DEFEND ENFIELD NHS

July 5th 1948: "A MILESTONE IN HISTORY
(said Nye Bevan)
But "WHEN IT'S GONE, IT'S GONE"
(says *DENHS)*

About Us ***04/19.***

Defend Enfield NHS is a small group of Enfield residents, from medical and other professional backgrounds and different political persuasions, seeking to share more widely our concerns around NHS and Social Care. The creeping privatisation of our treasured NHS is proving expensive, inefficient and sometimes dangerous, while many good doctors and nurses are leaving the service because of huge financial cutbacks. We must act, locally and nationally, to ensure that the NHS remains publicly-owned and that its world-renowned quality of service is sustained for the future.

Despite the celebration last year of a national health service which since its birth 70 years ago has delivered world-class care to all on the basis of need rather than the ability to pay, in recent years it has been under constant attack from under-funding and top down reforms. Services have been cut, cancelled or closed, or increasingly out-sourced to private companies.

Enfield is linked with Barnet, Camden, Haringey and Islington in a "footprint" now known as the North Central London (NCL) Partnership in Health and Care. There are 43 other "footprints" throughout England. The size of each of these 44 footprints, in population terms, "conveniently" matches the size of market that American private health insurance companies are seeking to pursue. And yet the establishment of, and work planned for, these footprints, which include huge financial cuts across the capital, have **no legal status** whatsoever. Who knew!

DENHS members meet monthly, attend public meetings of health organisations in Enfield, including those of the Clinical Commissioning Group Governing Body, and ask questions in a bid to seek out the truth behind the rhetoric. We are affiliated to an umbrella organisation, *Health Campaigns Together (HCT)*, which over-arches campaign groups country-wide to enable information, experiences and, sometimes, successes to be shared more widely.

"How Come We Didn't Know?"

Illustrating the dangers facing the NHS and the need for wider understanding and greater support by the public at large, a photographic exhibition was hosted by *DENHS* at the Dugdale Centre during last July and August. This exhibition, entitled *"How Come We Didn't Know?"*, which details how global corporations are rapidly buying up NHS contracts, had previously been shown at venues across the country. On 13 March 2019, having been revised and up-dated, the exhibition was on display in the Jubilee Room at the Houses of Parliament. Dr Tony O'Sullivan, co-chair of *Keep Our NHS Public,* Eleanor Smith, the MP sponsoring the NHS Reinstatement Bill, and Peter Roderick, a barrister and co-author of the Bill, were among the speakers at its launch. *DENHS* members were pleased to support the event and to congratulate photographer Marion Macalpine on her impeccable research.

In reality, cuts in services, and underfunding generally, are a means of undermining the NHS both locally and nationally in order to make privatisation look more attractive to the general public than it actually is. The NHS is held in high esteem throughout the world and there are few people in England whose lives have not been touched by it in some way and who do not have cause to be grateful to its dedicated health workers and its ethos - a public service, publicly funded, publicly owned and free at the point of need.

Our Concerns - General

Enfield has an acute shortage of some 60 GPs and yet there are proposals to exacerbate this still further by compelling all surgeries to become part of "Primary Care Networks" covering between 30,000 – 50,000 patients. "Consultations" have focused on reducing access to treatments such as knee and hip replacements, inguinal hernias and many others. Other worries include: bed shortages and inadequate social care funding; long waits in A&E; long waiting times for cancer treatment; the selling off of NHS land; and the crisis caused by below-inflation pay rises for valued NHS staff.

The introduction by hospital trusts of wholly-owned subsidiary companies, "Subco's", adversely impacts upon staff when their terms and conditions of employment are changed by sleight of hand. Another major issue is the serious lack of skilled midwives and the increasingly frequent "temporary" closure of maternity units when full, causing untold distress and uncertainty to women turned away when about to give birth.

Our Concerns - Financial

Enfield has suffered historic under-funding and is under NHS England "legal direction". It was said that the aim was to achieve a funding balance across the five North Central London boroughs but that this could take time as most of the NCL boroughs were in difficult, not to say precarious, financial circumstances. A proposed NCL-wide financial strategy aimed at greater parity had actually been rejected by Islington CCG, the only one not in deficit.

The deficit in Enfield is forecast at around £20 million at the March year end. And although there will be 6% of new money for 2019/2020 there are also new targets around mental health and community services which means there is not enough funding to fill the gap.

To make matters worse, NHS England has proposed certain tariff changes within its funding arrangements. These changes are to a "Market Forces Factor" intended to correct "unavoidable cost differences". CCGs were given very little time to respond to this information so it is telling that leaders of the NCL CCGs, together with executives from the Royal Free and UCL hospitals came together to set out in great detail their concerns. These include an estimated **reduction in funding of £180m per year** which over a proposed four-year transition period represents a cash reduction to London of **£0.5 billion.** In a four-page letter to NHS England and NHS Improvement they state their belief that the methodology is flawed and will jeopardise the co-ordination and provision of NHS care across North London. The changes proposed are seen as de-stabilising and a distraction from the work of integrated care. The letter concludes with the need to avoid unintended consequences and asks for early sight of the proposals' supporting information before funding allocations to CCGs were finalised.

Despite this, all CCGs have now been informed of their allocations for the forthcoming year. Following questions put to Enfield CCG governing body, it is apparent that no reply had been received to the letter but that what was to have been a four-year transition would now be a five-year transition. "So that impact was less than it would have been……..".

The NHS is this country's greatest peace-time achievement. Sadly, it is seen by some as a potential source of financial gain and funding reductions on such a huge scale will only serve to endanger the NHS even more. If people were, however reluctantly, persuaded that the health service were no longer fit for purpose they might then turn to private providers. And yet, when failures occur, it is left to the NHS, already stretched beyond belief, to pick up the pieces.

Our Aims

The aim of *DENHS, HCT* and the 120+ other local groups across the country which are affiliated to it (a number which has grown from around 20 a couple of years ago), is to publicise and challenge in whatever way possible the potential dismantling of our national treasure, the NHS. Linking with similar groups in Enfield's neighbouring boroughs is seen as crucial to success, to give more and better voice to our endeavours. Any similar group in Barnet, Camden, Haringey or Islington is encouraged to liaise with us to share ideas and experiences for the common good. Individuals who are concerned about and who wish to support the NHS are also very welcome to make contact.

There is no better way to sum up the rationale for the existence of *DENHS, HCT, Keep Our NHS Public, Doctors for the NHS, Junior Doctors Alliance, NHS Patient Voice, We Own It,* and many others than in the words of Nye Bevan, founder of the NHS in 1948:

"THE NHS WILL LAST AS LONG AS THERE ARE
FOLK LEFT WITH THE FAITH TO FIGHT FOR IT".

We are those folk - come and join us!
defendenfieldnhs@gmail.com
04/19.

DEFEND ENFIELD NHS

FOR EASY REFERENCE…….

ACCOUNTABLE CARE OR COUNTING THE COST?

First we had STPs (Sustainability & Transformation Plans), then we had ACOs (Accountable Care Organisations - a term which has since fallen into disrepute being neither "accountable" nor "caring"), and now we have ICPs (Integrated Care Providers). It is fast becoming clear that these constant changes to names and acronyms are little more than a smokescreen for unpopular and insidious plans, making them more difficult to comprehend and enabling them to more easily circumvent current legislation and parliamentary scrutiny.

In December 2018 a new NHS Long Term Plan was published by the government and NHS England (NHSE) with the stated aim of "improving" healthcare, a claim which appears doubtful after a decade in which our national health service has been grossly underfunded and undermined. The focus on allowing private companies and consortia to tender for NHS contracts will continue, endangering democracy in that local communities will no longer be able to hold their local health service to account. Performance by private providers is also not accountable to public scrutiny, and the ability to question through Freedom of Information requests will be severely curtailed.

CAPPED EXPENDITURE PROCESS

NHSE and NHSI (NHS Improvement) have imposed a Capped Expenditure Process on 14 areas across England which are deemed "financially challenged". Enfield is one such area. Any deficits are expected to be swiftly reduced and, should trusts or CCGs overspend, they will be threatened with "special measures". Local leaders making difficult decisions on NHS spending are told to "think the unthinkable" including "changes which are normally avoided as they are too unpleasant, unpopular or controversial".

What is unthinkable is the fact that North Central London and North West London combined are said to carry 50% of the whole NHS debt putting them under inconceivable additional pressure if deficits are to be reduced.

CCGs (Clinical Commissioning Groups)

CCGs are clinically-led statutory bodies responsible for planning and buying health care services from hospitals and other providers in their area. Their members are local GP practices, led by an elected governing body. They meet in public to discuss progress reports and statistics. Meetings are open to the public and agenda may be found on the CCG website a few days before the meetings.

ENFIELD HEALTHCARE COOPERATIVE LIMITED

Early last year it emerged that a new cooperative, the Enfield Healthcare Cooperative Limited, had been set up to provide, through a Single Offer, services already delivered by GPs in the borough. Widely referred to as the long-promised GP Federation, this is actually a limited company with 400 shares split between three shareholders who are also employed as GPs in Enfield.

Whether or not this is really helpful remains to be seen because in neighbouring NCL boroughs the NHS gives funding to the respective CCGs which then pass it direct to individual practices. In Enfield the CCG now passes the funding to the GP Federation. This then takes its "cut" before sending it on to the practices. GP practices have had no extra money for some time. How does this help?

INTEGRATED CARE

What could be more desirable than a fully integrated care service with all elements working together for the good of patients and public health? But this is "integrated" in name only. What it really means is the fragmentation of the health service by opening it up to further privatisation for the benefit predominantly of shareholders and speculators. The aim is to reduce the cost of the health service by introducing new models of care which reduce hospital capacity and expect people to provide their own "self-care".

It is based on the premise that an ICP, i.e. a single organisation, private company or a consortium, will hold a contract with a set budget to provide the majority of services in a specific area. Payment is not linked to the number of patients treated and/or the complexity of the medical treatment in question so fails to ensure sufficient money is available to meet the cost of delivering services to the required quality.

These models are being introduced without adequate public consultation; outside of any legal framework; at reckless speed; and at a time when NHS and social care services are seriously under-funded. With no robust evidence to support them they will asset strip NHS land and buildings and increase the scope of privatisation.

And there are statutory duties imposed upon NHS bodies which are not imposed on private providers. Why not?

JUDICIAL REVIEW

There have been two applications for Judicial Review in order to challenge the introduction of ACOs.

In April 2018, the campaigning group *999 Call for the NHS* challenged the lawfulness of the payment mechanism in a draft ACO contract on the grounds that in contradiction of the Health & Social Care Act 2012 it abandoned the concept of payment by results. The Judicial Review was initially unsuccessful in the High Court. In August the campaign was granted permission to appeal and in November the Court of Appeal ruled against the claim that the government's ACO contract is illegal. The group now intends to pursue the case in the Supreme Court.

The second challenge, by *JR4NHS,* was against government plans to bring local health and social care under one contract. The original claim was brought on four grounds two of which were dismissed by the High Court. It was decided not to appeal as the two remaining claims, concerning consultation, were withdrawn when NHSE and the Secretary of State for Health & Social Care conceded that they would not proceed to introduce ACOs without full national consultation. It was concluded that this should strengthen public resolve to hold the government to account and raise awareness of the issues at stake.

MATERNITY CARE: BUDGETS AND TRANSFORMATION PROGRAMMES
Following the Better Births Review in February 2016, seven recommendations were made for maternity care, to improve outcomes by personalising care, ensuring continuity of care to provide safer care and better postnatal and perinatal mental health care. Multi-professional working and working across boundaries were identified as critical priorities.

NHSE has now circulated a resource pack *Implementing Better Births: Continuity of Carer* to help Local Maternity Systems achieve the recommendations in the Review. In two community hubs, one in Camden and one in Haringey, teams of midwives supported by obstetricians provide continuity of ante and postnatal care, have been established by NCL STP.

NAYLOR REPORT (or the great land grab)
The proposals in Sir Robert Naylor's report centre on selling off £5.7 billion-worth of land and assets where these are deemed to be surplus to requirements. In November 2017, central government, the NHS and the London Mayor entered into a Memorandum of Understanding, an informal understanding between parties, with a view to accruing funding from the planned sale of NHS land and property in London despite resistance from many local councils. These proposals completely ignore the fact that land accumulated over centuries for use in perpetuity should more properly be used to provide either affordable housing for health workers or step down accommodation for patients. A detailed submission to that effect has been made by *DENHS* to the Mayor of London.

More recently, a similar submission has been made by *DENHS* in response to the Enfield Local Plan Consultation. The response agrees with Naylor's conclusion that a national estate strategy is required but considers that such a strategy should be in place before anyone can possibly know what land is surplus to requirements, and why. No sale of NHS land in London should occur before a strategic framework is in place that has been subject to meaningful public consultation. While it is acknowledged that the plan's aspiration is to create thousands of new homes, to release NHS land for this purpose is simplistic and damaging. There exist more nuanced opportunities for NHS land to deliver housing gain at the same time as providing health and welfare benefits to Londoners, and preserving the estate assets of the NHS.

DENHS therefore proposes that, when any NHS land is identified as not being in clinical use, a sequential test should be adopted to appraise possible options and the land should be safeguarded from sale into the private sector unless and until it is demonstrated that other potential uses have been considered and rejected. These include:

Building re-organisation, maintenance or renewal;	Expansion, replacement and new facilities;
Step-down care to relieve acute beds;	Residential units for NHS staff;
Land swaps with other public sector land;	No unsuitable developments on NHS land near hospitals

And, finally, that should land sales proceed for housing development, regardless, it would be unacceptable if the dwellings so created were then found to be unaffordable for many Londoners, thereby adding insult to injury.

NHS LONG TERM PLAN
The NHS Long Term Plan published in December 2018 was predictably introduced with little opportunity for professional NHS staff to comment or caution in any way. Thankfully, campaigning organisations *Keep Our NHS Public* and *Health Campaigns Together* have undertaken forensic examination of the 60 promises that are put forward albeit with little prospect of coming to fruition. Their concerns encompass the following:

- The lack of workforce strategy or costings of the proposed initiatives
- Formation of ICPs will mean that the performance of private providers will not be accountable to public scrutiny, and many private healthcare companies already specialise in limiting eligibility to health care.
- The requirement that trusts maximise their income by charging overseas patients, a proposal opposed by the Royal College of Physicians as any deterrent from treatment could have wider implications for public health.

- The introduction of primary care networks for GPs which will surely involve some local closures and a reduction in patient access as GP practices are being cut from 7,500 to just so-called "super practices".
- The focus on digital health initiatives which could disadvantage certain demographics and be less safe
- Where the proposed increase of 20,000 extra staff would come from given the current recruitment crisis.
- Fire sales of NHS properties and land will be forced through to fund deficits.
- The Long Term Plan is seen as unfair and unsafe, a plan to maximize private revenue and reduce public costs resulting in increased privatisation and rationing of treatments.

NORTH MIDDLESEX HOSPITAL: FUTURE DIRECTION

On 4th October 2018, North Middlesex University Hospital Trust decided not to pursue a proposal that it become a full member of Royal Free London Hospital Group following consultation with its stakeholders. On 26th March 2019, the Enfield Over 50's Forum Health Group held a meeting at the Civic Centre at which Maria Kane, Chief Executive of the NMUH Trust, was invited to give a presentation. Ms Kane gave a positive and interesting talk on the progress being made by the hospital, its current CQC inspection grading of "Requires Improvement" and the way in which everyone was now working towards a grade of "Good".

She spoke of the opening of a refurbished Accident & Emergency Department on 18th March as well as a new facility for A&E patients needing mental health support. She spoke also of the challenges faced by NMUH, not least the financial inequity of the fact that NHS hospitals are required to pay business rates while private hospitals are registered as charities and can escape this cost. This represents some £5 million per year in the case of NMUH, money which could otherwise be spent on frontline care.

ONLINE SERVICES - GP PRACTICES

NHSE's vision of what patients would like to see happen includes being able to do more for themselves on line. Many practices now offer patients the opportunity to book and cancel appointments, order repeat prescriptions, obtain test results, even consult on line or see their own health and care records. For those who are comfortable with this approach this is good news. For those who do not have access to a PC, tablet or smart phone, it is crucial that they are not left behind and that more traditional ways of liaising with their GP are not ignored given that those most in need of medical attention are likely to be those for whom on-line access is least available.

ONLINE SERVICES - GP AT HAND

A word of caution……Beware *GP at Hand!* Advertisements on London tube trains proclaim that their patients can see a GP "in minutes", a statement which has been denounced as misleading by the Advertising Standards Authority. Initially, there is no GP appointment. Symptoms are typed in to a mobile app and from a series of questions and answers a "chatbot" will use a computer programme to check against a database of illnesses. Normally, in a face-to-face consultation, a doctor will consider other factors when reaching a diagnosis.
If a face-to-face consultation were needed, the patient would then visit a *GP at Hand* clinic in London where they could incur charges in the region of £25 for a one-off, or subscribe to monthly payments of £9.99 or even a yearly payment of £89.99. There are also financial repercussions for the NHS.

GP at Hand is a practice in Hammersmith which has teamed up with a private digital technology firm, Babylon Healthcare. Firstly, prospective patients must de-register from their local GP and register with *GP at Hand* which can take several weeks. GP surgeries are funded per capita and when a patient de-registers their proportion of the funding goes with them leaving fewer resources locally. And yet, if that person then requires a home visit in their local area then that responsibility falls upon the practice whose funding has just been reduced.

GP at Hand targets young, fit adults who are IT literate, comfortable with signing up on line, and are, in other words, less expensive to treat. It claims to be suitable for anyone who lives or works within forty minutes travel time from Hammersmith. Some patients may be deemed ineligible to register including pregnant women, the frail and elderly, those with terminal illness, have mental health conditions, drug dependency or learning difficulties. They may not treat children under 16 and may not be suitable for managing medical emergencies. A trial is being evaluated by NHSE; the BMA and consumer champion *Which?* have carried out their own checks. Even Babylon's own medics employed to develop the app have urged caution and the company's terms and conditions apparently state that its symptom-checking services "do not constitute medical advice, diagnosis or treatment".

So, there is a clear element of patient safety to consider - *GP at Hand - Keep Them at Arms' Length!*

PATIENT REFERENCE GROUP

The Patient Reference Group planned by Enfield CCG is now in the process of being set up. In order to be able to seek the views of the patient and public community, applications have been sought from local residents who have experience of local health services and want to help improve provision for Enfield patients.

Enfield CCG intend to recruit at least nine suitable candidates to reflect the experiences and opinions of this diverse population. The closing date for application was 17 March 2019, the group will meet four times a year and will be chaired by the newly-appointed Lay Member for Patient and Public Engagement, Mr Kevin Sheridan.

PHARMACY2U

The National Pharmacy Association (NPA) has issued a leaflet which cautions patients against using a company called Pharmacy2U in order to obtain repeat prescriptions. The NPA lists the following advice: Pharmacy2U is not your local community pharmacy and has nothing to do with it;

Pharmacy2U is a distance selling (internet only) outlet with which patients can have no face-to-face contact; prescriptions are delivered by mail, unlike medications from your local pharmacy; in October 2015, Pharmacy2U was fined £130,000 for selling its patients' details to marketing companies; over Christmas 2015, Pharmacy2U failed to send out prescriptions for three weeks leaving many patients without their medication.

Pharmacy2U continues to advertise its wares on line, despite a report by the Care Quality Commission (CQC) in 2017 that the service was "not safe, effective or well led". The NPA believes that an internet business of this sort is no substitute for a local pharmacy.

PHLEBOTOMY - BLOOD TESTING SERVICES

The Royal Free London NHS Foundation Trust has recently announced that from 1 April 2019 it will no longer provide a phlebotomy service at a number of Enfield GP practices. This arrangement was originally put in place by the former Barnet and Chase Farm Hospitals NHS Trust and was specifically for the patients of those particular practices. The Royal Free will continue to provide blood testing on site and from Barnet and Chase Farm hospitals.

North Middlesex University Hospital NHS Trust has also provided a phlebotomy service at the hospital site and at a number of GP practices in Enfield. These include: Winchmore Hill Practice; Forest Primary Care Centre; Evergreen Surgery; Freezywater Primary Care Centre; Grovelands Medical Centre; and White Lodge Medical Practice. This will continue and can be accessed by ***any*** patient who is registered with an Enfield GP practice.

For further information on how to access blood testing services please contact website: http:/www.enfieldccg.nhs.uk/blood-testing.htm., or:
www.northmid.nhs.uk/Our-Services/Blood-tests.

PRIMARY CARE NETWORKS

General practice is the foundation of the NHS. GP practices based in local communities with "family doctors" knowing the vast majority of their patients. However, there is now widespread concern at a move to provide GP services "at scale". In August 2018, the NHS Head of Primary Care reportedly said that there are "too many" smaller practices which should instead be "rationalised" into bigger centres.

North Central London is now developing a new strategy, setting out its vision of what patients might want. This includes a requirement that GP practices form locally into "Primary Care Networks" covering population sizes of between 30,000 – 50,000 although there is no actual upper size limit. This is despite practice closures and huge shortages of GPs nationally and locally. Primary Care Networks (PCNs), formed around communities based on GP registered lists are intended to provide greater collaboration between practices and others in the health and care system. Each PCN will have a Clinical Director and additional funding for a range of staff including clinical pharmacists, physiotherapists, physician associates and first contact community paramedics. Social prescribing link workers will also be funded.

GP practices must submit applications as to how they wish their networks to be configured by 15 May 2019 and by the end of May the CCG is expected to be able to confirm that arrangements that have been set up. Concerns have been expressed that smaller practices may be lost as a consequence and that this development is actually a "top down" requirement driven by the bait of much needed funding. It also begs the question of where the extra staff, an additional 20,000 + by 2023/24, will be found.

REFERRAL MANAGEMENT

Referral management is a process introduced by Enfield CCG to make financial savings by cutting the number of procedures deemed to have limited clinical benefit *(PoLCE).* However, it has also served to ration necessary and highly effective surgical procedures. GPs must refer patients to hospital consultants via a third party panel which will consider their treatment's cost-effectiveness without actually seeing the patient. This could delay surgery until pain is no longer bearable.

Subsequently, all 32 London CCGs have followed suit with a similar programme. Concern has been widely expressed that such profound changes happening at speed should not be implemented until adequate funding is restored, the effects of the proposals are better known and the public have the opportunity to make their views known. The latest list to be produced contains the following procedures:

Procedures of Limited (?) Clinical Effectiveness

Breast reduction (unless related to cancer treatment); Tonsil removal; Haemorrhoids ("piles"); Varicose vein surgery; Cataract surgery; Dupuytren's contracture release; Total hip replacement; Total or partial knee replacement; Carpal tunnel surgery; Knee arthroscopy; Trigger finger release; Ganglion removal; Severe back pain interventions; "Port wine" stains on head and neck; Hernias; Vasectomy only under local anaesthetic; Reversal of sterilisation; Vaginal prolapse; Bunion removal.

SAFETY FOR ALL

Concern has been expressed, quite rightly, about patient safety in the NHS. But what about the staff? The funding squeeze has taken its toll on staffing levels and there is now a shortage of more than 100,000 health workers. As a consequence, those remaining on the front line, loyal staff overworked and underpaid, are in danger of becoming overstressed and fearful that they might make errors in the care of their patients. They are not responsible when more realistically it is likely to be system failures that are to blame, ways of working over which they have no control, rota gaps, inadequate skill mix or lack of supervision. Areas which can potentially undermine job satisfaction and leave them vulnerable to disciplinary action. Areas where management action needs to be taken to ensure that serious incidents and "never events" cannot be repeated in the future.

Consideration is currently being given to the possibility of a conference being held on making the NHS safe for all, including addressing the difficulties faced by whistle-blowers and how they might best be protected.

Crucially, over-arching safety for patients and staff alike, the clear and present danger here is that any implied criticism of the NHS could be seized on as "evidence" that a private provider might do better. Whereas anyone who has studied the accompanying texts to the photographic exhibition "How Come We Didn't Know?", shown in Enfield and more recently at the Houses of Parliament, will know that that is unlikely to be the case.

SOCIAL CARE CONFERENCE

In November 2018, *Health Campaigns Together* hosted a very successful Social Care Conference in Birmingham. Discussion focused on the need for a social care system that gives proper support to the elderly, the disabled, people with long term illnesses, and their carers. Social care should be free to all on the basis of need, properly funded and properly staffed. Staff should be provided with training qualifications, a career structure and decent pay; "informal" carers should receive support and respite care as required. This was a hugely important discussion and a steering group was formed to plan a specific campaign on this issue.

SUBCOs (Wholly Owned Subsidiary Companies)

Some hospital trusts are creating subsidiary companies of their own to which certain services are outsourced and to which former NHS workers may be transferred but without the guarantee of existing terms and conditions of employment remaining the same.

Despite the fact that, nationally, an NHS Improvement notice had been issued which said "Please pause any plans to develop subcos" some trusts were ignoring this advice. They were ignoring the NHSI notice because they wanted to pay much lower wages, less than the living wage. The jobs of people such as porters, cleaners, caterers, security guards and estates and maintenance staff have been most affected. It was anticipated that, subsequently, buildings might also then be transferred into subcos.

UNDERFUNDING

The government is demanding £22 billion of "efficiency savings" by 2020/21. And yet by March 2017 it had spent £17.6 million on consultants' fees for firms such as KPMG, McKinsey and PwC to draw up plans that will lead to the closure or downgrading of NHS hospitals. This, despite the fact that in mid-July 2017 the NHS was ranked the number one health system in a comparison of safety, affordability and efficiency in 11 major countries. And despite the UK spending only 9.1% of GDP on healthcare against the USA's 17.1, the USA with its private healthcare system came bottom.

defendenfieldnhs@gmail.com *04/19.*

FURTHER READING

For those interested in delving a little more deeply into the background of things that are happening in the NHS, there are three books, written from completely different perspectives, that are thoroughly recommended:

"Your Life in My Hands" **by junior doctor Rachel Clarke, publisher Metro;**
"NHS For Sale: Myths, Lies and Deception" **by Davis, Lister and Wrigley, publisher Merlin;**
"How to Dismantle the NHS in 10 Easy Steps - The Blueprint that the Government Does Not Want You to See" **by Dr Youssef El-Gingihy, publisher Zero Books.**