Hertfordshire

Health services BACK TO THE FUTURE?

A response to the consultation document 'Delivering Quality Health Care for Hertfordshire' on behalf of UNISON Hertfordshire health branches, and UNISON Eastern Region.

Submitted by UNISON **Hertfordshire Health branches and UNISON Eastern Region** as part of the formal consultation procedure, September 2007

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UNISON's response to Consultation Questions

(on behalf of UNISON Hertfordshire health branches and UNISON Eastern Region)

(See also attached document 'Back to the Future?' for UNISON's detailed response to the plans outlined in the consultation document 'Delivering Quality Health Care for Hertfordshire', and in particular for a discussion of issues not addressed by the consultation document, the questions below or the 'Business Case'.)

QUESTION 1

With respect to the proposed consolidation of acute hospital services in east and north Hertfordshire on to a single site which of the following options do you prefer?

- **OPTION A: Consolidation of emergency and acute hospital services in east and north Hertfordshire at the Lister Hospital site in Stevenage (with the QEII site in Welwyn Garden City providing local general hospital services).**
- **OPTION B: Consolidation of emergency and acute hospital services in east and north Hertfordshire at the QEII Hospital site in Welwyn Garden City (with the Lister site in Stevenage providing local general hospital services).**

UNISON rejects *both* options, since each involves a 20% reduction in hospital beds and worsened access to front-line hospital services for many of the county's residents. The proposals are cash-driven and do not correspond with the latest authoritative clinical evidence. The PCTs have been unable to demonstrate significant public support for the proposals, and UNISON, representing over 7,000 health workers in Hertfordshire, is firmly opposed to the cutbacks.

QUESTION 2

Why do you favour your chosen option from question 1?

See response above: UNISON remains convinced that all four general hospitals in Hertfordshire are vital in securing sufficient capacity to meet the health needs of Hertfordshire's growing 1-million population. The case for closures and downsizing has not been proven.

QUESTION 3

What non-acute services do you think should be provided on the local general hospital sites? Please write your proposals below.

UNISON does not support the model of “local general hospitals” as set out in the consultation document: these are not “hospitals” in the conventional sense of the term, since they lack any in-patient beds, and operate simply as large out-patient clinics.
Instead we support the existing model of four general hospitals working together to deliver a full range of acute and non-acute services, until such time as adequate investment is available to fund a new hospital of sufficient size to meet the county’s health needs.
We note the recent report from the medical Royal Colleges which weighs the evidence and comes to broadly similar conclusions, arguing that the case for centralization of acute services (the essential premise for the creation of local general hospitals) is based on little if any evidence.

QUESTION 4

We are proposing to develop seven urgent care centres in Hertfordshire. Two at the main acute hospitals, two at the local general hospital sites and two at St Albans City Hospital and Herts and Essex Hospital in Bishop’s Stortford.
Do you think the seventh urgent care centre should be located at Cheshunt Community Hospital or at Hertford County Hospital?

If additional resources are available to expand minor injuries services we are quite happy to see the new centres established, but only if the issues of adequate staffing, and training of nursing and other professional staff can be resolved. These are not addressed in any way in the consultation document or “Business Case”.

QUESTION 5

Do you have any comments on the proposal to establish seven urgent care centres in Hertfordshire? If so please write them in the box below.
UNISON is not convinced that urgent care centres represent an effective or efficient model of care, or that they can ever offer value for money in comparison to a system of triage and the location of 24-hour primary care services in or close to the main A&E sites. We agree with Welwyn Hatfield Council that any new facilities along these lines would need to be up and running before any other services could reasonably be closed.

QUESTION 6

Do you agree children’s emergency care and children’s planned surgery should be consolidated together at Watford General Hospital?

No. UNISON favours retention of the full range of acute hospital services at Hemel Hempstead.

QUESTION 7

If you do not agree that children's emergency care and children's planned surgery should be consolidated together at Watford General Hospital, do you have any alternative proposals that would be equally safe and sustainable? If so please write them below.

UNISON favours retention of the full range of acute hospital services at Hemel Hempstead.

QUESTION 8

It is proposed that in west Hertfordshire NHS planned surgery should be consolidated at either Hemel Hempstead or St Albans. Which of the following options do you prefer?

- **OPTION A: Establish planned surgery services in west Hertfordshire at Hemel Hempstead Hospital.**
- **OPTION B: Establish planned surgery services in west Hertfordshire at St Albans Hospital**

Option A

QUESTION 9

Why do you favour your chosen option from question 8?

UNISON favours the location of NHS treatment centres on general hospital sites, where they can benefit from other support services, so our preference would be for the new centre to be located at Hemel Hempstead.

UNISON's Key questions on Hertfordshire consultation

1) If the reconfiguration is not, as UNISON believes, cash-driven, why is the consultation being pushed through NOW, before the findings of East of England SHA's Looking to the Future and before Darzi's review of England's NHS? Why not a decent delay to allow these issues (and the likely changes in north London re Barnet and Chase Farm) to be resolved first?

2) How can the plans be taken seriously when they take no account AT ALL of the transport and travel difficulties of patients and visitors accessing just two main hospital sites for Hertfordshire?

- Where are the travel surveys?
- Where are the data on car ownership and access to private transport, especially for the elderly, low income groups, single parents and those with long-term illness and mobility problems?
- Where is the consultation/research that shows patients would accept and can cope with the longer journeys?

3) Where are the plans for expanded community services that are supposed to lift the burden from A&E?

- HOW MANY staff would be recruited?
- how would they be organised?
- where will they be based?
- and how much will it cost?
- What training arrangements are being put in place for this new model of care?

4) HOW will an increasing number of emergency admissions (NB increasing population in Herts) be treated in 20% FEWER beds?

5) How will the hospital Trusts remain viable under Payment By Results if a large amount of their outpatient work is hived off to primary care? How does this scattering of services make organisational or financial sense, given the waste of consultant time travelling between numerous small clinics?

6) Why have no lessons been learned from the expensive experiment with Minor Injury Units in the 1990s, which proved to be high cost and ineffective ways of diverting a minority of less seriously ill patients away from A&E?

7) What are the implications in terms of jobs, skill mix, relocation and training for the existing Hertfordshire NHS workforce? Why are no numbers of staff discussed?

8) Why do Hertfordshire Trusts and PCTs not support UNISON's call for a fair share of NHS funds for Eastern Region and for Hertfordshire, which would wipe out the deficits and offer funds for improving services?

Hertfordshire's health services: BACK TO THE FUTURE?

A response to 'Delivering Quality Health Care for Hertfordshire' on behalf of UNISON Hertfordshire health branches and UNISON Eastern Region.

Overview

The consultation document 'Delivering Quality Health Care for Hertfordshire' was issued on June 12, although some of the supporting information was not published until later, and some information requested by local interest groups such as Welwyn Hatfield Borough Council still has not been made available as the consultation ends on October 1.

Some questions have been rebuffed with the response that the requested details were not available, and would require significant management time to prepare answers. This clearly undermines the claim that the "Business Case" is in fact a serious and comprehensive document, and underlines UNISON's concern that this consultation process has taken place without access to many of the relevant facts, on the basis of vague and speculative proposals. Hertfordshire's public is being offered a pig in a poke, and a misleading set of "options" which deliberately exclude the retention of existing levels of service, and seek to compel people to 'choose' between unacceptable cutbacks.

The documents sets out plans to reconfigure health services across the county, reducing the provision of A&E and acute hospital services from the current four district general hospitals (Watford, Hemel Hempstead, QEII in Welwyn, and Lister Hospital in Stevenage) to just two (Watford and either Lister or QEII, although the document explicitly favours the Lister). This reorganisation would result in 20% fewer beds overall for a county where the 1 million population is projected to grow rapidly by around 10%, and where bed occupancy is already at or close to 95%.

Back to the Future?

The plans, which are based on the argument that acute services should be centralised to improve outcomes, are based on controversial assumptions with little evidence to support them, and were published before the extensive 150-page report *Acute health care services* from the Academy of Medical Royal Colleges (September 2007) which draws the opposite conclusion:

> "There is some hard evidence that outcome for a select group of patients is improved in specialist centres where surgeons can maintain their specialist skills by treating a greater number of people. People who have experienced major trauma and those requiring specialist neurosurgery and vascular care do fare better if they are treated in specialist units.
> **"However, there is conflicting evidence that specialist centres are beneficial for other kinds of surgery. At this stage, any decision to withdraw 24-hour surgical cover from some hospitals in favour of centralisation is not supported by current clinical evidence.**
> […]
> "The Royal College of Surgeons considers that care must be delivered as locally as possible providing there is no compromise on the safety and quality of that care. Our March 2006 report Delivering High Quality Surgical Services for the Future 75 outlined what we believe to be the three main drivers for reconfiguration:
> - clinical need (for example, the need to reconfigure specialised services such as paediatric cardiac surgery, or the need to reconfigure services in smaller hospitals);
> - the introduction of contestability and competition in the health service; and
> - the cost of providing services.
>
> **"The RCS insists that any reorganisation of health services has a sound clinical and evidence base. Financial, political and managerial expediency must not be primary drivers for service reorganisation."**
>
> **(3.11, A71, emphasis added)**

In the light of these authoritative findings by leading clinical researchers, UNISON calls upon Hertfordshire's PCTs to reconsider their proposals and open a fresh consultation.

The consultation document also makes additional proposals for the establishment of "local general hospitals" which would provide largely out-patient and day-case services, along with "urgent care centres" which would amount to minor injury units. There are also plans for the reorganisation of out-patient and diagnostic services across the county. The document proposes two new elective treatment "surgicentres", one (subject to the consultation) to be based in West Hertfordshire (Hemel Hempstead or St Albans) and delivered by the NHS – after the private provision proved not to represent value for money – the other (which has been excluded from the consultation) to be located on the Lister Hospital site and delivered by a for-profit private sector provider (Clinicenta).

Missing from the main consultation document is any discussion of transport and access issues (a separate report was subsequently published, which addresses few of

the concerns that have been raised). Significantly there is also no discussion of cancer services, which are currently provided from Mount Vernon Hospital in NW London, where services are currently also subject to a major review.

UNISON is opposed to this style of piecemeal and blinkered consultation which ignores problems and issues in adjacent areas which can prove decisive for the viability of local services.

The London-wide review of hospital services is discussing proposals including the possible relocation of Mount Vernon services to central London – and it would seem relevant for Hertfordshire's PCTs to open up a serious debate on the implications for the county's population and the possible alternatives that may have to be established: this in turn would logically link to the discussion on reconfiguration of Hertfordshire's main hospital services. Instead the process has been fragmented.

Context: why the rush?

The Hertfordshire consultation document appeared just a month before headlines were grabbed nationally and throughout London by Professor Ara Darzi's controversial report on restructuring health services in the capital. Lord Darzi has since been brought in to Gordon Brown's government as a junior minister, and invited to conduct a similar, high-profile review of the NHS in England as a whole.

Many of the themes Prof Darzi addressed in the London review are very similar to those in the Hertfordshire document, in particular the current fads for downsizing district general hospitals into "local hospitals" and restricting the number of "major acute" hospitals. Both of these are already central to the Hertfordshire proposals – even though this type of proposal is far from new. (In Hertfordshire a succession of Health Authorities, Health Agencies and now PCTs have been hatching up similar plans to scale down hospital care since at least the mid 1990s, despite the evident lack of any public support or confidence in the proposals and a complete lack of evidence to support claims of their effectiveness.)

However UNISON is concerned to note that the Hertfordshire consultation appears to be forging relentlessly ahead towards far-reaching conclusions, closing the consultation on October 1 despite the fact that the Darzi review is ongoing across the NHS in England, and another over-arching review process covering Hertfordshire is also under way – the *Looking to the Future* project being conducted by NHS East of England, with a number of specific work-streams yet to report their findings.

If either of these wide-reaching reviews is to be more than a cosmetic exercise, it would seem to make good sense for the Hertfordshire process to be put on the back burner until any conclusive findings have been drawn up: if not, we may find that decisions taken locally in this consultation effectively pre-empt other proposals that may emerge.

In this same context UNISON notes that NHS London, in launching an extensive and well-funded discussion process around the Darzi Report, has proposed a consultation process to run from November 2007 to February 2008, and has urged that more

localised consultations and service reconfiguration should only proceed on a more rapid timetable if there is some form of urgent and pressing need for action (NHS London Board Papers, August 2007). We would argue that a similar call should have been issued by the East of England SHA to delay the process in Hertfordshire, and that Hertfordshire PCTs should in any case have regard to these wider processes.

Nevertheless it is also the case that a consultation process in Barnet and Enfield which offers just two options – either of which would close emergency services and possibly even more acute services at Chase Farm Hospital – has been launched in June, and is running in parallel with the Hertfordshire consultation, despite the fact that again there could be a knock-on impact between the two proposals for rationalising hospital services. It seems very likely that the closure of services at Chase Farm will substantially increase the pressure on the small and inconveniently-sited Barnet General Hospital at the very point where the proposed closure of acute services at QEII would also substantially increase the flow of Hertfordshire patients to Barnet – resulting in a potential shortage of beds, staff and services.

UNISON therefore registers the formal call for the consultation in Hertfordshire to be extended at least until the end of the year, by which point the Looking to the Future review and its workstreams should be complete, and some feedback may be available on the direction of the Darzi review.

However UNISON notes that however much sense it may make, the main obstacle to allowing any further time for discussion is that the Hertfordshire exercise, like the underlying drive for similar downsizing and hospital rationalisation in London, in Sussex, Surrey, Kent, and other areas, is essentially ***cash-driven***. The "clinical" arguments – contentious as they are – have been added as a cosmetic diversion from an overall reduction in health services. In the case of Hertfordshire, the most recent NHS financial returns at the time of the consultation show the scale of the problem:

Hertfordshire NHS finances, Quarter 4 2006-7 (DoH June 2007)				
	2005-6 surplus /(deficit) £000s	**2006-7 provisional surplus /(deficit) £000s**	**2006-7 provisional turnover £000s**	**2006-7 provisional out turn (surplus/ (deficit) as % turnover)**
East & North Herts PCT	**(12,501)**	**(23,625)**	577,378	**(4.1%)**
East & North Herts Trust	**(22,379)**	**(1,527)**	270,257	**(0.6%)**
Hertfordshire Partnership	10	546	174,252	0.3%
West Herts PCT	**(24,550)**	**(26,637)**	584,055	**(4.6%)**
West Herts Trust	**(26,785)**	**(11,413)**	219,562	**(5.2%)**
Herts totals	**(86,205)**	**(62,656)**	**1,825,504**	**(3.4%)**

With only the Partnership Trust breaking even last year, and the prospect of much less generous funding from the Treasury from 2008, there is clearly pressure on the PCTs to find ways to cut back on hospital budgets. We note that the most recent Financial Report from East & North Herts PCT is now projecting "a 'risk adjusted' projected year end figure of between £376k and £5,206k overspend." (26 September), while the West Herts PCT is also projecting a 'risk adjusted' overspend of £1m-£5.9m

(September papers). According to the Business Case, the two hospital Trusts, too, see the reconfiguration of services as a way to reduce spending and clear cumulative debts, with West Herts Hospitals explicitly aiming at savings of over £8m a year.

It is therefore no surprise to find that the consultation looks to reduce numbers of hospital beds, while also seeking to scale down plans for capital investment in new hospital facilities. Most notably health chiefs have scrapped plans for a new hospital to be built in Hatfield, primarily on cost grounds – arguing that the £424m headline costs, to be funded through the controversial and costly Private Finance Initiative, would infringe new spending guidance from the Department of Health.

UNISON has always opposed the use of PFI as the mechanism to fund new hospitals and public sector investment, and has had serious concerns that the planned new hospital – as with so many PFI hospitals – would not be large enough and would raise problems of access for some sections of Hertfordshire's rising population. We have challenged the inflated costs of PFI as a funding arrangement, and noted the consequent problems of affordability and the loss of beds and pressure on community services where PFI hospitals have been built.

However UNISON has always supported the need for public investment in new hospital facilities, and we share the local anger at the abandonment of a long-standing promise of a new hospital, especially in the absence of adequate capital funds to upgrade the existing hospital buildings where required. We echo the concerns raised by Welwyn Hatfield Borough Council on the inadequate way in which the decision to scrap this scheme has been explained, and the lack of transparency on the medium and long term costs involved, with key data still not published.

Unfair shares

Even without the promised PFI hospital the plans for Hertfordshire still involve a drastic (20%) reduction in acute hospital beds (see detailed figures below). This plan to further reduce hospital capacity in the county comes on top of a historic under-provision.

Hertfordshire's one million population is just on 2% of the total population of England: but Hertfordshire's two hospital Trusts have far fewer than 2% of the England total of acute and general and acute beds (1.3% of the English total and 1.4% respectively): indeed if mental health is included, Hertfordshire has just 1.1% of the English total of beds to deliver health care to its population. However the county's age profile more or less exactly fits the national average, with 15% of the population aged over 65 in 2001, and just over 7% in the more dependent 75+ age group.

The plans in the main consultation document are so vague it is hard to know exactly how many beds are planned for the new system: only the Business Plan carries detailed projections showing a near 20% cutback in acute beds in East & North Herts – to just 618 – if the Lister site is selected as proposed. It seems a similar reduction is planned for West Herts. Whatever the precise numbers, it is clear from repeated statements that the proposed 2-hospital set-up is intended to have fewer beds than are currently available.

To make matters worse, Hertfordshire – like much of the East of England SHA – also receives significantly less than the English average allocation of NHS budget per head: in fact both Hertfordshire PCTs have been receiving even less than the East of England average.

With a population of over 1 million, the sums of money add up: if Hertfordshire even received the East of England average allocation of cash per head, the two PCTs would gain enough to push them both well into balance.

UNISON has already calculated that the SHA as a whole received substantially below England-average funding, and was short-changed to the tune of £550 million last year. That's more than enough to wipe out all of the deficits and pay for new hospitals in Hertfordshire and elsewhere: now it seems that this long-term policy of cash starvation is set to trigger a new round of hospital cutbacks.

Not only are the hospital plans being further downsized to restrict spending, but there is very little serious explanation, or attempt to calculate the costs, of the alternative pattern of services which the consultation document assumes would be put in place:

> "Other services currently provided in hospitals, could and should be provided in community settings" (page 7 and passim)

Obviously such a switch in responsibilities would require the active engagement and commitment of GPs and other professional staff to ensure it was carried through and that patients were not disadvantaged. We see nothing in this consultation to convince us that Hertfordshire GPs and community health teams are ready, willing or equipped to take on this additional work. Nor is there any evidence that patients, whose "choice" is supposed to be so important to the planning of health services, want the type of changes proposed in the document, especially if it involves the loss of well-loved general hospitals and a net reduction in services.

Silences that speak volumes

UNISON also notes that the document makes no reference to the cost and practical issues involved in recruiting and training suitably qualified staff to run the new and increasingly complex range of services which it proposes should be delivered to patients at home or in new, local settings. Yet without staff none of these services will be viable.

UNISON would further argue that any services that are not costed in detail or linked to any concrete plan for implementation are unlikely to get even as far as the drawing board. Our questions centre on the lack of basic information: HOW MANY additional medical, nursing, and other professional and support staff would be required to deliver the services? On what grades? WHERE would they be located? What resources would they have available? What range of services would they provide? How would they be funded and managed? **And how do these plans correspond with the drastic reduction imposed on training budgets, and claims that there are already too many doctors in training?**

Indeed so vague are the proposals that we question how serious some of them really are: it seems they have been included purely as a means to make the downsizing of existing services slightly less unpalatable to local people.

Despite this window-dressing, the document more or less concedes that there is little if any popular support for its proposals. That is no surprise. There is very little on offer to attract local people fearful of longer journeys to a reduced provision of hospital services at the point they most need health care.

Indeed while a whole range of vital services remain at the level of abstraction and platitudes in the consultation document, the elephant in the room, which is nowhere discussed or addressed, is the logistical nightmare of peak time travel across Hertfordshire.

Astonishingly, especially given Hertfordshire's experience of more than a decade of angry protests by local people rejecting previous plans to axe local hospital services, the 48-page document does not devote any space at all to the issues of travel times or access. It ignores the increased distances that will face thousands of patients and their visitors who would be forced to travel to the planned centralised services in Watford and Stevenage. The document does not discuss public transport options, travel times or the issues to be faced by the many older and low-income families who do not have access to a car.

Even the *Transport and Access Supporting Paper* published by the two PCTs as part of the consultation does not address the hard questions of some of the county's poorest and most vulnerable residents – who are often also those with greatest health needs – being faced with long and awkward additional journeys to access treatment. The high levels of car ownership in the county as a whole tend to make it even less likely that satisfactory public transport alternatives will be put in place or prove viable in the long term.

UNISON is concerned to see so many crucial issues have been dodged or omitted, and so little detail offered on how the proposed alternative pattern of services would be financed or provided.

We also note that under the system of "payment by results" NHS hospital Trusts receive income – according to a fixed national tariff – only for those patients they treat. The PCTs' proposals to divert thousands of patients to alternative forms of treatment will therefore dramatically reduce the budget for both of the acute hospital Trusts, worsening their financial situation after years of long-running deficits.

Worse: the reduced hospital capacity and the reduced accessibility of the new profile of services will divert thousands of Hertfordshire patients – and the resources to pay for treatment and facilities – to hospitals outside the county, weakening Hertfordshire's own NHS services.

Again, payment by results means that every patient diverted in this way would take the funding with them – and both of Hertfordshire's hospital Trusts are set to suffer a fresh haemorrhage of resources. According to the *Transport and Access* paper, the

closure of acute services at Hemel Hempstead would result in the loss of no less than 42% of that hospital's current caseload (and income) to Trusts outside Hertfordshire – 28% to Luton & Dunstable, and 14% to Stoke Mandeville in Buckinghamshire (page 11). This will be a very serious financial blow to the already struggling West Herts Hospitals Trust.

In East and North Herts, the *Transport & Access* document projects a 13% loss of caseload and income to Addenbrookes, Luton & Dunstable and Princess Alexandra Hospitals if services at the Lister Hospital were closed, whereas the closure of the QEII would trigger a projected 24% loss of caseload and revenue to Barnet (16%) Princess Alexandra (7%) and Luton & Dunstable (1%).

The implications for Barnet are doubly worrying, since not only are Hertfordshire's services undermined, but there is no guarantee that the small cash-strapped Barnet General will be able to handle the additional influx of large numbers of patients displaced from both QEII and Chase Farm: according to the Business Case at least half of the Hertfordshire caseload arriving at Barnet General would be "non-elective", i.e. emergency cases.

The combined result could be between a doubling and a four-fold increase in numbers of Hertfordshire patients requiring treatment at Barnet General[1], in addition to the Enfield residents forced to make the awkward journey to Barnet, and a massive increase in pressure on front-line beds for the emergency admissions. These patients would bring revenue funding with them under payment by results, but none of the capital required to expand the hospital on the scale necessary.

Not only are the finances of Hertfordshire's hospitals undermined by these proposals, but there is no evidence presented that the new system would be any more efficient or cost-effective: nor despite all the empty rhetoric about 'patient choice' is there any evidence that patients and the wider public in Hertfordshire have been convinced that these changes represent a step forward rather than back.

UNISON is alarmed that these implications are not seriously addressed in the consultation document: the tough financial regime in today's NHS "market" means that any miscalculation on this front could result in one or even both of the county's hospital Trusts facing serious problems of financial viability. The end result could be a forced merger, or just one of the two Trusts surviving this high-risk surgery, leaving tens of thousands of patients facing even longer journeys for care and queues for treatment.

This really could potentially put lives at risk – but would also jeopardise the jobs and livelihood of hundreds or even thousands of Hertfordshire health workers.

[1] Up from 4% now plus Chase Farm, to a total of over 16% once Chase Farm closes

THE CENTRAL CONCEPTS: BACK TO THE FUTURE?

Although the proposals are floated in the current consultation document as if they are brand new, state of the art "modernisation", for anyone with a memory lasting 12 years or more they bring a distinct sensation of déjà vu.

Back in 1995 the then Hertfordshire Health Agency set out very similar plans in a document entitled ***"Where do we want to be?"*** It focused heavily on switching patients from reliance on A&E units to primary care, but with no clear or detailed plans on how an additional £12-£16m would be spent on primary care services. Using language which is the direct precursor to today's consultation document (and the Darzi report) it announced that:

> "The blueprint for district general hospitals is now thirty years old, and more recent studies … are identifying different roles for the hospitals of the future. "With the strengthening of primary care and the implementation of community care programmes, much of the traditional work of the district general hospital will move out to the community and thus be more accessible for patients. Acute hospital services will be concentrated onto fewer sites …"
>
> ("Where do we want to be?" page 8)

The same consultation document attempted to reduce services to "fewer, bigger" A&E units, while diverting "inappropriate" cases elsewhere: it went on to outline plans for "Minor Injury Units" – highly reminiscent of today's plans for "Urgent care centres" – which the Health Agency then claimed could handle 50% of cases attending A&E.

In the event, the unit costs of MIUs proved to be much higher than A&E, and many of the new facilities that were built on that basis in the 1990s – as a means to close down A&E units – have subsequently closed themselves, or seen their opening hours cut back.

The Health Agency in 1995 even proposed (in the vaguest possible terms) a "trauma unit", a suggestion that proved an expensive and inefficient flop in a pilot study in Staffordshire, and sank without trace in the 1990s.

Only recently has the idea once more been dusted off and wheeled out in the Darzi report on London, despite the lack of evidence that it would significantly improve outcomes for most patients – and despite the chronic underfunding of the existing trauma unit at the Royal London Hospital, whose vital Air Ambulance service is only partially funded by the NHS and relies heavily on charitable tin shaking to keep it in the air.

Nonetheless we can expect to see a revived call for Trauma centres flagged up in Hertfordshire and around the country in coming months as health chiefs struggle to convince local people of a clinical case for unpopular closures.

Back to the Future?

The 1995 Health Agency plans incurred the unanimous opposition of all ten district councils in Hertfordshire. The councils waged a battle, backed by local residents, to maintain district general hospital services at The Lister, QEII, Hemel Hempstead and Watford. Their success means that we still have those services today.

The ten councils jointly commissioned a detailed response, which challenged many of the core assumptions made by the Health Agency: it pointed out that despite well-resourced experiments, no Trust or health authority had then come close to switching even half of the attendances away from A&E to Minor Injuries Units.

The councils also argued that the focus on this aspect of the work of A&E was distracting time and energy from the need to improve services to the minority with the most serious health needs who attend A&E and require hospital admission and treatment. This is also clearly the case in today's proposals.

We believe the same weaknesses undermine the consultation document proposals twelve years later, and it is regrettable that no similar stance has been taken by the same councils today in response to a revamped plan with similar implications for their residents. However UNISON notes and endorses many of the strong criticisms of the proposals put forward in the cross-party response from Welwyn Hatfield Borough Council. Among the key criticisms which we support are:

- The critique of the consultation proposal's failure to address transport issues (page 3)
- The concerns raised over the viability of the proposed changes to maternity services and emphasis on home births if acute hospital services providing vital back-up are to be a greater distance away. (page 4)
- The criticism of the limited range of services which the consultation proposes should be available from the new "local general hospitals" (page 5)
- The demand that elective surgery, ante and post-natal care and midwifery services should be available at local general hospitals (page 5)
- The insistence that the proposed urgent care centres should be built, up and running before anything is closed, and that the purpose and function of these centres has to be clearly defined and explained to the public if they are to be effective (page 6).

UNISON also endorses much of the Welwyn Hatfield Appendix, which discusses further on issues that do NOT appear in the consultation document, in particular:

- criticism of the document's failure to identify and address the need for future capital investment after the proposed refurbishment of the Lister and/or QEII hospitals, and the "suspiciously low" estimate of the costs of rebuilding the Lister, which had previously been estimated as high as £200 million.
- the failure to consult on the plan to establish a privately-run surgicentre, when an NHS-run unit has been found to represent better value in West Herts, and to locate this on the Lister site despite the fact that the original proposal was for a centre located away from the main acute hospital (page 11).
- The exclusion of cancer services from the Hertfordshire review which Welwyn Hatfield describes as "at best disingenuous, at worst negligent" (page 11).
- Serious questions raised over the ability of East of England Ambulance services to maintain national standards of emergency cover given the greater

journey times if services are centralised at the Lister, citing an Ambulance Trust spokesperson admitting that the longer journeys to Stevenage would leave fewer ambulances available in Welwyn Hatfield (page 12)
- The additional access problems for St Albans residents, who can currently use the easier-access QEII instead of Watford, if they are obliged to travel instead to the Lister
- Likely problems of MRSA and cross-infection if the reduced number of beds in the county result in further increased occupancy levels above the recommended 82%
- The contrast between the consultation document's proposals to switch 14% of outpatient services from hospitals to GPs with Special Interests, and the low level of availability of such GPs in Hertfordshire, with just 4 out of 19 specialities available in Welwyn Hatfield

In our view the strong Welwyn Hatfield response (with which we substantially disagree only on the – understandable – acceptance of Option B and some of the analysis of the abandoned Hatfield hospital project) is an indication of the case that should have been made by other Borough and District councils and by the County Council which has regrettably failed to take the lead in defending local and accessible health services.

UNISON, representing over 7,000 health workers in local Trusts and PCTs in addition to thousands of staff working for local authorities and other public services in Hertfordshire, will press for the evidence to support any changes before we give our consent to policies which in our view threaten vital services, and place our members' jobs at risk.

1) "Urgent care services"

The 2007 document suggests a new network of "seven urgent care centres" across Hertfordshire, two of which would effectively be triage units at the remaining A&E departments in Watford and (probably) Stevenage. Two would be on the downsized hospital sites in (probably) Welwyn Garden City and Hemel Hempstead. Two more would be located at

- St Albans City Hospital (site of the county's first Minor Injuries Unit, which proved to be less well utilised and more expensive than expected[2])
- Herts & Essex Hospital in Bishop's Stortford (a site rejected for a Minor Injury Unit back in 1995, on grounds that it would not have been cost effective!)

and one would either be at

- Cheshunt Community Hospital or
- Hertford County Hospital.

[2] "The re-attendance rate is over 25%; there are no nursing cost savings; overheads have tended to be high as the unit replaced an A&E department and continues to use the large floor area and most of the facilities; the number of attendances was not up to the capacity in the first year."
"The St Albans minor injuries unit does not appear to be a cheaper option on the basis of the current cost per case. Since this is an evolving model, with few current examples nationally … there is greater uncertainty about the costings than with well-established models such as large and small A&E departments" (Hertfordshire Health Agency *A&E Services Review* 1995).

Back to the Future?

According to the new consultation document, urgent care centres will be integrated with the GP out-of-hours service, and open 24 hours a day, 7 days a week where they are on "local hospital" sites or alongside A&E: elsewhere there is less precision on when they would be available. What is clear is that they will deal with only minor cases and will therefore not receive blue light emergency ambulances.

The UCCs will apparently be "managed by GPs, nurses and other health practitioners", although whether any of these professional groups has agreed to take on this substantial additional workload, or on what basis of funding, or additional training, has yet to be explained.

The consultation text claims that a 24-hour urgent care centre:

> "could see around 50,000 minor injuries and ailments per year and approximately 50,000 out-of-hours contacts." (page 28)

This seems to suggest a caseload of 100,000 per unit per year: to take on this much extra work, GPs and professionals would need to have a fair amount of time on their hands at present, and also be willing to take on an extra workload averaging 300 cases a day.

UNISON remains unconvinced that either of these is the case. Nor are we impressed by the total absence of any detail on how many staff would be employed, on what basis, to deliver this 24-hour 7-days a week service. We note that the terms of the new GP contract have already led to a mass exodus of GPs from provision of out of hours services, and we are sceptical that this will change with the introduction of UCCs.

All the available evidence of such minor injury units suggests that this type of service is a very expensive and inefficient way to treat people with the least health needs. There is a real danger that they lead to a real inversion of priorities, draining resources from services those with complex, chronic and life-threatening conditions.

We note with some concern that the consultation document argues that the proposals would "improve access to urgent care services" – but makes no such promise for access to A&E. This is clearly because for many patients across the county, accessing two hospitals rather than the present spread of four would involve much longer and more complex journeys. We are not convinced that this is what patients want, or what is best for those needing the most substantial level of treatment.

UNISON does not accept the argument that many people needing urgent treatment take an inappropriate decision to go to A&E, where there is a guarantee of 24-hour services, experienced personnel and facilities to deal with any health problems that may arise. Rather than try Canute-like to stem the well-established exercise of patient choice it makes more sense to locate out of hours primary and community services in or close to the A&E departments – where patients want them.

UNISON is more than happy to endorse a properly staffed and funded Triage system – preferably one staffed by GPs and local primary care professionals based in or next to the A&E Departments – to speed the workload and improve the focus of A&E care on those with the most serious health needs. However it

seems very likely that even if some of these free-standing units ever actually open, it will be a short time only before claims of "cost-effectiveness" and cash saving arguments are trotted out to cut them back and close them down again.

Nor do we believe that anything like the expected numbers of patients will define their condition as so minor that they will opt to go to one of these scaled-down units rather than a full A&E unit. UNISON is also concerned that the geographical separation of the two categories of urgent and emergency care and the limited hours of opening for many UCCs raise the danger of potentially violent and aggressive behaviour from frustrated patients who may be referred from an A&E to an urgent care centre, or who travel in error to discover that an urgent care centre is closed and have to travel further for assistance.

2) Accident & Emergency services

Department of Health figures show that since 2002 a reasonably constant number of around a quarter of a million people a year have presented at A&E in Hertfordshire, and of this total between one in six and one in five have been admitted to hospital. Emergency admissions have **increased** in number over the last five years, suggesting that for these most seriously ill patients there is little scope to reduce A&E services.

This also gives the lie to the claim by the PCTs and Trusts that "fewer people now need inpatient treatment in acute hospitals, so acute hospitals therefore need fewer beds" (page 10).

Number of patients admitted through major A&E

	ENH	WHH	Herts
2002-3	21,337	17,543	38,880
2003-4	21,880	18,054	39,934
2004-5	27,014	23,553	50,567
2005-6	27,687	24,054	51,741
2006-7	27,618	19,822	47,440
% change 2002-7	29.4	13.0	22.0

The figures above are only for those admitted through A&E: DoH figures show that a substantially higher number (a total of 52,735 in 2001-2 and 58,285 in 2005-6) were admitted as emergencies. The total figure for emergency admissions will include medical emergencies involving frail older patients referred to hospital by their GPs. In West Herts Trust, a majority of hospital admissions in 2005-6 were emergencies.[3]

[3] "In 2005/6, the Trust admitted 79,417 patients … 43,426 patients were admitted as emergencies and 35,991 patients where care was planned in advance. 38,485 patients were admitted to Watford General Hospital and 25,102 admitted to Hemel Hempstead General Hospital." (Trust Statistics http://www.westhertshospitals.nhs.uk/trust_facts_figures.html)

Back to the Future?

Around a quarter of all admissions to Hertfordshire acute beds are people aged over 75, and almost half were aged over 60 in 2005-6, with this share actually *rising* in recent years as a proportion of the total emergency admissions.

In other words despite the rhetoric, primary care is currently supporting *FEWER* frail older people at home, not more.

This makes it very clear that before this pattern of hospital use can be changed there needs to be a culture shift in primary care, together with a major investment in alternative community-based services, services which need to win and hold the confidence of local people and of the GPs who are currently referring so many older people for hospital care..

The level of emergency admissions also raises the issue of hospital capacity: even assuming an average length of stay of just 5 days (the average claimed for emergency patients in East & North Herts Trust) , this number of emergency admissions would be enough to tie up 650 beds 365 days a year.

At present this caseload is shared between four major hospitals: but the emergency caseload would more than fill all of the planned total of 618 acute beds in the new 2-hospital scheme, leaving standing room only and no scope for elective work.

UNISON believes that before cutting back and downsizing hospitals we need to see concrete evidence that viable alternative services are in place and being utilised by the vulnerable patients who need them most. In other words we need to see some under-used beds and some genuine proof that the new system is adequate to the task.

And with the planned new hospital in Hatfield having been axed for lack of cash to build it (partly because of the extortionate costs of the Private Finance Initiative), UNISON wants to see hard evidence that the PCTs and Trusts have the funding to establish the new system and substantially refurbish and expand the crumbling hospitals in Watford and Stevenage before we are willing to take it seriously.

Nobody would benefit from a cheap and cheerful reshuffle in which downsized services are simply "concentrated" on the Lister and Watford sites: the consultation document's glib talk of "temporary buildings" at Watford should give every concerned citizen cause for doubt over the long-term likelihood of the promised investment and refurbishment taking place.

The reduction in A&E units also poses another major issue that is deftly avoided by the consultation document: the longer distances and greater number of emergency journeys will put a massive additional strain on the county's ambulance services: how will that be resourced, and can the ambulance Trust be certain that it can deliver adequate standards of emergency response to category A calls, on Hertfordshire's notoriously congested roads?

A recent Sheffield University study found evidence that longer ambulance journeys for emergency treatment significantly increased the danger of loss of life: Hertfordshire NHS management have tried to dismiss this research, claiming that the

evidence it is based on is seven years old and therefore "out of date". **UNISON challenges Hertfordshire PCTs to produce more recent evidence in the form of statistics and research to support their assertion that longer journeys result in better treatment for the majority of patients, rather than simply benefiting the very small minority of patients who need the most specialist hospital care.**

Arguments seeking to brush aside the latest available research evidence have regrettably been reinforced by assertions from East of England Ambulance managers, who have endorsed the proposal closure of services. This stance by Trust managers has been taken without consultation with ambulance staff, who have yet to be asked their views, and who remain unconvinced that the proposed plan will not put an impossible strain on services.

UNISON members working in East of England Ambulance services are proud of the high level of training and professional skill they are able to bring to the treatment of emergency cases: but this training and experience also serves to remind staff that in many instances it is vital to get the patient to hospital as soon as possible, and that the back of even the most hi-tech and sophisticated ambulance, travelling through traffic and swaying around bends is not an ideal environment to deliver top quality care to patients. Longer journeys to fewer hospitals can therefore not only tie up ambulances for greater periods of time, but the extra minutes of travel do in some cases mean the difference between life and death.

3) "Local general hospitals"

The consultation document proposes two so-called "local general hospitals", one on the Hemel Hempstead Hospital site and one (almost certainly) on the QEII site in Welwyn Garden City.

But the term is misleading: these will not be "hospitals" in the sense that anyone normally uses the term. They are more akin to a large health centre (or one of Professor Darzi's "Polyclinics"):

- They will have extremely limited emergency services, running an "urgent care centre" which would not receive 999 ambulances or handle serious medical conditions or trauma;
- They would provide outpatient services
- They would provide facilities for "minor operations" – to be conducted by GPs or possibly by visiting consultants
- They would have diagnostic facilities (X-ray, ultrasound, mobile MRI plug sockets, "point of care testing" and blood tests)
- They would provide therapies – physio, speech, OT services, dietetics and podiatry
- In pursuit of a "vibrant mix" of services at the derelict hospital sites, the consultation document invited Hertfordshire residents to suggest one or two "non-acute health services" they might like to add to the limp list of minor and peripheral services they have already proposed.
- **But they are unlikely to offer any beds or inpatient services: they "may also include intermediate care beds" … "however this may mean closing beds at existing smaller community hospitals" (page 28).**

This type of limited service will simply underline the fact that once-busy District General Hospitals will have closed down, and local people needing hospital care – and anyone hoping to visit them in hospital – will have to travel to Watford or Stevenage. Given the extremely limited nature of the services to be provided, and the comparatively large sites that would be the home of the new "local hospitals" it is hard to see why they are projected to cost as much as £30m.

It is even harder to see why Hertfordshire residents faced with longer and more stressful journeys for health care would see this as money well spent. The proposed services would rattle in the large sites like peas in a pod, presumably awaiting a subsequent decision that they do not offer cost-effective care and that services should be "centralised" at the two surviving hospitals.

4) "Specialist" care

"Specialist doctors save more lives" is the argument on page 11: this rehashes a series of really ancient arguments that the Royal College of Surgeons has been rolling out since the 1990s. They have been pressing for hospitals to have increased catchment areas of up to 500,000, compared with district general hospitals of 150-250,000, despite the limited evidence to support the claim that this enhances patient care.

It does not take a genius to work out that this suggests far fewer hospitals: but nor is it rocket science to recognise that fewer hospitals covering specialist treatment will need MORE beds to ensure they are able to offer prompt and satisfactory care to a larger population. Unfortunately the RCS and most of those who have subsequently parroted their arguments appear until very recently to have forgotten this bit: the result is that their call for an extended catchment area to help them deliver the most specialised care has been shamelessly milked by NHS bureaucrats and ministers from this and the previous government as a formula for reduced hospital provision.

Only now is there evidence of more mature reflection: UNISON welcomes the fact that the 2007 report from the Academy of Medical Royal Colleges has pulled away from the call for greater centralisation as a universal model, rejected rationalisation based on financial expediency, highlighted the lack of evidence for centralising any but the most complex and specialised of services, and insisted that new services must be up and running PRIOR to any closure of services.

The most recent body to climb aboard the rickety bandwagon of centralisation was the so-called 'think tank' the Institute of Public Policy and Research (IPPR), which has argued for the closure of 52 A&E units across the country, not on the basis of viable clinical care, but based on a crude number-crunching exercise, measuring catchment populations. Interestingly the Hertfordshire consultation echoes the IPPR formulations when on page 10 it argues that unless hospital services are downsized and centralised they will become "sub-standard, unsustainable, unattractive to clinical staff and ultimately unsafe".

IPPR relies heavily on claims that larger hospital units achieve better results than very small ones. The same argument is brought forward (page 9) in the Business Case that accompanies the Hertfordshire consultation: however this also gives away the fact that the document is not comparing like with like. It argues that:

> "Across a broad range of specialities, larger units have been shown to achieve better results. Fore example research shows that mortality can differ by up to 58% for patients with emergency conditions such as aortic aneurysms, depending upon whether they are treated in a hospital that treats more or less than six such patients per year." (Business Case, page 9)

Yes, the Business Case really does say **SIX** cases is the dividing line between a "large" and a "smaller" hospital. This is because around the world most private sector hospitals are extremely small: in the UK the largest private chain averages just 50 beds per hospital. The research shows that most NHS-style larger general hospitals are already well above the size needed to ensure maximum clinical effectiveness.

But far from being a strong argument for reducing Hertfordshire to just two main hospitals, this clinical evidence should raise serious doubts over the wisdom of handing over some hospital outpatient work to GPs and very small community units and primary care clinics which will handle only a very few cases each year.

UNISON does not oppose the case for centralising some highly specialised treatment – some cancer treatment (though the Hertfordshire consultation conspicuously has nothing to say about cancer services), some paediatric services, some highly specialised surgery – in larger units: but we would point out that these treatments are delivered to just a small minority of NHS patients, while the vast majority are better served by swift and uncomplicated access to a district general hospital.

UNISON is especially disturbed at the slow development of adequate services for stroke patients in Hertfordshire, especially since a national service framework calling for improved local access to specialist stroke care units was adopted by this government many years ago, and has been ignored by Trusts and PCTs – except when they want to make a case for centralisation of closures of DGHs.

In theory all Hertfordshire patients suffering a stroke should have been receiving specialist care in stroke units since 2004: health chiefs have ignored these guidelines, and we are concerned that stroke services now are simply being used as a further pretext for rationalisation of hospital care.

As with so much of the Hertfordshire consultation it is the missing details, the studied vagueness over exactly what services are proposed and where, the failure to elaborate any serious plan for staffing the new services that gives us serious grounds for concern that the future plans are simply window-dressing to conceal a reality of steadily declining services across the county. New scanners, for example and other hi-tech equipment to deliver specialist care carry a heavy capital and revenue cost which makes them incompatible with the new "payment by results" system which gives Trusts no long-term guaranteed income, and no access to capital.

Where would the funding come from to equip the Lister and Watford General with new scanners? How does this plan correspond with the cash crisis faced by both PCTs and Hertfordshire Trusts?

Nor is UNISON convinced of the wisdom of reducing well-established and popular district general hospitals to a purely "specialist" role and devolving many of their

existing services to smaller scale and almost inevitably more expensive and less efficient units in community and primary care. In the longer run such restructuring seems set to increase costs and undermine the financial viability of the hospitals, while piling additional tasks and responsibilities onto GPs, primary care and community health staff without any guarantee of the requisite funding and resources.

5) Two "centralised" hospitals delivering "acute services".

Department of Health figures (table below) show that far from declining, the use of inpatient beds has increased, with a 9% increase in Finished Consultant Episodes and an 8% increase in hospital admissions in the last five years, while the rate of increase of day surgery has slowed dramatically.

There is therefore no evidence on current performance to support a plan for fewer hospital beds in Hertfordshire: indeed with the government pressing plans for a vast increase of 93,000 additional houses as part of its expansion of housing in the South East of England, it seems likely that services will face additional pressures from a growing population, in addition to the demographic pressures of increasing numbers of older residents.

Hospital bed use in Hertfordshire

Hospital provider	Finished Consultant Episodes	Admissions
West Hertfordshire Hospitals NHS Trust	89,579	79,574
East and North Hertfordshire NHS Trust	88,971	80,980
Hertfordshire total 2005-6	**178,550**	**160,554**
West Hertfordshire Hospitals NHS Trust	77,321	70,416
East & North Hertfordshire NHS Trust	85,943	77,667
Hertfordshire total 2001-2	**163,264**	**148,083**
% change 2001-2006	9.36	8.42

Source: Department of Health

However the Business Plan reveals that bed numbers are planned to fall (assuming the preferred Lister Hospital option is adopted) by around 20%, from 765 (or as high as 800 (page 22) to just 618: this requires the addition of another 150+ beds on the Lister site – expanding its capacity by over 30%.

The reduction involved in the Watford centralisation is not by any means as clearly stated: but an equivalent 20% or more cut in beds would leave the West Herts Trust falling from a current total of 671 (Business Plan page 23) to around 540 beds. To achieve this, the Watford site would need to be extended to incorporate another 120, again almost a 30% increase in beds: this turns out to be among the proposals set out in the Business Plan.

Back to the Future?

UNISON notes the repeated assertion that "the NHS needs even fewer hospital beds" (page 15 and *passim*) despite the fact that the county already lags well below its proportional share of beds compared with the rest of England (see table below).

Hospital beds in England and in Hertfordshire, 2005-6

	Total	General & Acute	Acute	Geriatric	Maternity
England	175,646	133,033	108,113	24,920	8,883
East And North Hertfordshire NHS Trust	1,077	967	754	213	110
West Hertfordshire Hospitals NHS Trust	925	856	687	169	69
Herts total	**2,001**	**1,822**	**1,440**	**382**	**179**
Herts as % England	**1.1**	**1.4**	**1.3**	**1.5**	**2.0**
Post-plan Herts beds total			**1,158**		

Source: Department of Health

We also note that there will almost certainly be no inpatient beds at any of the so-called "local hospitals", so the two remaining hospitals would be operating with substantially fewer beds but would have little or no residual capacity to cope with potential peaks in demand for emergency treatment. Higher than recommended occupancy levels also massively increases the risk of hospital acquired infections such as MRSA – and UNISON notes that there is no discussion of the issues of patient safety and hygiene standards in the consultation document.

UNISON is not opposed in principle to the separation of emergency and elective (**"**planned") care as proposed on page 14: and we positively support the creation of NHS-run Treatment Centres, a concept that has subsequently been hijacked by for-profit private companies in the so-called "independent sector treatment centres" that are proving such an expensive failure for the government where they have been introduced. NHS-run units such as the SW London Elective Orthopaedic Centre have proved highly popular with patients, and deliver efficient and high quality services with NHS professionals.

However it is clear that such projects carry substantial investment costs, and in the new-style NHS "market" that can involve a serious level of risk, which can go horribly wrong. UNISON is concerned that Hertfordshire's hospitals should not make the same costly mistake as Hinchingbrooke Hospital in Huntingdon, which is saddled with paying out £93m through a PFI scheme for a £22m NHS Treatment Centre, which has subsequently stood largely idle for lack of the promised referrals from local PCTs, and is now a factor undermining the viability of the Hinchingbrooke Health Care Trust.

6) Surgicentres

With the above note of caution, one area where UNISON can welcome the consultation proposals and endorse the plans outlined, however is in the decision to reject a privately-provided "Independent Sector Treatment Centre" (the planned "Surgicentre") in West Hertfordshire and the decision to deliver this enhanced elective service in-house.

However we are most concerned that a very different decision has been taken with the E&N Herts surgicentre, which apparently is still to be sited at the Lister Hospital, and still due to be privately funded and run for profit by Clinicenta, despite evidence of increased costs and poor value for money. we note that this issue has been deliberately excluded from the consultation – perhaps to avoid debate over the fact that the original proposal for the surgicentres was for units based away from the main acute hospital sites. UNISON believes very strongly that all treatment centres should be owned and run by the NHS.

Over the last few years an increasing body of evidence, notably including information published last year by the Commons Health Committee and a succession of revelations this year, has served to underline UNISON's long-standing position that private sector, for-profit treatment centres are costly, poor value for money, and by charging above tariff prices for the most minor and least demanding cases undermine the finances and stability of local NHS specialist units and front-line services.

We are happy to endorse the conclusion (page 37) that a private sector deal would result in a more complex and costly unit, that its services would be more expensive, and that directly-delivered NHS services from a custom-built unit would offer much better value for money.

We do not have strong views on whether the NHS unit should be at St Albans or Hemel Hempstead, although we do note that once again the document avoids the vexed question of travel times and access for those who might be expected to use the new unit – leaving open the issue of whether the Hemel Hempstead site might be preferable from that point of view.

7) Community services: how serious are the plans?

In a tantalising phrase on page 10, the consultation document asserts that "Across Britain we are seeing more community matrons". The issue never recurs, and no figures have been published to allow the public to assess how many community matrons are employed by the Hertfordshire PCTs. UNISON deplores the fact that the contribution of the existing Community Matrons is ignored, and that there are apparently no plans for any more.

UNISON favours improved training and greater focus of resources to improve community based services which are often the neglected component of local health care in England. But neither the consultation document nor the Business Plan addresses the issues of staffing, or establishing the local bases and resources which are key to a serious expansion of community health care.

Back to the Future?

The Business Plan reveals targets to increase the number of older people receiving "intermediate care" (another ill-defined and ambiguous term) by almost 12% to just over 10,000 by 2009. This could be ambitious if "intermediate care" is intended to mean substantial support for frail and vulnerable older people living at home.

A less ambitious target is to reduce the numbers of older people admitted to hospital for treatment, and to reduce the number of bed-days they spend in hospital by just under 3% over the same period. And "unscheduled bed days" of the more vulnerable 75+ age group are also to be cut by around 3%.

UNISON is in favour of this type of change so long as it is backed up by adequate numbers of suitably trained professional and other staff working in the community: but we are NOT in favour of closing hospital beds which are currently used to support such patients until it is clear that the alternative system is established, viable and trusted by patients and by GPs and consultants.

We are in favour of all of the proactive policies designed to minimise avoidable hospitalisation of older people – falls clinics, specialist clinics, home-based care, improved therapy cover and improved discharge arrangements to ensure suitable support is in place before a patient arrives back home (Business Plan page 32). However all of these policies have staffing and training implications: if done on the cheap with inadequate investment they could harm patients and are likely to fail to meet their objectives.

We also note the proposal that GPs should increasingly operate on 'lumps and bumps', while operations up to and including hernias are to be displaced from the hospitals that are geared up to doing them effectively and efficiently, and devolved to community-based units.

> "Over the next few years approximately 12,000 more clinically appropriate planned procedures will be carried out in primary care facilities such as Potters Bar Hospital and some GP Practices. This equates to 11% of the total procedures for 2007/08." (Business Plan page 35)

Do the GPs involved agree to take on this extra work? Have they the appropriate level of training and staff support?

How much will they charge compared with hospital tariff prices? We should note that Professor Darzi's report on London anticipates that "minor procedures" which carry a hospital tariff price of £870, and a tariff of £818 in an elective treatment centre, would be carried out on the cheap by GPs in Polyclinics: he has budgeted a cost of just £146 per procedure – less than 20% of the tariff. How do GPs react to being seen as a source of cheap labour?

Do patients want it? Has anyone ever asked patients their views? Would they prefer a proper hospital and a proven expert surgeon to treat them rather than a GP with a "special interest" and an almost inevitably low level of experience and restricted annual caseload?

How does this policy square with the assertion in the consultation document that "A surgeon who performs the same operation many times a year will become more skilled at it than a surgeon who conducts that type of operation along with many others" (page 11)?

And is there really any cost saving at all, given that the hospital caseload will be reduced to the more expensive and complex surgical and medical care, but staffing levels and skill mix will need to remain close to present levels to ensure quality care?

On the same theme, the document offers nothing to prove that it is either cost-effective or a sensible use of consultant time to deliver outpatient clinics in individual GP practices. Opponents of hospital cuts have been unfairly parodied for years as irresponsible advocates of "a hospital on every street corner", but it does seem that there is a basic argument on the provision of outpatient care in a way which ensures maximum productive use of the costly time of consultants and supporting professional staff.

Trekking round the county on congested roads to meet small numbers or individuals at GP surgery level does not seem to offer consultants either economies or job satisfaction – and also cuts across the training of junior doctors. Again there is no evidence that patients have requested this method of working: most would settle for seeing a doctor on or close to the time on their appointment card.

The promoters of the report will struggle on many aspects to show that they have any popular support for their proposals among the residents of Hertfordshire: but on this issue it is more than likely that there would be considerable resistance from patients. Is this one of those areas where "patient choice" is seen as a handy slogan rather than a general policy, and patients will be compelled, by withdrawal of other services, to use the new services or go without?

UNISON also notes the heavy emphasis on consultant-led obstetrics services (consultation document page 12). This conforms with the pattern across the country, in which popular, friendly and accessible midwife-led units are facing closure, while expectant mums are channelled in to ever-larger consultant-led factory-scale labour wards in hospitals.

What price the recent promise from the previous Secretary of State Patricia Hewitt of 'choice', including the possibility of increased numbers of home births for those who want them?

9) Finances

Whatever the "clinical" arguments that have been trundled out to support these proposals, it is clear that the fundamental driver of change in Hertfordshire is money, and the quest for balanced books in the two Trusts and PCTs at a time when it is widely expected that the rate of growth in NHS spending is about to slow down or halt completely.

However there is little if any evidence that the new model of care as proposed will necessarily deliver the promised reduction in costs, and free up the additional money that is being promised to expand primary care. Urgent Care Centres and bedless Local General Hospitals can both prove relatively costly ways to deliver care to those with the least health needs, while hospital services will be desperately stretched to deal with the more serious and complex cases, and the real emergencies in a growing and increasingly elderly population.

Conclusion

UNISON cannot support plans which are based on no hard evidence, and which threaten to undermine well-established local services in the hope that a new system will eventually work.

We are concerned that plans have been hatched up which offer security neither to patients nor to the thousands of health care staff who work loyally for the NHS in Hertfordshire.

Staff have yet again found themselves, their dedication and their skills taken for granted in a cavalier approach by PCTs and Trusts which offers no real details, no plan for Human Resources, no real discussion of the problems of access and travel in the county, and no basis to believe that the proposals will ever be fully resourced or implemented.

We welcome plans for an NHS-run Treatment Centre, and proposals to minimise hospital admissions and support older people at home and in the community.

If health chiefs in Hertfordshire want to convince local people and their own staff that their plans are viable, they need to fill in some of the blanks identified in this response, and begin from the ground up with serious investment in expanded community services to prove that they are capable of handling additional workload and reducing the pressure on local hospitals.

Researched for UNISON Hertfordshire Health Branches
and UNISON Eastern Region
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September 28 2007