



Unite response to the Department of Health ‘Listening Exercise’ on NHS reforms

This evidence is submitted by Unite the Union - the country’s largest trade union. The union’s members work in a range of industries including manufacturing, financial services, print, media, construction and not-for-profit sectors, local government, education and health services.

Unite in the National Health Service represents approximately 100,000 health sector workers. This includes seven professional associations – the Community Practitioners and Health Visitors’ Association (CPHVA), Guild of Healthcare Pharmacists (GHP), Medical Practitioners Union (MPU), Society of Sexual Health Advisors (SSHA), Hospital Physicists Association (HPA), College of Health Care Chaplains (CHCC) and the Mental Health Nurses Association (MNHA) – and members in occupations such as allied health professions, healthcare science, applied psychology, counselling and psychotherapy, dental professions, audiology, optometry, building trades, estates, craft and maintenance, administration, ICT, support services and ambulance services.

Executive Summary

- 1.1. Unite believe that the Health and Social Care Bill should be withdrawn.
- 1.2. Unite believe that the duties of the Secretary of State for Health should remain as set out in the NHS Act 2006.
- 1.3. The implementation of the “any willing provider” principle and the market mechanisms contained in the Health and Social Care Bill will bring commercial involvement on a scale we have not seen before. Unite believe this competitive model will decrease the quality and range of health services available to people; contribute to increasing health inequality; increase health care costs and reduce accountability.
- 1.4. Unite believe that the concept of ‘designated services’ within this competitive business model of delivering health services is deeply flawed, and will not prevent the widespread loss of valuable healthcare services to local communities.

- 1.5. Unite is opposed to the lifting or abolition of the current cap on the amount of private income Foundation Trusts can generate; Unite believe the cap should remain.
- 1.6. Unite believe that the public duties in the Equality Act and the provisions of the Freedom of Information Act should be applied to all organisations that are contracted to deliver services on behalf of the NHS.
- 1.7. Unite believe EU Competition Law should not apply to the NHS as healthcare is a collective public good.
- 1.8. Unite believe Monitor should not have a role in fostering or enforcing competition across the NHS; the focus and emphasis has to be on encouraging integration and co-operation between services and ensuring high quality services.
- 1.9. There are insufficient safeguards to ensure democratic oversight and scrutiny of health services at a local level; the proposed Health and Well-Being Boards are weak and are narrow in scope. The GP consortia do not have minimum standards on the breadth of professional representation included on their Boards; there at least should be specification for nursing and Allied Health Professional representation.
- 1.10. Unite believe that all staff working to deliver health care services on behalf of the NHS, whether directly employed or not, should receive Agenda for Change terms and conditions and be covered by that national, collective agreement.
- 1.11. Unite believe that what is required to analyse the issues raised by increased life expectancy (and continued inequalities), the management of chronic conditions, the use and funding of new drugs and technology is a Royal Commission that can take an evidence based view. Not the 'quick fix' and destructive policies contained in the Health and Social Care Bill.

1. Introduction

- 1.1. Unite remains firmly opposed to the Government's plans to restructure the NHS into a market of competing businesses and commercial involvement on a scale we have not seen before. Unite believe that the heart of the Government's proposals will transform and privatise the NHS so that services are geared towards fulfilling financial and business contractual relationships and outcomes, rather than meeting health needs. Unite believe it ultimately puts at risk the concept of a universal, free health care service. Overall, Unite believe that the Government's plans will; decrease the quality and range of health services

available to people; contribute to increasing health inequality; increase healthcare costs, and reduce accountability.

- 1.2. Unite believe that health services are being set on a path that will compromise health professionals autonomy. One of our Applied Psychology, Counselling and Psychotherapy members has said *"[My service] is introducing a system which reduces the number of average appointments for service user. The average number of sessions was previously determined by clinicians, it is now determined by a system"*. This is an example of autonomy being restricted at a very basic level.
- 1.3. The Government have sought to cast this debate as a choice between the NHS remaining as it is currently, and the reforms on the table. This is a false choice. Unite believe the Health and Social Care Bill should be withdrawn; given its fundamental flaws, tinkering around the edges is not an option.
- 1.4. The Government should ensure there are no cuts in NHS funding, and the investment made to develop co-operation across different services, not competition, and should further improve services by genuinely engaging with staff – not imposing top-down, ideologically driven reforms. **The democratically decided policy of Unite is for a National Health Service that is publicly owned, publicly funded and publicly accountable, providing comprehensive and universal health services, free to all at the point of need, not the point of use, before and after treatment.**

2. 'Listening Exercise' and the Future Forum

- 2.1. Unite wrote, in response to the 'Equity and Excellence' consultation in 2010 that *"There has been no proper explanation to the public of the full ramifications of what is proposed in 'Equity and Excellence'. This written consultation has been conducted over the summer period, and its outcome already presumed – as evidenced by the Chief Executive's letters to the service"*¹. The Government pushed ahead with establishing 'GP Consortia' **before** the Health and Social Care Bill was presented to Parliament – and have continued to establish such Consortia despite the Bill not finishing its passage through Parliament. At the start of February, when asked, Downing Street could only give the names of five organisations that supported their proposals² – yet again the Government continued to push ahead with their

¹ Unite response to 'Equity and Excellence', October 2010, http://www.epolitix.com/fileadmin/epolitix/stakeholders/Equity_and_Excellence_response.pdf

² Mirror, 2nd February 2011 <http://www.mirror.co.uk/news/top-stories/2011/02/02/david-cameron-s-dodgy-claims-on-nhs-reform-backing-exposed-115875-22892558/>

plans. It is a measure of how unpopular the Government's plans for the NHS are – across members of the public, professional organisations and the trade unions representing NHS staff - that the unprecedented step of 'pausing' the legislation for this Listening Exercise has been taken.

- 2.2. But given the recent history of the Health and Social Care Bill it is unsurprising there are serious concerns and widespread scepticism that this 'pause' is to enable the Government's plans to be better sold, rather than the Health and Social Care Bill to be substantially changed or stopped. As other organisations have highlighted, the Future Forum is unrepresentative. For example, it contains no trade union voice, or GP critical of the Government's plans. Professor Steve Field, Sir Stephen Bubb and many others have been hand-picked to lead the Future Forum, and are known to be broadly supportive of the thrust of Government plans. While Unite cautiously welcomes the comments from Professor Field in recognising that the Government's plans, as they are, would have a "destabilising" effect on the NHS and that competition could "destroy key services"³ we shall have to see what action emerges from the Future Forum report. Unite also note that Professor Field remains supportive of high levels of competition in the provision of health care and greater use of non-NHS organisations.
- 2.3. The Future Forum appears to be running in parallel with the Prime Minister's 'kitchen Cabinet' of health policy experts. This includes Mark Britnell who has reportedly said to a conference of executives from the private sector that future NHS reforms would show "no mercy" to the NHS and offer a "big opportunity" to the for-profit sector. This further adds to Unite concerns that the outcome of the 'pause' will be tinkering around the edges of the Bill rather than its withdrawal and the wholesale reassessment of the Coalition's NHS policy.

NHS Commissioning Board

- 3.1. Unite believe that the creation of an NHS Commissioning Board epitomises how the NHS, as we currently understand it, will end, to be replaced by a series of complex contracts to be monitored, enforced and wrangled over. The creation of the NHS Commissioning Board is also a 'contracting out' of the responsibility of the NHS by the Government; it is an attempt by the Government to be at 'arms length' distance when the quality and range of health services decreases because of the implementation of their proposals. The NHS Commissioning Board is an unelected body, and there is no proper mechanism for holding the Board and its decision to account or to experience Parliamentary scrutiny. This is also

³ Guardian, Saturday 14th May, *Andrew Lansley's NHS reforms are unworkable says review chief*, <http://www.guardian.co.uk/society/2011/may/13/andrew-lansley-nhs-reforms-unworkable>

reflected by the changes in Clause 1 of the Health and Social Care Bill, changing the Government's duty from that (in the NHS Act 2006) to "provide or secure the provision of services" to "act with a view to securing the provision of services" when dealing with the Board, consortia and local authorities. As the Health Select Committee have noted, the public will still hold the Secretary of State politically responsible for the performance of the NHS. This reality should be reflected in legislation and the NHS Act 2006 Secretary of State duties should remain.

4. Competition, privatisation and Any Willing Provider

- 4.1. The most widely scrutinised part of the Health and Social Care Bill is that of the GP Consortia. Groups of GPs will be handed most of the NHS budget – approximately £80billion - to contract or pay for healthcare services for their patients from "any willing provider". The Government has attempted to portray the "any willing provider" principle and the GP commissioning model as a way of engaging and empowering staff *and* argued that the business competition between services will drive up the quality of services that patients receive. All evidence and experience contradicts the this hypothesis of the Bill.
- 4.2. Developing a 'patient centred' NHS requires staff having sufficient time to spend with each patient and user. Healthcare staff who may not have direct interaction with patients and service users, but nonetheless play a vital role in the delivery of healthcare, need to be able to devote sufficient time to conducting their role properly and thoroughly. At the heart of achieving this is the need to address escalating staff workloads.
- 4.3. At the same time competition between services and the need to win contracts and generate profits (or surpluses) create a need to reduce costs as much as possible. This will lead to reduced staff numbers, as we are already seeing – and this will mean the ending of some health care provision and increased staff workloads for those employed. Unite believe that reduced costs also threaten to come at the expense of staff terms and conditions.
- 4.4. An emerging argument has been that the current Health and Social Care Bill can be 'tweaked' with the role of Monitor slightly redesigned so that it has an emphasis on making competing providers work within what may be termed an overarching collaboration framework. Unite rejects this as an acceptable outcome of the 'listening exercise'. Such a framework will fail to prevent the fragmentation of service delivery because it does not eradicate, but leaves in place, the competition between health care providers for income and contracts. As Unite noted in its submission to the White Paper consultation, that the

experience amongst our Not-for-Profit members has been that such competition drives organisations apart and stops the sharing of best practice and collaboration.

- 4.5. A 'health system' comprised of contracted, competing businesses will also lead to an incentive to 'cherry pick' or 'cream skimming' the most 'profitable' patients (i.e. those who are simplest and cheapest to treat), pushing the more complex cases (and therefore more expensive to treat) to the back of the queue. While it was feared that 'cherry-picking' would predominantly affect the delivery of simple, elective treatments there is emerging evidence that it is also affecting GP Consortia, with 'better performing' practices grouping together⁴.
- 4.6. It is likely that many groups of GPs will not have the time or expertise to deal with: the assessment of what local health services are needed, contract negotiations with different companies who want to provide those services, the invoicing and billing as companies are paid for services, and resolving problems with contracted companies. This 'commissioning' function is itself likely to be contracted out to a private management or health company. Christopher McCabe and Ian Kirkpatrick have noted that;

“the management of commissioning [is] worth £1bn. Firms such as Tribal, Humana, United Health and Aetna already offer referral management services that promise to help consortiums slash their costs by as much as 15% and turn savings into profits”⁵

- 4.7. Further, in the Health and Social Care Bill there are no adequate safeguards, or checks and balances, put in place to avoid conflicts of interests between GPs and others who sit on a Consortia Board and may also have a financial interest in a company or organisation that provides health care services.
- 4.8. The profits generated by private contracted firms, and the cost associated with 'managing the market', such as contracting, invoicing and so on all represent wasted funds that could have been invested in improving health services. In addition the *Health Service Journal* has found that the implementation of the Government reforms alone will cost £1.2billion⁶. The costs of the bureaucratic system the Government is establishing will grow.

⁴ HSJ, 31st March 2011, *Leading GP groups risk creation of 'sink estate' consortia*

⁵ The Guardian, 12th April 2011, *The NHS braces itself for privatisation*,
<http://www.guardian.co.uk/society/2011/apr/12/private-sector-involvement-nhs>

⁶ Health Service Journal, January 19th 2011, <http://www.hsj.co.uk/topics/health-bill-2011/commissioning-transition-to-cost-12bn/5024251.article>

4.9. A further, and very grave, concern that has been raised by MPU members of Unite, the Royal College of GPs and the BMA is the impact on the doctor-patient relationship. Under the new system a patient can no longer be wholly confident that what a GP is recommending is in their best interest. There will be suspicions that they are being recommended cheaper options because there is a need to balance the Consortia books, or that by recommending a particular treatment from a particular provider that the GP may stand to gain financially as a shareholder in that provider. This is a fundamental rupture in the trust between GPs and their patients.

5. Financial failure and designated services

5.1. The competitive business model of providing health services requires that services have to compete for, and win, contracts and patients to secure any income. While this opens the possibility of large profits for some operators it also opens the opportunity for financial failure and the loss of services for local communities. There are many examples of this across the public sector. The Impact Assessment that was released with the Health and Social Care Bill makes it clear that services going bankrupt and ceasing trading across the country will be inevitable when you have a market environment. Further, elected representatives such as MPs and Councillors cannot be allowed to distort this market – they will not be able to exert political pressure to stop a closure of a hospital or service. The solution that the Government has proposed is that of ‘designated services’; where a GP consortium can decide that a service should continue even if the provider goes bust and Monitor steps in to rescue the service and enable it to continue. This will be enabled by designated services having to pay an insurance premium to Monitor.

5.2. Even if the terms of the debate are accepted, there are several problems with this concept. In the system of business competition that the Government plans to establish with the Health and Social Care Bill providers are penalised for being a designated service – paying the premium will increase your costs and reduce your profit. Within the Government’s own framework the premium may act as a disincentive to a service being designated. Secondly, there is currently no democratic input into what should be a designated service. Finally, Unite note the comments of Professor Steve Field that one option going forward may be that there is a list of ‘core’ services that hospitals have to continue to provide to maintain a level of national service⁷.

⁷ The Guardian, 13th May 2011 <http://www.guardian.co.uk/society/2011/may/13/andrew-lansley-nhs-reforms-unworkable>

- 5.3. As an organisation representing staff across NHS services – including seven professional bodies – Unite is concerned that what is being envisaged is a whittling down of the NHS to core acute services and an abandonment of the comprehensive principle. There are many services that the NHS currently provides which are not necessarily life saving, but are life transforming. There are also a great number of primary care services which are preventative, improving lives and saving money in the longer term. The spending cuts in real terms and the imposition of ‘efficiency savings’ are already giving us an early indication of what fewer services may mean in practice. Some PCTs have already made some treatments, such as hernia and cataract operations very difficult to access, despite healthcare needs. The Government abolished the waiting list targets last year and there are already seeing delays for treatment growing, before the full force of the cost-cutting exercise has hit. This trend will be further exacerbated by the Government plans under the Health and Social Care Bill.
- 5.4. Despite the Government rhetoric of patient choice, the Government is drawing what ‘choice’ means narrowly by defining it solely in a competitive business environment. At the same time the Government are reducing it in many meaningful senses. When local services fail and close in a local area only those with economic and social means will be able to travel to areas where that service is available. Cutbacks in, and the ending of, services through staff cuts again reduce choice. Unite members are reporting high workload volumes and having to rush through patients through their appointments, and decreasing the numbers of follow-up appointments patients have. There are also reports of increasingly restrictive thresholds, or criteria, patients must meet to gain access to certain treatments. This places tighter limits on the time staff can spend making sure that patients and users understand their treatment options, and restricts what treatments can be accessed by patients.

6. Foundation Trusts

- 6.1. Under Government plans all hospitals, mental health trusts and ambulance trusts that have not yet done so are to become Foundation Trusts. The current cap on the level of private income that Foundation Trusts can generate exists to ensure that a hospital, clinic or service cannot be turned over mostly or wholly to fee-paying patients and users. The abolition of the cap opens the door to a two, or multi-tiered service, where cash strapped providers needing to generate income will enable people to pay to be prioritised, to receive quicker treatment, or receive a better standard of treatment which should be standard for all. Unite believe that at the least the income cap should remain. Unite believe that it is perhaps time that all the freedoms of Foundation Trusts and their ability to operate as businesses should be reviewed.

- 6.2. It should also be repeated and emphasised that Foundation Trusts do not have freedom to set their own pay, terms and conditions. Foundation Trusts have specified and a narrowly drawn room for manoeuvre under the Agenda for Change national agreement. The benefits of these restrictions are outlined below.

7. Increased Inequality

- 7.1. The Government keeps repeating that NHS care will still be free at the point of use; based on need not ability to pay. Unite is concerned that this is being repeated, but what is being hidden is that rather than the comprehensive, universal system we currently have the health services that remain freely available will be much fewer in number, reduced in range, you will have to wait longer for treatment and the Government has opened the door to others paying to jump the queue in front of you. This, combined with how GP Consortia are grouping and the post code lottery that is likely to open up in services will increase inequality.
- 7.2. In a further compromising of the GP-patient relationship, a model where the GP restrict has responsibility for 'balancing the books' and acting as gatekeeper to accessing services, may full services to patients with complex (and therefore more expensive needs) neglected or rejected as patients compared to younger, fitter, healthier (and therefore cheaper) patients).
- 7.3. As well as the growing inequality in the provision of health care services that will arise from 'market mechanisms' Unite is also hugely concerned that organisations contracted to deliver public health care services by the 'NHS' will fall outside of the public bodies duties of the Equality Act. This should not be the case; Unite also believe the Freedom of Information Act should also apply to such organisations.

8. Accountability

- 8.1. Monitor is an unelected and unaccountable body which the Government is planning to give wide ranging powers to, with little in the way of democratic scrutiny to Parliament nationally or Council's locally. This applies to the appointment of personnel and its decision making power. The Health and Social Care Bill charges Monitor with fostering and enforcing competition across the health system. Its proposed role under the Government plans has rightly come under review in recent days. Unite are opposed to an organisation having the power to foster and enforce competition – the emphasis must be on co-operation. EU

Competition Law should not be applied to the NHS as healthcare is a collective, public good.

- 8.2. Despite the Government's repeated assertions of increased local and democratic control their proposals provide no opportunity for people to exercise power over the direction of policy – involvement is narrowly defined to a choice of provider within a competitive business model, and ensuring commissioning decisions are legal. It is important to note that even within these narrow boundaries the actual choice about who to commission to provide local health services – and therefore determine what is available to people in a local area – lies with the GP Commissioners, not the new Health and Wellbeing Boards, on which there is insufficient numbers of seats for elected representatives. There is no clear genuine accountability structure on the decision making of the GP Commissioning bodies.
- 8.3. Unite would add that the model the Government is adhering to of elevating GPs above other health professionals is an old-fashioned throwback. The NHS has evolved into an integrated, multi-professional service with clinical leadership across the service. The GP consortia do not currently even have minimum standards on the breadth of professional representation included on their Boards; there at least should be specification for nursing and Allied Health Professional representation to achieve a breadth of expertise.
- 8.4. The very real concern here – and as expressed at the Liberal Democrat Spring Conference – is that the GP consortia will be of varying sizes, the decision making power about what services should be available locally sits with them (and may be outsourced) and they are properly accountable to no-one.

9. Agenda for Change and staff pay, terms and conditions

- 9.1. Unite have highlighted above that efficiencies and cost savings are often found at the expense of staff pay, terms and conditions. This has a direct impact on the recruitment and retention of staff – the relative low pay of the early 1990s saw widespread recruitment and retention problems in the NHS to the detriment of service delivery.
- 9.2. Unite are concerned that the removal of national collective bargaining will be sought in order to drive down costs and maximise the profits of companies winning contracts to deliver services. 'Agenda for Change' is the nationally developed and agreed NHS pay and conditions structure. Negotiated over years by the Departments of Health, the trade unions and the NHS Employers it has been in operation since October 2004. It covers all those who are directly employed by the National Health Service – 1.3 million people - in England,

Scotland, Wales and Northern Ireland across all occupations except doctors, dentists and senior managers.

9.3. Agenda for Change is a 'Job Evaluation scheme'. This is where roles and occupations are measured, or scored, on factors such as knowledge and skills required, decision making and independent working, physical effort and so on. These scores then add up to a total which allows the occupation or role to be placed on a payment scale. **This was implemented in order to ensure equal pay for work of equal value within the health service**, replacing the large variations that existed between the different pay and conditions structures which had previously operated in the NHS. Alistar Hatchett, from the respected Income Data Services has written that under the last Conservative government the Treasury had been a firm advocate of local pay bargaining in the early 1990s but by 1993 issued a note stating that "*In practice, extremely devolved arrangements are not desirable. There are risks of workers being treated differently for no good reason*"⁸. As well as bringing about equal pay for work of equal value and providing a framework for career development and progression for staff, the operation of a national agreement brings a myriad of other benefits. One national negotiation prevents the duplication of resource intensive HR functions and negotiation at local and regional organisations across the country. A single pay spine across the country brings a great deal of stability to the healthcare labour market and means organisations do not get into a 'bidding war' for occupational staff that are in short supply. Unite support the continuation of national collective bargaining and the operation of the Agenda for Change agreement; staff employed to deliver services on behalf of the NHS should be employed on Agenda for Change terms and conditions and covered by the agreement.

10. Training and workforce planning

10.1. There remains a huge hole in the Government's plans in the areas of training, education, workforce planning and issues such as clinical placements. At the same time as the NHS is being asked to make unprecedented levels of cuts in funding under the guise of efficiency savings and years ahead of real terms cuts in funding a model of service delivery is being put forward that needs spare capacity to effectively operate 'choice'.

10.2. At the same time there are real concerns about the future of workforce data collection. To effectively plan workforce development and measure the success (or failure) of training meeting the supply needs of provider, yet so far there are no effective measures (with sanctions) being put in place that would compel providers to take part in training, both

⁸<http://www.publicfinance.co.uk/features/2010/06/paying-the-price/>

funding and clinical placements, and on-going career development and training opportunities, for all occupations not just professionals.

10.3. Part of this on-going workforce development is the provision of appropriate supervision structures. Patients and service users very often have multiple needs; they require support and intervention from a number of different professionals and services. For example, a patient can have a need for occupational therapy, diabetic care and physiotherapy. The needs of this patient would be for integrated and professional team working, with referrals across services and clinical professional judgement being exercised about the level of care needed. The commissioning of services and the requirement of the Consortia to keep an eye on the cost of this patient's care is likely to result in something else. Each of these services are likely to be commissioned separately, with the patient being bounced back to the GP each time a 'need' is identified, approval having to be sought for each strand of treatment and support. At the same time each of the professionals delivering this patients care require the professional supervision over their case load and work. The Government's proposals will not deliver quality services for the patient, and will not quality professional supervision within a specific discipline.

11. Conclusion

11.1. As outlined above, Unite believe that there are serious flaws in the fundamental assumptions and proposals laid out in the Health and Social Care Bill. For this reason Unite believe the Health and Social Care Bill should be withdrawn.

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