SLaM News update - June 2006

Following the recent announcement of Lambeth and Southwark Primary Care Trust (PCT) disinvestment in SLaM services, UNISON Branch Secretary Brian Lumsden caught up with Chief Executive Stuart Bell to find out more about exactly what is happening and why. Here is the conversation that followed.

Brian Lumsden (BL): 'Disinvestment' is a horrible word. It's trying to make the situation sound better than it is. This is about cuts at the end of the day.

A lot of people have been concentrating on the fact that there are going to be cuts within Lambeth and Southwark adult services. But, just to reiterate, it does include children's, old age, addictions and other services doesn't it?

Stuart Bell (SB): It affects all the services the Trust provides to the populations of Lambeth and Southwark, because it's a reduction in our baseline income across the board.

BL: I think many staff feel dismayed and shocked by all this. They feel let down really. Just when we thought mental health services were at last coming to the public fore, particularly now that the connection between physical health and mental well being is becoming more clearly understood. And all of a sudden it's almost as if mental health services don't matter. Personally, I blame Payment by Results. Any thoughts?

SB: It's a factor, but it's not the only one. Lambeth and Southwark PCTs are affected more than any others in London by two changes. The first one is shared – all PCTs have had 3% top sliced from their allocations. They will get it back eventually, but in the current year they are not allowed to use it. And that's being made available to offset those bits of the NHS that are in deficit. In London, that is largely acute trusts and some PCTs. And ironically it doesn't include any of the NHS Trusts in Lambeth and Southwark.

They've also been very badly affected by something called the Purchaser Parity Adjustment, which is linked to Payment by Results for acute hospitals. And again, rather ironically, it's designed to cushion the impact of the introduction of Payment by Results where PCTs have been paying less than the national average for their acute services.

In Lambeth and Southwark the historic prices for acute services are below the national tariff (the set price which determines how much payment acute hospitals receive for the work they do). So, as they move to the tariff, Lambeth and Southwark PCTs have to pay more for the same. And the Purchaser Parity Adjustment is a means of smoothing that transition. That reduces the both PCTs' purchasing power and leaves them each with a £20m problem.

Now they are spreading that across all services, so it's not just mental health services that have been affected. They are looking to us for £4m each, but they are looking to their acute providers for about £15m each, and they are also taking money out of their own directly managed services such as district nursing.

We've made the argument to them that this is about the acute sector Purchaser Parity Adjustment, so why does it affect mental health? And the point they make is that they actually spend proportionately more on mental health than most PCTs – which is true, though the need is higher – and one of the reasons they have been able to do this is because they have been spending proportionately less on acute care. And now that they are having to spend something that is more like the normal on acute care they are saying they need to look across the whole picture.

It does raise questions about how PCTs which have very high levels of mental health morbidity are going to going to cope with this kind of situation. And I think the point you make about the impact of mental well-being upon people's physical health and use of acute health services is really important in the long-term.

BL: It would be a long-term shambles if we start closing services like forensic rehab – people will end up having to stay longer in hospital and the Trust will end up paying an arm and a leg for private sector hospital care.

SB: You're right. It's important that we maintain the ability to rehabilitate people and get them back into the community. Otherwise, all the effort we've put in over the last seven years to get things working better starts unravelling. One of the things which is uppermost in our minds about all of this is we don't want the impact to be something that harms the long-term effectiveness of the whole system, so that you actually end up with something that works less well at the end of it. There's a risk that might happen but it's something we are going to try and avoid if we possibly can.

I'd rather hear bad news from you now, rather than bad news at the last minute. People do need to know what's happening

Brian Lumsden

Part of the negotiations we've had with the PCTs is to insist that we move to activity based contracts in October this year. The PCTs have agreed the principle, but the issue of quite when and how we do it is still under discussion. Establishing a clear link between the funding we receive and the care and treatment we provide is very important.

BL: We had a branch meeting recently at the Maudsley and it was the first time in a long time that it was fully attended. People came from all over the Trust. It goes without saying that the biggest concern was jobs.

If this had happened 10 years ago because of the Trust's incompetence over money, we would have been talking strike action, demonstrations, the lot. But we've been satisfied with how things have been going on in the Trust since the merger in terms of services being offered to the community and patients. I think there's vibrancy around the place. There has been a feeling that we're on a bit of a roll, mental health is being taken seriously, and we seem to have a Board that's part of that success. When we people talk about proper partnerships, I think we've achieved that between management and staffside.

SB: I think you're right, and that's down to both parties.

BL: Personally, I'm against strike action at the moment because it would be affecting patients and staff. Our priority at UNISON is to protect jobs. But given the extent of the cuts taking place, I'm not sure – and I could be wrong – that we can deal with this just by deleting vacant posts. My worry would be that we could lose a lot of core, experienced staff that are virtually irreplaceable in the present market – and I'm not just talking nurses here, I'm talking all professions – and that would be a big mistake.

Has anybody thought this through yet. I'd rather hear bad news from you now, rather than bad news at the last minute. People do need to know what's happening.

SB: We don't the precise details yet about the effect of this situation on jobs, because you've got the detailed discussions about what's going to happen where still to be finalised. Some things we know, others we don't.

There is the timescale by which these changes happen to think about. The longer it takes to make the changes, the more scope we've got for redeployment just in terms of natural turnover. You've also got retirements – there are quite significant numbers of retirements in some parts of service which are due to happen quite soon, so that will be an offsetting factor. And you've got services opening at the same time – the Lambeth forensic service is opening next month and the Bethlem one is a year away, and we've still got other developments happening in other places as well. So you've got to put all of those into the picture together.

The PCTs have to own the responsibility that this is to do with the amount they spend and where they choose to spend it on in mental health services

Stuart Bell

The fact that we have achieved relatively low usage of nursing agency staff is one of the reasons why we haven't got the option of tackling this problem by reducing agency staff. But I agree with you that it would be really sad and counterproductive if we lost people who have lots of skills and experience who we would want to have in the future, just because of some short-term hiatus. I want to avoid doing that. But it's going to involve quite a lot of careful work. Redeployment isn't just a case of any job – it's got to be a job you're equipped to be able to do, so we've got to think about that as well.

BL: And I suppose another issue in a Trust this size is that someone working in North Southwark isn't necessarily going to want to work in south Croydon. In terms of partnership, I'd like staffside to be in there working these kind of issues through. And there's also the issue of how much it would cost if you have to look at redundancies.

SB: Yes, if you make all the savings and then use them on redundancy payments, then you have to make the savings all over again.

BL: Traditionally, in lots of industries, employers have looked at voluntary redundancies. Have you thought about that?

SB: We've considered it, and I don't think we're going to be in a position to be able to.

BL: I'd like all things taken into consideration really. It's looking at things sensibly and centrally – traditionally we've done things Borough wide.

SB: I agree with that, because you've got the interaction between all the different services, and I think we need to look at it across the Trust as a whole. It's going to be a balancing act, and it needs intelligent judgement. The touchstone in the end has got to be what's the best thing for the service. And we need to look at individual human factors.

BL: I fully agree with you about the needs of services. But from my point of view it's about trying to preserve jobs – and I suppose we might have to look at redundancy potentially.

SB: I hope to avoid this if we possibly can, but it we may have to take it into account in all of this.

BL: In terms of new jobs and vacancies, have you decided on a job freeze yet?

SB: Not across the board. Obviously, in the areas affected we're saying to people be very, very cautious about recruitment. We need to think about at what point, and to what extent, we think about slowing down on recruitment generally. There are some areas that are relatively unaffected by this – such as acute inpatient wards and medium secure services (there are actually more jobs there). But not everybody necessarily is going to be in a position to go into those jobs, it might not suit their skills.

So the point I'm making is that if you simply just put in a blanket freeze across the board that's not the right thing to do. But we are getting close to the time when we need to think about our priorities in terms of redeployment – who's going to need deployment and when.

BL: How clear is it about exactly how services will be affected? I'm thinking in particular about the knock on effect of cuts.

SB: One of the issues we need to work through in more detail is the interaction between national services and local services. Are we looking at mergers of services, for example? That's one of the reasons these kind of decisions have got to be taken across the Trust as a whole, and not within individual directorates.

BL: What about the knock on effect to infrastructure services?

SB: I think the PCTs would like us to achieve all these savings by reducing infrastructure costs, but that's just not realistic. That would affect the whole Trust. We've said to Lambeth and Southwark PCTs that, as this is about what they spend on their bits of the Trust, they can't expect Lewisham and Croydon to subsidise the impact of what they are doing – this is about their disinvestment.

And we have already made significant reductions in infrastructure costs through the business planning process. This year we asked corporate directorates to come up with a higher level of efficiency savings than the clinical service directorates, 40 per cent higher actually. That said, I think we will have to look all infrastructure services to see if we can do them more effectively in future. One of the issues that is common across the NHS is thinking how to make most effective use of resources.

BL: Is there any scope for us to expand our infrastructure services to take on services for other trusts and PCTs?

SB: We haven't been looking at that lately because we've been so busy with Agenda for Change. But it's certainly something that's open to us – are there ways we could provide services for others?

And there are already bits of our infrastructure that do generate income. So, for example, the consultancy service generates income from providing services to other NHS organisations and overseas. And for some bits of our infrastructure that's absolutely the right thing to do. Some of the training we offer, we ought to be offering more widely for people who are interested in it. If that helps us support something here that we wouldn't otherwise be

able to do then that's all to the good. This issue is connected with the discussion in the Trust strategy about whether we should be thinking about mental well-being as well as directly provided services, and what of the kinds of things we might be doing that would have an impact there. Where I'd be a bit more sceptical is if we just do this kind of thing willy nilly, irrespective of whether it makes sense.

BL: You seem to be putting across that it's the PCTs who need to make the final decision about the service cuts. And I think you're right, but the worry for me is that they'll come up with the wrong decision.

SB: This is about what they choose to fund. Obviously, we're giving them our views – and they're asking us for our views. They're saying to us "what do you think is feasible, what is not". They've got some ideas of their own, and if we think those ideas are daft then we tell them so. But in the end, I think they have to own the responsibility that this to do with the amount they spend and where they choose to spend it on in mental health services. I'm anxious to avoid the position where the responsibility for how it all functions is solely the Trust's, because I don't think we can do that independently of decisions that commissioners make.

That's one of the reasons we have been so insistent on the need for activity based contracts, partly so there's ownership of that responsibility but also so that there is an alertness on the part of commissioners to the consequences of their decisions. If they cut something that means we can't function, then we'll have to use the private sector – and they will need to pick up the tab for that in future, whereas that wouldn't have been the case in the past. If we're not running our services properly then that's our responsibility, but if it's about what they fund, then it's theirs.

BL: What happens if they don't understand and if they do make daft decisions, who oversees that?

SB: You try very hard to persuade people before that happens, but in the end that responsibility will be the new London Strategic Health Authority. But actually I think our PCTs are pretty sensible on the whole. I think they are certainly open to reasonable discussion and I think they listen to us. And we need to remember that they are experiencing very significant changes themselves. It's important for us to keep the relationship so we can have those conversations, rather than just being at loggerheads all the time.

BL: Will we be able to avoid this kind of situation in future if we are a Foundation Trust? How would things be different?

SB: Interesting point actually. To become a Foundation Trust you need to have legally binding contracts with the PCTs. That means a contract which is related to a certain amount of money over a certain amount of time – with some kind of activity threshold attached to it.

I agree that people are just getting on with their jobs, despite all this uncertainty

Brian Lumsden

BL: This is what you're trying to do in October anyway?

SB: Yes. And you have to have that in place as a Foundation Trust, which is what we're hoping to achieve. So, with those legally binding contracts in place, the PCTs aren't in a position to say "our own position has suddenly changed, we're going to have to take this amount of money out".

It is not possible to be definitive about this, but I think becoming a Foundation Trust gives more structure to your position. One of the big problems for mental health trusts generally is that there is Payment by Results in the acute sector, but not in mental health. So if you've got a direct relationship between how much you do in the acute sector and how much you get paid, the PCTs have got very little choice other than to pay up. We don't have that in mental health yet. So if they can't afford mental health services they could just pay you less instead. And we would just have to get on with it. Foundation status gives you that legally binding relationship between money and activity – it isn't absolute, but it's there. It's really important for us to get that, and I think you get it more securely as a Foundation Trust. Given the turbulent times in which we live, I think that's really significant. It doesn't insulate you absolutely – Foundation Trusts are still part of the NHS – but it does mean that if there's a change there's a recognition that if you have less capacity, you can't be expected to do as much work. So you are more secure.

BL: Until your contract finishes

SB: Yes, but then the theory is that by the time we get to the end of the three-year contract, we'll have Payment by Results and a national tariff in place within mental health.

BL: Is it true you've kept £4m back to fund Foundation status?

SB: We're funding certain pieces of work that we need to get done, like supporting the membership, and there's an expectation that Foundation trusts make a surplus – but there's now an expectation that we make a surplus this year as an ordinary NHS trust anyway, whether or not we are an Foundation Trust – but I don't know where you've got the figure of £4m from.

BL: I thought you'd have to keep money back to become a Foundation Trust, in terms of financial viability. My worry is that if that had been the case, that would be wrong if it's at the expense of people losing their jobs. We're still opposed to Foundation status– I was opposed to Trust status, Agenda for Change and a range of other things. But, in a pragmatic way, once it happens it's better for us to get involved. I'd rather SLaM becomes a successful FT Trust. So we'll do it jointly, even though we don't agree with it.

One of the things at the staff meetings I've been to "what happens to all these people in suits, these managers who cost a lot of money, who we don't really need", that type of thing.

SB: Who do they mean?

BL: I don't think they know who they mean. They see loads and loads of people in jobs, and I get the impression that they don't know what they do (I actually don't think we have enough managers in some areas of the health service, I think that's quite clear). But that is the sort of thing that will come up. I think we need to get this message across why these people are important.

I saw the bit about professionalism in your letter to staff, and I have to say that I agree that people are just getting on with their jobs, despite all this uncertainty. But I think there's a risk that attitudes may change when the changes actually happen.

SB: I think when we actually get to the period of change, we need to do it as quickly as we can, because the less a period of uncertainty there is for individuals the better.

BL: That means getting information out to people, up front, to prevent that myth mongering that goes around. People can pick things up wrong or just hear what they want to hear.

SB: The critical thing is our discussions with the PCTs around process. This is the thing which sets the timetable. We need to work through what we need to do and who it's going to affect – whether it's a service closure or merger. That's how we get to grips with redeployment. We had to come up with these proposals at very short notice to deal with the disinvestment. Now we need to work through the implications carefully. And we will work with staffside on that.

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Stuart Bell

Glossary of terms

Activity based contracts	A process by which funding is allocated to NHS Trusts based on the actual amount / nature of care and treatment provided to patients and/or the actual number of patients treated.
Acute health services	Services providing care for a disease or illness with rapid onset, severe symptoms and brief duration.
Allocations (PCTs)	The annual amount of funding Primary Care Trusts receive from the Department of Health with which to commission NHS services on behalf of their local populations.
Business planning	The annual planning process which determines and sets out the Trust goals and spending plans for the coming year.
Commissioning	The full set of activities that local authorities and PCTs undertake to make sure that services funded by them, on behalf of the public, are used to meet the needs of the individual, fairly, efficiently and effectively.
Foundation Trusts (NHS)	NHS organisations that are run as independent, public benefit corporations, controlled and run locally, with increased freedoms to decide how best local services should be delivered.
Infrastructure services	Non-clinical functions which support the running of the organisation and the delivery of clinical services.
Payment by Results (PbR)	A scheme that sets fixed prices (a tariff) for clinical procedures and activity in the NHS whereby all trusts are paid the same for equivalent work.
Primary Care Trust (PCT)	Freestanding statutory NHS bodies with responsibility for delivering health care and health improvements to their local area. They commission or directly provide a range of community health services as part of their functions.
Staffside	Trade Union representatives.
Strategic Health Authority	The local headquarters of the NHS, responsible for ensuring that national priorities are integrated into local plans and for ensuring that PCTs are performing well. They are the link between the Department of Health and the NHS.
Tariff	A fixed price – determined as part of the introduction of Payment by Results – which determines how much payment NHS acute hospitals receive for specific treatments.
Trusts (NHS)	Self–governing bodies with the freedom to decide staff numbers and rates of pay, and also have some powers to invest and borrow money. They provide services for their local population and may also develop specialist services for a wider, regional population.
UNISON	Britain's biggest trade union which represents people working in the public sector, including frontline staff and managers working full or part time in the NHS.

Further information:

This issue was discussed at the SLaM Trust Board meeting on 6th June 2006. A copy of the paper presented to the Board is available on the intranet: click on 'About SLaM' on the left hand side of the homepage, then go to 'Trust Board meetings'.

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