to the ***Times*** to challenge the ongoing media criticism.

Only last week one GP told ***Pulse*** they felt there was "a deliberate and co-ordinated attack" by the right-wing press, with an underlying agenda patients were starting to believe if left unchallenged.

But the news that NHSE is not planning a public information campaign to explain why GPs are cancelling non-urgent blood tests is hardly reassuring, posing as it does a risk of further abuse from angry patients towards surgery staff.

Unions, campaigners, join us!

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

- **TRADE UNION** organisations – whether they representing workers in or outside the NHS – at national, regional or local level
- local 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 supporting Health Campaigns Together, please contact us to discuss.

You can sign up online, and pay by card, bank transfer or by cheque – check it out at at *https://healthcampaignstogether.com/joinus.php*