Unite the union

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Unite for the NHS

PEOPLE'S INQUIRY REPORT

18 point plan to rescue London's NHS

By John Lister

After six months of work, seven public hearings, evidence from almost 100 witnesses, over 30 hours of testimony and 144,000 words of transcripts, the Peoples Inquiry into London's NHS, initiated and supported by Unite has published its final report, London's NHS at the crossroads.

Its 18 recommendations, all unanimously endorsed by an independent panel , chaired by former trust chair, management expert and blogger Roy Lilley, start with a firm warning: unless George Osborne's financial stranglehold on the NHS is relaxed, London's NHS will become unsustainable.

Osborne's plans would at best freeze NHS funding until 2021, while inflation and cost pressures, including drug costs, new technology and the needs of an ever growing older population would continue to rise.

The Nuffield Trust and others have warned that the gap between resources and the amount needed to meet demand is spiralling. The experts agree the total gap in England could be another £30 billion, on top of the £20 billion the coalition hope to have squeezed out of the NHS in "cost savings" by 2015. NHS England says the gap in London alone could be a massive £4 billion.

Already the period since 2010 is the meanest-ever period for growth in NHS funding. Some budgets are not just falling behind inflation, but being actually cut back year by year.

Of course the decision to freeze and reduce NHS spending as a share of national wealth is a political decision, reflecting the priorities of this government of millionaires. It doesn't have to be this way. The UK – no big spender when it comes to health is a lowly 15th in the league table of health spending: the booming German economy spends a far higher share of its wealth on healthcare than the UK.

Over £4 billion in surpluses that have been so painfully accumulated by NHS commissioners have been handed back unspent to the Treasury. Billions more sit in the reserves of foundation trusts.

The Inquiry wants that money back, and more for the NHS to be raised through progressive taxation – getting the rich and big business to pay.

But it also wants more sensible planning of how the money is spent and services are planned – with the restoration of a new type of strategic health authority for London, possibly linked with the Greater London Assembly to provide democratic input.

The Inquiry points out that unlike any other big city in England, London – split as it is into 32 boroughs and the City of London – lacks a unified city council, and London's NHS is more fragmented than ever, with 32 Clinical Commissioning Groups and no proper planning structure.

The Inquiry also wants a new regime of transparency in decision-making, with all the key bodies required to meet in public, publish their board papers and subject to the Freedom of Information Act. It wants a willingness to accept accountability under the FoI Act to be a condition of any contract with non-NHS organisations.

More money, more planning, more accountability and control: this is the formula to set the NHS on the path to recovery in London. The Inquiry spells out its challenge to all the main political parties: if they profess commitment to the NHS they must commit to fund it properly and reorganise it to ensure the services work for people, not profits.

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Giving local communities a voice on healthcare

The panel noted the general lack of response from Health Watch organisations in the rest of London to our appeal to participate in the Inquiry, and the consistent absence of any Health Watch voice or visible involvement in any other local campaigning around issues of public concern such as hospital reconfiguration and other issues.

This is especially noticeable in comparison with the much greater powers, local legitimacy and roots in local communities which were previously enjoyed by most Community Health Councils until they were abolished by Alan Milburn in 2003.

There seems to be little confidence anywhere that Health Watch can ever achieve any of the energy, impact and focus that were previously a feature of the best and most active CHCs. So poor have Health Watch been at sticking up either for local patients or themselves that a quarter of their funding has been effectively cut from Health Watch budgets with barely a whimper of protest.

As they stand, local Health Watch groups, seem doomed to remain as toothless and largely irrelevant organisations left on the sidelines as the public and local communities campaign on issues that concern them.

The Panel recommends that Health Watch England is closed down, and local Health Watch bodies are separated from the CQC and remodelled on the old CHCs, linking up with local community organisations, pensioners groups and other community organisations, and given statutory powers to inspect hospital and community services, to object to changes which lack public acceptance, and to force a decision on contested changes from the secretary of state.

Peter Kavanagh
Unite regional secretary
London and Eastern region

Welcome!

Welcome to the first edition of the London and Eastern region's news-sheet, 'Unite to Save the NHS'. Your region has taken the decision to launch this paper because we feel strongly that the NHS is not safe in this government's hands – in fact it is very clear the ConDems are handing it over, bit by bit, to the privateers, whose primary motive is profit rather than patient care.

'Unite to Save the NHS' will tell the truth about what is happening to our NHS in our region. We will keep you informed about what the privateers are getting up to in your area, as well as keeping you up-to-date about how Unite members, other trade unionists and campaigning groups within the wider community are fighting back to defend our NHS. In this first issue we focus on the People's Inquiry into London NHS. Its findings are a damning indictment of the government's reforms.

You too can do your bit to help fight to save the NHS by distributing this paper in your workplace, talking to your workmates about the devastation our NHS is facing and getting involved in your local campaigns.
As Aneurin Bevan, the architect of the NHS, said many years ago `The NHS will last as long as there are folk left with the faith to fight for it'. It is time to join that fight!

Dump Hunt's clause 119

The task of reorganising London's NHS needs more and better assessment of the capital's health needs,and engagement with local communities, not brutal new tough legal powers to impose unpopular cuts and closures.

That was the Panel's response to the effort by Jeremy Hunt to add clause 119 to the otherwise unrelated Care Bill, which has now been passed by the Commons.

The Inquiry heard, especially in the South East London hearing at Lewisham Hospital of concerns at the sweeping powers the Trust Special Administrator already had, allowing them to override the normal planning processes of the NHS.

Clause 119 goes further: it means no hospital can feel secure from potential intervention if any neighbouring trust ran into difficulty.

The proposal by the Trust Special Administrator for very substantial cutbacks in services and closures of buildings at Lewisham Hospital would have been driven through unchanged despite its many flaws – and without the possibility of legal challenge – had clause 119 been in place.

It could open up a fast track for the implementation of bad policy without any local public support or engagement. The Panel called for the swift repeal of clause 119 by whichever government takes over in 2015.

But it also called for a London-wide needs assessment and analysis of patient flows and existing resources, to be drawn up without delay for the new Strategic Health Authority at the earliest possible opportunity, by a panel including public health experts, commissioners, providers and local authorities.

This assessment should then serve as the basis for community planning of integrated health care services in the various geographical localities in London, within available resources.

The full proposals, objectives, resource implications and action plan would then be put to a thorough and inclusive consultation including staff, local communities and patient groups.

Invest to improve primary care

The Panel also noted that previous attempts to invest in and expand primary care services in London had been largely abandoned, and the share of NHS budgets spent on primary care has been falling, despite the low level of GP numbers and the growing pressures on the service.

It called for an investment programme in primary care to be reinstated as a priority of a new Strategic Health Authority for London, linked with a full needs assessment.

Part of this must involve realising long-standing promises and aspirations to ensure that smaller GP practices be urged to collaborate more effectively with others, and that all GP practices in London are able to make use of modern, accessible local facilities in a health centre.

The Panel also called for a further initiative to expand the workforce of GPs for the future by those planning medical education through Health Education England in conjunction with the three Local Education and Training Boards that cover London.

Scrap Lansley's Act!

Evidence to the Panel showed that the Health and Social Care Act which took effect from April 2013 has created a more complex structure for London's NHS – and one which is less accountable to Londoners. It increased the number of decision-making organisations, while removing the body responsible for strategic overview and planning.

With so many additional decision-making bodies, the expected savings in terms of management cannot be realised.

Moreover, quite contrary to what we were told with the establishment of CCGs, the Act has brought not local control but a much greater centralisation of control in the hands of NHS England, Monitor and the Trust Development Authority.

To make matters worse, Section 75 of the Act specifically aims to create a competitive market in health care. Regulations that were adopted in April 2013 could now effectively compel London's 32 CCGs each to put dozens or even hundreds of contracts for services out to competitive tender.

in London, tendering in this way could lead to fragmenting existing integrated services as well as increased bureaucratic costs that detract from resources for front-line care.

The Panel found no enthusiasm for this new competitive market, even among foundation trusts which have so far been successful in securing substantial contracts. Not one witness told the Inquiry of any positive benefits to the NHS from all this additional bureaucracy and management effort.

Experience outside London where large community health contracts have been awarded to private providers has been mixed at best, with negative impact on the development of other related NHS services, and questions over the quality and viability of the privately delivered care.

Since many of the proposals that might be brought forward for the improvement, integration and greater efficiency of services in London run into the obstacle of the new Act, the Panel calls for the rotten core of the Act, those sections that impose competitive tendering, to be repealed at the first available opportunity, along with steps to restore the explicit duty of the Secretary of State to provide a universal service, as proposed in Lord Owen's short Bill.

999 for London ambulance service

The Panel heard a detailed account of some of the problems developing in London's ambulance service. Malcolm Alexander, who chairs the Patients' forum for the London ambulance service (LAS) spoke of the increasingly long delays in responding to C1 and C2 category calls.

These people are not regarded as being the most urgent cases, but may have fallen, had an accident or have taken an overdose – and may wait for 2 to 3 hours for an ambulance.

The LAS Trust's performance for these patients in September 2013 was just 66 per cent for C1 and 59 per cent for C2, against a target of 90% to reach the patient within the required 20-30 minutes. This seems to suggest that frontline staffing levels and resources of the ambulance service are not keeping pace with the rise in urgent and emergency calls across London.

Future plans are confusingly presented with a misleading rhetoric of "pathways of care" – which conceals the fact that none of these pathways appears to have been clearly established or viably operating.

There are significant problems especially for mental health patients, older patients – and for primary care, which seems to be expected to shoulder most of the responsibility for providing these so-called pathways.

There is the question of whether it makes sense for skilled ambulance crew to be waiting hours at a call, arranging a package of care for one individual patient, instead of on the road responding to emergency calls.

Many of the legitimate concerns raised by witnesses in the various panel meetings centred on the awkward and lengthy journeys that they might face to access alternative hospital services if their local hospital closed. These arguments are often simply brushed aside by those leading reconfiguration, or responded to by highly misleading claimed journey times which take no account of the actual experience of patients and relatives.

The Panel calls for an urgent review of emergency ambulance services to establish the resources needed to meet and sustain target standards, along with a review of the system of pathways of care, to quantify the resources required to make these a reality rather than an empty phrase, or simply another complex task dumped onto already overstretched GPs.

And the Inquiry calls for an appraisal of the costs, benefits and viability of the expanded network of Patient Transport Services that would be required for LAS to provide reliable services that could enable less mobile patients to travel further for outpatient treatment in the event of hospital reorganisation.

Time for a fair deal for mental health

The medical director of the South London and Maudsley trust, Dr Martin Baggaley told the Inquiry of his concerns over the growing shortage of mental health beds in London, and the growing waste of public money in purchasing less effective care for NHS patients in private psychiatric hospitals.

Others also spoke of their concerns over the resource constraints on mental health care. Mental health trusts have been campaigning for mental health care to be subject to the same type of targets for maximum waiting times as apply to the acute sector.

The inequality is stark: while acute services now have to be delivered within 18 weeks, waiting times for some Child and Adolescent Mental Health Services are now 18 months, with young people having to travel huge distances to access appropriate beds. The 'Francis effect' is driving a panic recruitment of additional nurses for acute hospitals – while numbers of nurses in community health services such as mental health have reduced.

Targets for improved access to talking therapies for mental health care have also been missed in primary care. National level spending on mental health services has declined for the second successive year, after 10 years of growth. To make matters worse, mental health trusts face a 20% larger annual reduction than acute trusts in the tariff price to be paid next year for treatment in NHS hospitals.

In London all the reconfiguration plans have ignored their potential impact on mental health provision, and largely omit any serious discussion on mental health services.
Although the government has just published a substantial new policy document Closing The Gap calling for equal status for mental health, in London efforts to close the gap need to start with challenging the priorities that prevail in CCGs and in NHS England.

The Panel calls for a moratorium on any further service reductions in mental health, pending a rapid, full-scale review of the resources available, to be followed by swift action to respond to the gaps and shortfalls and resources
that are identified.

And after hearing of the threat to specialist NHS forensic services from the flawed tariff introduced by NHS England, the Panel calls as a matter of urgency for NHS England, and its London regional office to revise its tariff taking account of the average cost per episode and the effectiveness of treatment, rather than the crude daily cost per bed, which favours low quality private providers.

Integration, Integration, Integration

Like many other parts of England, London suffers from a desperate lack of a viable infrastructure of integrated services to support patients discharged from hospital. Without such services promises to prevent unnecessary admissions to hospital ring hollow. Many patients need a package of care at home – but that's more than routine primary care services can provide.

The Inquiry heard no convincing evidence that substituting community based health care for hospital-based care would necessarily save much money, let alone facilitate the closure of NHS beds. But the Panel agrees with those who argue that there are benefits to patients in minimising levels of hospitalisation wherever possible, and keeping hospital stays as short as possible.

The fundamental stumbling block to developing services along these lines is the continued organisational separation of health and social care. This is made worse by:

- NHS cash constraints (worsened by the top-slicing of additional money for social care),
- Limited capacity in primary care to undertake any additional responsibilities,
- and continuing council cutbacks in social care budgets.

One major problem is the new competitive market system brought in by the Health & Social Care Act.
The former boss of NHS London, Ruth Carnall, told Panel members her preferred solution would be the integration of services into 5, 6 or 7 large integrated care organisations, led by large secondary care trusts like Imperial or UCLH – but she admitted that this was "anti-competitive", and that Monitor would not approve.
Successful providers such as UCLH chief executive Sir Robert Naylor, and Central and North West London Foundation Trust finance director Trevor Shipman also told the Panel that more cooperation and integration and less competition would benefit the development of sustainable, high quality services.

Yet Wandsworth CCG, following Section 75 of the Act, has announced it plans to break up the community services currently provided by St George's Healthcare Trust, and put them out to tender.

The Panel calls for a halt to the costly and complex extension of competition and piecemeal tendering of NHS community services, "especially given the problems already being faced in some areas by private providers such as Serco and Virgin in delivering community services of acceptable quality at a profit".

It recommends the integration of community services with existing NHS and foundation trusts where this has not already happened, as part of a renewed initiative to establish joint working with NHS and borough social service departments. This type of arrangement would help to discharge quickly and safely and give genuine incentives for hospitals to reduce admissions.

Bedfordshire CCG launches new "review"

What could be next to go?

By John Lister

After forcing through a major new contract for Musculoskeletal (MSK) services, awarding the contract to a consortium led by Circle and including a company owned by GP practices in the county, Bedfordshire CCG is now going through the motions of "consulting" local people on the future of a range of other services.

The "review" of health services will involve a motley crew, headed by the CCG, but overlooked by Monitor, NHS England, the NHS Trust Development Authority, and costly management consultants McKinsey and PA Consulting.

The four main areas to be reviewed include urgent and emergency care, planned care, long term conditions and children and maternity. In other words all the core services of a district general hospital. It follows on the previous "review" of services in the south east midlands, which concluded that fewer hospitals were needed, and the tightening squeeze on NHS funding.

This will reinforce concerns over the future of the struggling Bedford Hospital Trust, which has consistently been squeezed in recent years, and left out of the MSK contract, which conspicuously involves Luton & Dunstable Hospital Foundation Trust 17 miles away. However for local Bedford patients wanting local MSK treatment rather than a 35-mile round trip, there is a glimmer of hope. The CCG has been forced to agree that local patients who specify a preference for Bedford Hospital can opt to go there, and the CCG will have to pay the hospital the full tariff for their treatment.

So for staff and patients the campaign watchword must be "use it, or lose it" – and a close watch must be kept on the plans emerging from the health service review. Watch this space.

Campaigners in Cambridgeshire force a delay but CCG responds with a sham consultation

Unions and campaigners fighting the possible privatisation of a whole bundle of NHS hospital and community services for older people in Cambridgeshire and Peterborough have forced a delay in the process: but now the CCG has launched a phony "consultation" in place of listening to local people.

The consultation was launched with the belated publication of a few of the sheaf of documents that have been jealously hidden from the public eye by furtive commissioners, under the blanket pretext of "business in confidence".

One of the first to be released turned out to have a majority of its pages and significant content literally blacked out by "redactions": the CCG has claimed they will publish the full proposals only after the contract has been signed.

With so little actual information to go on, there is no chance of any informed response from the local public. But that seems to be the way the CCG wants it as they go grudgingly through the motions of a consultation they previously insisted was not necessary.

It has already been rocked back on their heels by the threat of campaigners to take legal action under the Freedom of Information Act if at least some of the details of the proposals were not published.

One immediate question about the new fake consultation is how much the CVCG are paying its consultants for formulating a deeply flawed series of questions. Among other obvious errors, local people are asked to rank a range of things against each other that are completely unrelated. In each case the questions are loaded to give positive ratings to the CCG's favoured proposals.

People completing the response are several times given the option to increase use of voluntary sector, but no option to decrease reliance on voluntary sector and provide services via state-owned provision. Of course no evidence is offered to show the voluntary sector is superior.

The questions are also stacked in favour of switching care into the community sector, rather than protecting hospital provision. There are no realistic costings for providing care in the community: there is an especially constipated silence over the cost of providing comprehensive 24/7 urgent care in patients' homes. It's clear this will never be anything but a hugely expensive option, and cannot be provided.

If the CCG really wanted people's opinions they could simply ask outright if they want services to stay in the NHS or not.

Meanwhile the privatisation gravy train is conspicuously shorter after the shortlisting to just four consortiums bidding for the £800 million 5-year contract. The private sector banner is now held up by Virgin, Care UK and a consortium led by non -clinical support service corporation Interserve. To trust any of these would be a massive gamble for the CCG. Virgin is already known to be losing money on the contracts it has won, and has no experience of liaison with acute hospitals, Interserve has no relevant experience at all, and Care UK has a chequered history in its NHS contracts.

This could mean the NHS-led consortium headed by Cambridgeshire University Hospital foundation trust looks like an increasingly strong contender, having enlisted the services of the demon privatisers of the Special Projects Team that masterminded previous privatisations in the East of England, and the cooperation of almost all the surrounding NHS providers.

Could it be that after all the shenanigans and waste of millions on consultancy and bureaucracy, Cambridgeshire and Peterborough CCG will wind up doing a deal with neighbouring trusts that they could have organised more quickly and simply by picking up the phone? They can't say they weren't told.

No wage rise for over 50% of NHS staff

Wednesday 12 March, the secretary of state for health in England Jeremy Hunt showed NHS workers utter contempt when he chose to ride roughshod over the Pay Review Body (PRB). Instead of the 1 per cent that had been promised, half of the NHS workforce, including thousands of nurses, health visitors, mid-wives and pathologists will get no wage rise – 0%; a real terms cut.

The Scottish Government has announced that it will honour the Pay Review Body recommendations.

The English government's decision to award the 1 per cent pay increase only to those not receiving annual increments is a blatant divide and rule tactic that won't be tolerated. Incremental pay increases are in recognition of increased knowledge and skills as staff progress in their careers – not part of the annual pay rise process. Your union, Unite recognises the dedication that our health workers show day in and day out caring for patients and keeping the NHS running against incredible odds.

The coalition government has thrown a lot at workers in the NHS over the past few years –the biggest ever reorganisation in NHS history, on top of a massive £20 billion funding squeeze and reals terms cuts. NHS staff have not had a decent pay rise for years – three years of pay freezes and just 1 per cent last year, cuts to terms and conditions and downbanding is making it harder than ever before to make ends meet.

Today is a day to be angry, but we cannot let this government continue to run roughshod over our fantastic NHS staff. 40,000 NHS workers are paid below the Living Wage (£7.65/hour). They give more than 100 per cent, often working unpaid overtime, covering for service shortages and always committing to giving their best. But while half the workforce will get no pay increase there are roughly 400 senior managers earning over £250,000 a year.

The distribution of resources within the NHS has to be shared more equally and as for those that created the financial crisis, they are drowning in money, whilst billions in tax are lost in tax avoidance and evasion. Britain remains one of the richest nations in the world, it is only right that NHS workers get enough to heat your home, pay their bills and support their families.

Enough is enough.
Our brothers and sisters in the NHS work hard taking care of others - and don't deserve this. It's time to get serious. Unite will be moving to consult NHS members over the best way to respond, including industrial action.

Get involved – the NHS needs you

Right across the capital there are people coming together to defend their hospitals and save our NHS.

Find details of NHS campaign groups near you at: www.unitetheunion.org/NHSLondon

David Cameron is wrecking our NHS

Stop him.

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