East Midlands Health Committee

UNISON Health Care NEWS

Special bulletin on NHS reorganisation plans: ● SHAs ● PCTs ● Ambulance services

Fighting them on the beaches … UNISON led the charge against the planned changes to PCTs at last year's Labour Party conference in Brighton (right)

Big step backwards for accountability in East Midlands

Mergers and markets: a magical mystery tour

THE PROPOSAL for the merger of two Strategic Health Authorities into a single East Midlands SHA, and the accompanying proposals to merge many of the existing PCTs have been set out in a series of consultation documents.

UNISON is most concerned that these documents are desperately lacking in detail, and that they fail to address the underlying context and framework within which this latest reorganisation of the NHS is taking place.

In fact the process towards mergers of PCTs is being driven by an accelerating national drive towards the fragmentation, privatisation and marketisation of our NHS.

It flows from the controversial circular to all NHS managers last July – 'Commissioning a Patient Led NHS' – which pressed for the separation of PCTs' commissioning role from their direct provision of services.

The call for PCTs to divest themselves of their directly provided services left (and still leaves) unanswered the question of who should take over these services. The private sector? The voluntary sector? Or other sections of the NHS?

With over 250,000 staff working for PCTs, the majority of them in directly-provided services, the issue is an urgent and worrying one. Who would be their employers once the full proposals come into effect, leaving the PCTs acting purely as commissioners, and delivering no services themselves?

UNISON thinks the plans to for a new "super-quango" Strategic Health Authority represent a new step backwards for accountability in the East Midlands NHS.

We believe the mergers of PCTs will bring even less responsiveness to local needs and issues. Here's why.

The Commons Health Committee, in a hard hitting report last December expressed itself "appalled" at the lack of clarity over the future of services provided by PCTs, and unconvinced by ministerial assurances that they were not obliged to hive off services.

Ministers are looking to create an increasingly marketised health care system, embodying a systematic separation of purchaser and provider roles.

The SHA consultation document specifically looks forward to the "creation of a competitive market" as a means to "introduce patient consumerism" and encourage "patient choice".

Making no secret of her agenda, and defending the line of privatisation, Health Secretary Patricia Hewitt went as far as to claim at a press briefing on February 17 that PCT staff were eager to be privatised:

"there was 'widespread enthusiasm' from staff to move out of the NHS and work for the social enterprises invited to bid for primary care provision."

We don't know how Ms Hewitt could have formed such a false impression, but UNISON wants to state categorically that no such sentiment is being expressed by our members whether in PCTs, NHS Trusts or Foundation Trusts.

There have been sufficient disastrous experiences with the private sector in the last 20 years for all NHS staff to fear that it will inevitably lead to a reduction in pay and conditions, reduced staffing levels, and plunging standards.

UNISON has consistently opposed the remodelling of the NHS along market lines. We strongly reject the implicit assumption that the introduction of more private sector providers offers any guarantee of improved quality or reduced costs within the NHS.

Evidence from around the world confirms that far from reducing costs, competitive systems in health care increase transaction costs, requiring more bureaucracy and administration, while private sector providers will also cream off an additional profit from any payments they receive.

UNISON believes that the NHS needs some form of mechanism to make local services accountable to local people, but that while the existing PCTs are far from perfect in this regard, the new, larger, and more remote PCTs threaten to make matters even worse, while offering no compensating improvements.

Privatisation

Fewer, larger, and less accountable PCTs will be more vulnerable to future pressures from above to privatise, hive off or close down services.

But more alarmingly the consultation document also fails to tell us anything about the proposed new giant SHA that will control a combined health economy of more than £4 billion.

The merger into a single East Midlands super-quango appears to represent a further reduction in democracy, accountability and connection with the views and needs of local people.

Ambulance service merger: why we aren't impressed

The document *Configuration of NHS Ambulance Trusts in England* has been issued nationally by the Department of Health at the same time as the wider consultation on SHAs and PCTs.

In our view there is a real danger that a major opportunity to restructure the service in a more radical and helpful way will be missed.

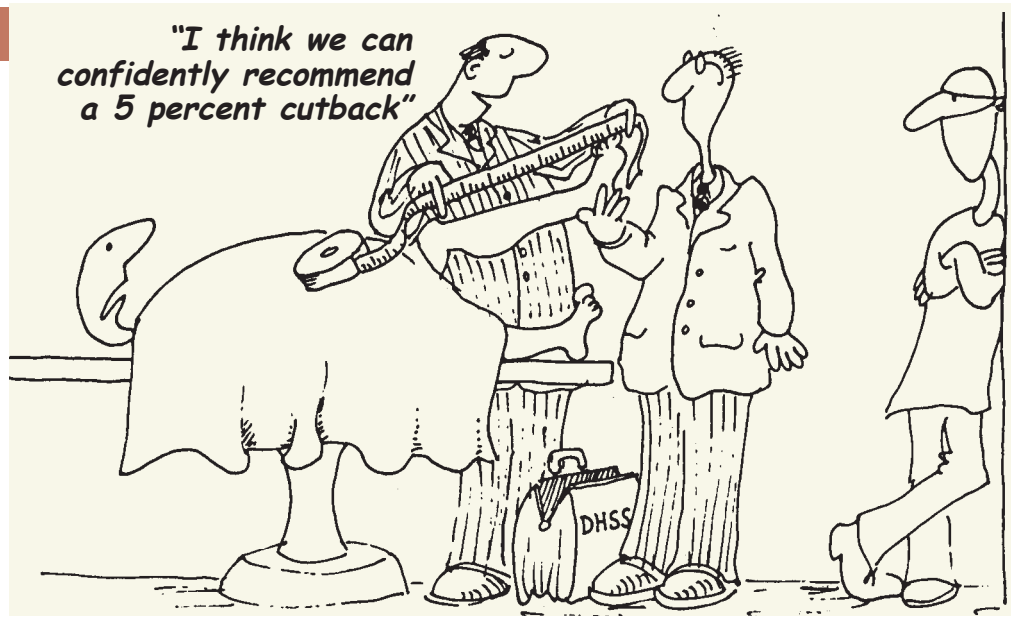
UNISON notes that the consultation proposals centre on a reduction from 31 ambulance trusts in England to 11, which would be largely coterminous with regional government boundaries: this is described as a radical reform, but falls well short of our proposal for a single ambulance service to cover England, Wales, Scotland and Northern Ireland.

Enormous disparities that exist between the levels of training, the skill mix in staffing levels and the equipment and vehicles used in the existing 31 Trusts.

UNISON believes that a single national service could raise the general level of training, offer a wider and more flexible structure for staff, and open the possibility of using standardised equipment that would facilitate emergency planning and avoid any of the communications glitches that were revealed in the events of July 7 2005 in London.

■ See Back Page

Making a bad system even worse



We hold no brief for the existing PCT and SHA structures: UNISON was critical of the thinking behind the continued separation between purchasers (now redesignated as "commissioners") and providers that was embodied in the PCTs when they were set up just a few years ago.

However we do believe that the NHS needs some form of mechanism to make local services accountable to local people, and while the existing PCTs are far from perfect in this regard, the new, larger, and more remote PCTs threaten to make matters even worse, while offering no compensating improvements.

We are also concerned that fewer, larger, and less accountable PCTs will be more vulnerable to future pressures from above to privatise, hive off or close down services.

We note that even during the consultation process itself steps have been taken towards the privatisation of GP services in Derby and in North Derbyshire – with rumours in the medical press that up to 15 percent of GP practices could be hived off in similar fashion to private companies such as United Health Europe or for-profit groups of GPs.

The NHS nationally has also embarked on the disastrous experiment of privatising the delivery of home supplies of oxygen

The current reform process seems set to continue down the road of eliminating any residual element of democratic involvement or accountability, even as it hypes up the deceptive rhetoric on 'patient choice' and 'responsiveness'.

The proposals for a single East Midlands SHA epitomise this process: we are told that there is "a requirement" to make the borders coterminous with the government's East Midlands regional bodies – but not why this is regarded as so important, who has pronounced it to be a "requirement", or what the purpose might be of staging a 'consultation' on an issue in which policy is already so firmly decided in advance, regardless of any public views.

But more alarmingly the consultation document also fails to tell us anything about the proposed new SHA that will control a combined health economy of more than £4 billion, span a population of 4.3 million people and reach from the North Sea coast to the edges of Greater Manchester and from the Humber estuary to Northampton

The document says nothing about:

- How many members will sit on the new SHA,
- How they will be selected,
- On what basis, for how long, or by whom,
- Whether or not there will be any attempt to ensure geographical areas are represented,
- Any means by which this new super-quango might be held to account by the 4.3 million people whose health care services would be in their control.
- We are not even told where the new SHA would be located, or
- What mechanism – if any – would enable people to contact its members, lobby for policies, or protest against policies which are seen to undermine local services or fail to meet local demands.

On all of these grounds alone it seems that the population in this large geographical area are being asked to buy a "Pig in a Poke", and sign what is effectively a blank cheque for privatisation, marketisation and fragmentation of their NHS.

The proposed new SHA will control a combined health economy of more than £4 billion, span a population of 4.3 million people, and reach from the North Sea coast to the edges of Greater Manchester and from the Humber estuary to Northampton – but has no mechanism to make it accountable or scrutinise its decisions

The merger into a single East Midlands super-quango appears to represent a further reduction in democracy, accountability and connection with the views and needs of local people.

To make matters worse, the clear impression is also given that regardless of any response that may be forthcoming the decisions are effectively a fait accompli – making a nonsense of the document's specious claim that "your views will be crucial".

If that really is the case, the SHAs should listen to UNISON and to their thousands of health workers, stop this process and think again about the wisdom of breaking up and privatising the services that our members have worked so hard to develop for patients.

Private eyes on GP budgets

The decisions by NE Derbyshire PCT and by Derby City PCT to make United Health Europe (UHE) the preferred bidder for GP practices in Langwith and Cresswell and in Derby's Normanton practice opens a new chapter in the privatisation of clinical care under a government that once pledged that even in PFI hospitals clinical care would remain within the NHS.

UHE is of course a subsidiary of United Health, a highly profitable £16 billion Minneapolis-based corporation, which is interested not in delivering mundane primary care to deprived Derbyshire pit villages and urban areas, but in tapping in to the multi-billion commissioning budget that will increasingly be controlled by GPs as a result of the current reorganisation.

The questionable process that led to UHE beating a list of 17 rival bidders despite having no staff, no experience and no track record of delivering primary care in this country is forced this very significant change in services into local and national headlines, and has now been made the subject of a judicial review after a successful challenge by a local patient.

The July 28 circular

A prescription for privatisation

The latest round of restructuring and "reforms" flows from a circular last July to NHS managers by then NHS Chief Executive Sir Nigel Crisp, bizarrely entitled "Commissioning a Patient-led NHS".

But though it purported to reshape the way services are commissioned "to reflect patient choices", we know that the last people to have been consulted – or have their views taken into consideration – were patients. Nor were NHS staff asked their views in advance on this new, unwelcome and major upheaval in the structure of the NHS.

Despite Crisp's claim that the reforms are reshaping 'from the bottom upwards', we know that the opposite is the case: the reforms are being relentlessly driven from the top, allowing no time to hear or heed critical views from professionals or the public.

In fact opinion polls and surveys confirm that the first choice of NHS patients is the opposite of government policy: people want continued access to comprehensive local NHS services in the hospitals they know and love.

Most of the public and many staff are also utterly bemused and disorientated by the constant rounds of 'reform' that have stripped away the old local health authorities and recognisable regional health authorities.

Instead they have brought in a confusing and constantly changing system involving Trusts, Primary Care Trusts and Strategic Health Authorities (SHAs).

They have also scrapped the Community Health Councils that once had a brief to stand up for local people, replacing them with a baffling array of toothless and pointless bodies that few people hear about or understand.

The policies set out in Crisp's July 28 circular ' are important because they drive another critical nail in the coffin of an NHS based on principles of planning and social justice.

Instead they open the door still wider to a health care "market" in which healthcare is reduced to a commodity, and NHS providers are forced to compete at every level with the private sector and rival NHS providers, with the losers going to the wall.

This notion of "commissioning" re-emphasises precisely the "purchaser-provider split" which was first controversially introduced to the NHS under Margaret Thatcher's reforms in the early 1990s, and established an 'internal market'.

Despite Crisp's claim that the reforms are reshaping 'from the bottom upwards', we know that the opposite is the case: the reforms are being relentlessly driven from the top, allowing no time to hear or heed critical views from professionals or the public.

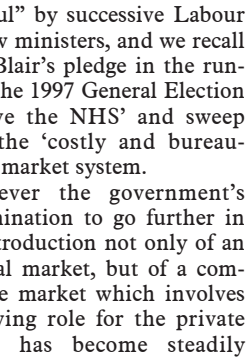
This system was correctly branded as "bureaucratic and wasteful" by successive Labour shadow ministers, and we recall Tony Blair's pledge in the run-up to the 1997 General Election to 'save the NHS' and sweep away the 'costly and bureaucratic' market system.

However the government's determination to go further in the introduction not only of an internal market, but of a competitive market which involves a growing role for the private sector, has become steadily more apparent,.

PCTs, which currently hold the purse strings for most health care services, employ upwards of 250,000 health workers, many of them delivering front line services including community and mental health care.

Crisp's plan would mean that PCTs will have to be broken up, and reduced to commissioning only, with their role in provision of services "reduced to a minimum". It is not at all clear how this will be done: services

Hewitt thinks staff want to be privatised! ... or so she claims



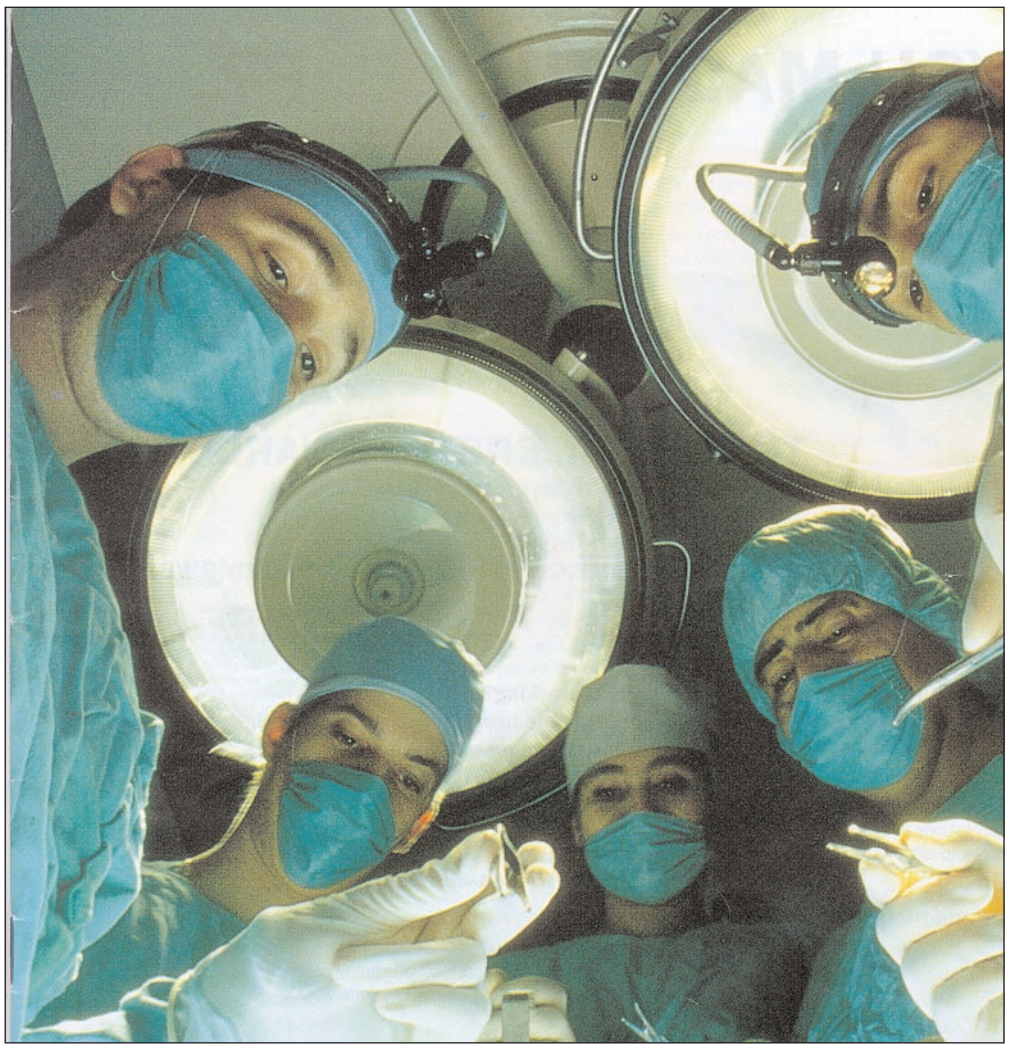
Making no secret of her agenda, and defending the line of privatisation, Health Secretary Patricia Hewitt went as far as to claim at a press briefing on February 17 that PCT staff were eager to be privatised:

"There was 'widespread enthusiasm' from staff to move out of the NHS and work for the social enterprises invited to bid for primary care provision.

"She called for 'unions and professional bodies to start to see it as something which their own members are very interested in, and that there is a need out there to which they should be responding'." (*Health Service Journal*, February 23, p7)

We don't know how Ms Hewitt could have formed such a false impression, but UNISON wants to state categorically that no such sentiment is being expressed by our members whether in PCTs, NHS Trusts or Foundation Trusts.

There have been sufficient disastrous experiences with the private sector in the last 20 years for all NHS staff to fear that it will inevitably lead to a reduction in pay and conditions, reduced staffing levels, and plunging standards.



■ *This special bulletin is a summary of a more extended response which UNISON submitted to the documents on the reforganisation of PCTs and SHAs and on a the merger of Ambulance Trusts.*

■ *It is part of UNISON's campaign to stop the government's drive towards marketisation of the NHS, which is also the subject of a resolution to this year's TUC.*

■ *For more details contact your Branch or regional officer.*

The missing "p" word in Hewitt's new NHS market

may be hived off to existing Trusts, privatised, or handed to the voluntary sector.

PCTs also face the prospect of mergers, on the basis of plans to be drawn up not by patients or health workers but by Strategic Health Authorities, which themselves also face a process of mergers. One of the targets of the new reforms is to cut management and administrative spending by a minimum of 15% (£250 million).

The July 28 circular gave the SHAs less than 3 months to submit proposals – which would then be vetted by the Department of Health, and then put out to "consultation". The changes to PCT boundaries were to apply from October this year: SHA boundary changes from April 2007, and the separation of all services to be completed by April 2008.

This is no local policy tailored to local needs but a rigid national blueprint, driven from the top downwards.

Meanwhile in the same July 28 circular pressure was brought to bear on PCTs to ensure that the commissioning of all contracts for services is transferred to groups of GP practices – so-called 'practice based commissioning' – "no later than the end of 2006".

It's not at all clear that GPs want this additional responsibility.

But the biggest losers are the hospital Trusts, many of which are facing huge problems as a result of long-term deficits, to be compounded by a new system of "payment by results" to be introduced in April.

UNISON also notes that this "payment by results" system is yet another key element of a competitive market in health care designed to maximise private sector involvement and siphon money out of NHS Trusts and Foundation Trusts. Since each hospital will only be paid on the basis of the number of patients it treats, every patient diverted to the private sector takes the cash with them out of the NHS, leaving local Trusts to cope with a reduced budget.

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HSJ sums up Sir Nigel's last set of calculations

The scheme, which has begun on a relatively small scale is due to be rolled out on a generalised basis to cover 60 percent of hospital Trusts' budgets from April – but it is already deep in crisis.

The final weeks of Sir Nigel's tenure as Chief Executive were marked by a shambolic decision by the Department of Health that the basic tariff of reference costs, stipulating how much Trusts will be paid for each item of treatment, had to be withdrawn and rewritten at the last minute – leaving Trusts, PCTs and would-be Foundation Trusts completely in the dark.

The situation has been aptly summed up in a *Health Service Journal* cover headline 'It's a total cock up' (March 2).

However UNISON is concerned that the PBR system itself is part of the same process of fragmentation that underpins the reorganisation proposals.

The destabilisation – and enforced rationalisation – of existing NHS units is another important part of the government plan to create a growing and sustainable private sector, delivering care to the NHS funded from NHS budgets.

We note that among the issues on the agenda for the two senior managers who have stepped into Sir Nigel Crisp's shoes is the establishment of a "failure regime" that will facilitate a fast-track system for the closure of hospitals and services which "fail" in the new competitive market system.

UNISON's opposition to the concept of Foundation Trusts is well known. However the July 28 circular insisted that Trusts must be press-ganged by SHAs down the road of Foundation Trust status, despite the fact that many are carrying deficits which would rule out any serious application to the regulator.

The whole restructuring is designed to cut spending on NHS hospital care, diverting more patients to private providers, and encouraging GPs and PCTs to "free up" cash by developing alternative forms of "care outside of hospital".

This too dovetails with the recent White Paper on the NHS, which proposed a mechanism that would enable PCTs to be compelled to put in-house NHS services out to tender, inviting bids from private sector organisations.

UNISON notes that this is a one-way street towards privatisation: there is no corresponding proposal to enable patients or staff angered at the poor quality of privatised services to force PCTs or Trusts to bring them back in-house.

Excluded from any aspect of the planning or commissioning process, and facing a drastic reduction in income, many hospital Trusts will need to look to hefty cutbacks to prepare for an even tougher year in 2006-7.

Exactly how this could result in a "patient-centred NHS" remains a mystery to all but Sir Nigel and his backroom band of pro-market advisors.

The documents do not discuss any planning or coordinating role either for the enlarged PCTs or for the new super-quango SHA: there is no reference to ensuring access and availability of vital health care services.

UNISON notes that the section on "Protecting staff" consists of just three brief paragraphs at the end of a prolonged exposition of a new system that will put staff jobs and conditions at risk.

The new SHA, the document argues, would seek to

"Expand choice – by introducing patient consumerism through the creation of a competitive market" (page 15)

UNISON does not share this ambition: we do not believe that a competitive market in health care, especially one which offers privileged access for the private sector to a share of the NHS budget, is in the best interest of patients or the long term future of the NHS.

It can only ensure accessibility and availability of services to those patients who need them if it retains its character as a *public* service, *publicly* funded and *publicly* provided.

As part of a package of changes which explicitly seek to subvert that arrangement, UNISON must declare its opposition to the new SHA arrangements in the East Midlands.

We are especially concerned at the lack of any proposals to establish a scrutiny mechanism to enable this huge potential super-quango to be held to account.

The government is planning a massive increase in salaries for Chairmen of strategic health authorities, who work a three-day week £21,882 to as much as £50,000 outside London – a rise of over 100%.

Yet still there is no mechanism to offer any local or democratic voice in the decisions they make or their competence in handling very large budgets, with the potential to affect the healthcare of millions of people.

None of the very limited official NHS watchdog bodies – Patient Forums, PALS or local authority scrutiny committees – would have any jurisdiction over SHAs, and there appears to be no connection or accountability to regional assemblies.

We are fundamentally opposed to giving such huge powers and budgetary discretion over billions in taxpayers' money to organisations with no defined chain of local accountability.

PCTs: fewer … and further from local people

■ The plans involve scaling down from a current profile of 19 PCTs in Trent SHA to as few as three, or a maximum of five.

■ Plans outlined by Leicestershire, Northamptonshire and Rutland SHA involve a reduction from the present nine PCTs to either three or four PCTs, which again implies significant potential management savings – although as with Trent it will still be necessary to sustain and manage the existing PCT services – and this will carry a cost even if they are hived off to the private sector.

A shambolic process provides no answers – even for MPs!

No clarification for six months – now Crisp is toast

The Commons Health Committee, in a hard hitting report last December expressed itself "appalled" at the lack of clarity over the future of services provided by PCTs, and unconvinced by ministerial assurances.

The MPs concluded that

"As far as we can see the overall direction of travel in fact remains unchanged, and PCTs will ultimately divers themselves of provider services" (…)

"We are appalled at the continuing lack of clarity about whether or not PCTs will eventually divest themselves of their provider functions.This announcement was first made at the end of July,together with a firm timetable for its implementation,which was withdrawn in October.

"Various ministerial announcements have failed to clarify the position,and even our witnesses,drawn from the senior ranks of the NHS, could not agree about whether or not these changes would eventually happen,with many appearing genuinely bewildered.

"As far as we can see,the overall direction of travel in fact remains unchanged, and PCTs will ultimately divest themselves of provider services. We urge the Government to either confirm or deny this immediately.

"We are deeply concerned that neither Lord Warner nor John Bacon were able to give us a confident assurance that NHS staff potentially affected by these changes would be able to retain their NHS pensions. The Government must provide clear information as to whether existing NHS staff who are transferred to other providers, particularly in the private sector, as a result of these changes will be able to retain their NHS pensions."

(*Changes to Primary Care Trusts*, December 15 2005; paras 35, 46, 47)

Don't face the reorganisation alone! join UNISON

Ambulance service is being driven the wrong way

UNISON is concerned that proposals for a major reorganisation of ambulance services across England, which flow from a different process of discussion and raise very different issues, have been submitted for consultation at the same time as the general, unrelated consultation on PCTs and SHAs.

In our view this serves to detract from proper discussion of the ambulance service changes and there is a real danger that a major opportunity to restructure the service in a more radical and helpful way will be missed.

The consultation proposals set out in the document Configuration of NHS Ambulance Trusts in England centre on a reduction from 31 ambulance trusts in England to 11, which would be largely coterminous with regional government boundaries.

This is described as a radical reform, but falls well short of our proposal for a single ambulance service to cover England, Wales, Scotland and Northern Ireland, which UNISON has proposed.

All of the projected efficiency gains and economies of scale that could be achieved by reducing the number of trusts could be enhanced with a single UK-wide ambulance Trusts, but additional benefits would also be available.

A single trust would achieve maximum purchasing power with its suppliers, and facilitate

a rapid move towards the use of standardised equipment that would ensure the greatest flexibility and responsiveness in routine and extraordinary events.

UNISON is aware that some Trusts are using unqualified staff to drive blue light ambulances, and the standard of one paramedic per vehicle has also been dropped.

UNISON also notes with concern that Fire Brigade staff are being pressed into taking over ambulance calls in Retford, despite their lack of adequate training for many ambulance duties.

UNISON believes that a single national service could raise the general level of training, offer a wider and more flexible structure for staff, and open the possibility of using standardised equipment that would facilitate emergency planning and avoid any of the communications glitches that were revealed in the events of July 7 2005 in London.

We also note the misleading claim in the consultation document that the merger to 11 Trusts would bring "more opportunities for staff" – when it is clear that some sections of staff could see their jobs disappear.

Clearly the best prospect for improving staff opportunities would be the establishment of an integrated national service, working to similar specifications and with resources allocated on the basis of local needs.

■ The new ambulance Trusts will have very definite borders, making way for a series of problem areas where traditionally different ambulance services have shared the responsibility or assisted each other.

Grimsby and Scunthorpe, for example, currently covered by Lincolnshire ambulances is to be handed over to a new trust covering Yorkshire: but there will be no responsibility to help out across the new boundaries, and the new system will have an impact on Louth.

This would not occur if there were a single ambulance service.

■ We are promised "increased investment in new technologies", when we know that one of the biggest problems is the lack of standardisation of communications equipment, vehicles and other basic kit.

■ The new Trusts would ensure spread of "good practice": however some would almost inevitably cling on to bad practice inherited from existing local managements and systems. A national system, with training and organisation arranged in consultation with the unions could ensure a systematic effort to raise standards throughout the entire national service.

■ The consultation document implies that some of the "property rights and liabilities" of the existing ambulance trusts might be stripped out in the process of merger, since they would be "transferred, for the most part," into the new Trusts. We want a guarantee that there will be no asset-stripping of ambulance services, and that all existing assets are retained within the service.

■ As with the reorganisation of SHAs and PCTs UNISON is concerned that fewer boards covering larger population is a formula for reduced levels of accountability and that there are no proposed mechanisms to ensure that the 11 new Trusts are in any way responsive or sensitive to local needs, demands and pressures.

The plans also lack any system for the scrutiny of the decisions and policies of the new ambulance trusts.

■ Indeed the entire document significantly fails to address the growing pressure on ambulance crews to deliver a cheap and cheerful "treat and go" version of community care.

UNISON is concerned that in some cases these contracts reflect the pressures of acute Trusts seeking to reduce emergency admissions at all costs, and that there is the danger that some patients with a legitimate need for hospital treatment may effectively be kept out and denied a bed.

■ Missing from most of the document, and banished to a footnote, is the issue of Patient Transport Services, which successive governments have worked to privatise and to separate from the emergency service.

However in some areas PTS contracts help fund the core of ambulance services, and the vehicles together with their trained and experienced crews offer a useful back-up for emergencies involving large numbers of casualties.

■ UNISON believes that PTS services face an even bigger threat of privatisation if they are merged into larger units within bigger and less accountable Trusts, with organisations like Group 4 waiting in the wings.
We also note that any move to privatise PTS services effectively destroys any possibility of career progression for staff who begin in the PTS but seek to develop their skills and qualifications and transfer to the emergency service.

■ UNISON reiterates its opposition to Foundation Trusts, in practice and in principle, and notes that Foundation Trusts are more prone to financial difficulties and less likely to be able to identify support from within the NHS to preserve services.

In East Midlands, experience with Foundation Trusts so far in the region has brought only industrial relations problems, a lack of information, and a growing separation from the wider health community.

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£96.17–£153.84	☐	£5,001–£8,000	£1.22	£5.30	C
£153.85–£211.53	☐	£8,001–£11,000	£1.52	£6.60	D
£211.54–£269.23	☐	£11,001–£14,000	£1.81	£7.85	E
£269.24–£326.92	☐	£14,001–£17,000	£2.24	£9.70	F
£326.93–£384.61	☐	£17,001–£20,000	£2.65	£11.50	G
£384.62–£480.76	☐	£20,001–£25,000	£3.23	£14.00	H
£480.77–£576.92	☐	£25,001–£30,000	£3.98	£17.25	I
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