UNISON

Health Care

West Midlands merger plans:

A blank cheque for privatisation

From quango to super-quango - a new step backwards for accountability in the NHS.

A response to the consultation documents on Strategic Health Authority arrangements and the reorganisation of Primary Care Trusts in the West Midlands, researched for UNISON West Midlands Health Group.

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EXECUTIVE SUMMARY

1. UNISON is most concerned that the documents proposing the merger of three Strategic Health Authorities into a single West Midlands SHA, and the accompanying proposals to merge many of the existing PCTs are desperately lacking in detail, and that they fail to address the underlying context and framework within which this latest reorganisation of the NHS is taking place. In fact the process towards mergers of PCTs is being driven by an accelerating national drive towards the fragmentation, privatisation and marketisation of our NHS.

2. The plans flow from a controversial circular to all NHS managers last July – 'Commissioning a Patient Led NHS' – which pressed for the separation of PCTs' commissioning role from their direct provision of services. The Commons Health Committee, in a hard hitting report last December expressed itself "appalled" at the lack of clarity over the future of services provided by PCTs, and unconvinced by ministerial assurances that there was no actual instruction for all PCTs to divest themselves of all services immediately.

3. Making no secret of her agenda, and defending the line of privatisation, Health Secretary Patricia Hewitt went as far as to claim at a press briefing on February 17 that PCT staff were eager to be privatised. UNISON wants to state categorically that no such sentiment is being expressed by our members whether in PCTs, NHS Trusts or Foundation Trusts.

4. UNISON has consistently opposed the remodelling of the NHS along market lines, and we strongly reject the implicit assumption that the introduction of more private sector providers – with or without competition – offers any guarantee of improved quality or reduced costs within the NHS.

5. We hold no brief for the existing structures: however we do believe that the NHS needs some form of mechanism to make local services accountable to local people, and the current reform process seems set to continue down the road of

eliminating any residual element of democratic involvement or accountability, even as it hypes up the deceptive rhetoric on 'patient choice' and 'responsiveness'.

6. The document says nothing about:
    - How many members will sit on the new SHA,
    - How they will be selected,
    - On what basis, for how long, or by whom,
    - Whether or not there will be any attempt to ensure geographical areas are represented,
    - Any means by which this new super-quango might be held to account by the 4.3 million people whose health care services would be in their control.
    - We are not even told *where* the new SHA would be located, or
    - What mechanism – if any – would enable people to contact its members, lobby for policies, or protest against policies which are seen to undermine local services or fail to meet local demands.

7. There is no explanation of how a new system with fewer quangos covering larger population gives "people" any control at all over the level, location or quality of the services they will be offered.

8. Opinion polls and surveys confirm that the first choice of NHS patients is the opposite of government policy: people want continued access to comprehensive local NHS services in the hospitals they know and love. The proposed changes are not a local policy tailored to local needs but a rigid national blueprint, driven from the top downwards.

9. UNISON also notes that the "payment by results" system is yet another key element of a competitive market in health care designed to maximise private sector involvement and siphon money out of NHS Trusts and Foundation Trusts. Every patient diverted to the private sector takes the cash with them out of the NHS, leaving local Trusts to cope with a reduced budget.

10. Conspicuously, the new policy proposes the need for "stronger PCTs" but avoids any reference to them delivering services.

11. "Your views are crucial", claims a document offering no options or alternatives other than a merger of three SHAs into a new super quango. But there is no attempt to explain why or how anyone's views are crucial – especially in the context of decades of cynical "consultation" exercises in which the entire process was simply a charade, with any critical views suppressed or ignored.

12. While the new system will destabilise NHS providers and force a new round of privatisation, government ministers and NHS managers will be keen to attribute these changes to "patient choice".

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

14. The Birmingham & Black Country SHA currently has 12 PCTs. The two options on offer would reduce this to 8 (leaving 3 PCTs in Birmingham) or to 6 (merging the Birmingham PCTs into one to cover England's second largest city. The reality is that each of the mergers will sever the local links and working relationships that have been built up – while the new merged bodies will be unaccountable to anyone at local level.

15. We agree with the Commons Health Committee, which has noted the research evidence that shows that

> **"increases in PCT size beyond populations of 100,000 patients do not necessarily generate substantial improvements in overall performance. … Health Authorities were large commissioning organisations, and their size does not seem to have made them effective organisations."**

16. In Shropshire and Staffordshire SHA, the plans proposed would reduce the number of PCTs from ten to just four or five – but again the arguments in favour are not very clear. The more radical solution would see a single Staffordshire PCT covering 786,000 people, alongside a Stoke PCT just a third of the size. The "reorganisation" process is moving from a situation where most PCTs are around the original target size to maximise local links and connections, to one where mega quangos with few if any links to the needs and view of local communities preside over services, with the danger that an ever larger budget would be diverted to purchasing services from the private sector.

17. West Midlands South is the only SHA to have outlined any attempt to remedy the worsening democratic deficit that will arise from the wholesale merger of PCTs. Indeed WMS appears to be the only part of the proposed new West Midlands SHA to have had any level of real debate on proposals, and the only one to present a range of options. The favoured option would result in county-wide PCTs that would effectively collapse any concept of local planning. UNISON sees no merits in the new proposals outlined for WMS either for patients or for health workers who are already suffering the consequences of previous ill-judged decisions and facing another year of cuts, closures and impending privatisation.

SHA and PCT mergers

The context

The proposal for the merger of three Strategic Health Authorities into a single West Midlands SHA, and the accompanying proposals to merge many of the existing PCTs to form county-wide or rural plus urban PCTs have been set out in a series of consultation documents.

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

In fact the process towards mergers of PCTs is being driven by an accelerating national drive towards the fragmentation, privatisation and marketisation of our NHS. The letter from the former NHS Chief Executive Sir Nigel Crisp which serves as the introduction to each of the documents, flows from his controversial circular to all NHS managers last July – 'Commissioning a Patient Led NHS' – which pressed for the separation of PCTs' commissioning role from their direct provision of services.

Sir Nigel's call for PCTs to divest themselves of their directly provided services left (and still leaves) unanswered the question of who should take over these services. Did he mean it to be the private sector? The voluntary sector? or other sections of the NHS – perhaps local hospital Trusts would be encouraged to move back in to an expanding community and primary care sector?

With over 250,000 staff working for PCTs, the majority of them in directly-provided services, the issue is an urgent and worrying one. Who did Sir Nigel expect would be their employers once his full proposals had come into effect, leaving the PCTs acting purely as commissioners by 2008, and delivering no services themselves?

Strikingly, Crisp himself, right up to the point of his enforced "early retirement" at age 54 to the House of Lords, offered no clarification or assurances despite the wave of anger which forced many Labour MPs to make strong representations to ministers, and ministers to step in and insist that there was no actual instruction for all PCTs to divest themselves of all services immediately.

Despite these assurances it is clear that many PCTs are continuing to work towards precisely the separation of services that ministers have disavowed. The Commons Health Committee, in a hard hitting report last December expressed itself "appalled" at the lack of clarity over the future of services provided by PCTs, and unconvinced by ministerial assurances. The MPs concluded that
"As far as we can see the overall direction of travel in fact remains unchanged, and PCTs will ultimately divers themselves of provider services" (Changes to Primary Care Trusts, December 15 2005; para 35, p16)

It is equally clear that ministers themselves, again despite assurances to the contrary, are looking to create an increasingly marketised health care system, embodying a systematic separation of purchaser and provider roles, if not now, then certainly within the next few years.

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

> "there was 'widespread enthusiasm' from staff to move out of the NHS and work for the social enterprises invited to bid for primary care provision.
> "She called for 'unions and professional bodies to start to see it as something which their own members are very interested in, and that there is a need out there to which they should be responding'."
> (*Health Service Journal,* February 23, p7)

We don't know how Ms Hewitt could have formed such a false impression, but UNISON wants to state categorically that no such sentiment is being expressed by our members whether in PCTs, NHS Trusts or Foundation Trusts. There have been sufficient disastrous experiences with the private sector in the last 20 years for all NHS staff to fear that it will inevitably lead to a reduction in pay and conditions, reduced staffing levels, and plunging standards.

UNISON has consistently opposed the remodelling of the NHS along market lines, and we strongly reject the implicit assumption clearly held both by ministers and by senior NHS managers that the introduction of more private sector providers – with or without competition – offers any guarantee of improved quality or reduced costs within the NHS.

No evidence for market reforms

There is no evidence at all that market-based health care can deliver a comprehensive health service, address issues of equity and health inequalities, or improve the quality of care. Nor, of course can it save money: evidence from around the world confirms that far from reducing costs, competitive systems in health care increase transaction costs, requiring more bureaucracy and administration, while private sector providers will also always cream off an additional profit from any payments they receive.

It is this underlying background of marketisation and fragmentation that makes UNISON especially reluctant to endorse the proposed reorganisation of SHAs and PCTs in the West Midlands.

We hold no brief for the existing structures: UNISON was critical of the thinking behind the continued separation between purchasers (now redesignated as "commissioners") and providers that was embodied in the PCTs when they were set up just a few years ago. We have never been fans of SHAs, which have never pretended to offer any democratic access, and which have largely acted as transmission belts imposing government diktats on PCTs and Trusts.

All three of the SHAs themselves have stubbornly refused to recognise trade unions as representatives of their own staff, remaining rooted in 19th century notions of labour relations – and this makes it hard to trust claims that they are now genuinely seeking any consultation on their proposals, or to believe that the new, mega-SHA they are proposing for the West Midlands will have any more enlightened view on trade union involvement or partnership working.

We also note that the latest plans for reorganising services in Dudley and Sandwell will belatedly reflect UNISON's rejected recommendations several years ago, when the PCTs were first established. We would point out that this long circular journey has squandered millions in bureaucracy and duplication of management structures, all of which could have been saved if our members' views had been taken seriously in earlier consultations. In Birmingham, too, the consultation now asks whether the new system should include three PCTs or one massive one – but we are not told why fewer organisations are now the answer, when apparently more, smaller, organisations were the preferred solution just three years ago.

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

Fewer, larger and less accountable PCTs

We are also concerned that fewer, larger, and less accountable PCTs will be more vulnerable to future pressures from above to privatise, hive off or close down services. We note that even during the consultation process itself steps have been taken towards the privatisation of GP services in Derby and in North Derbyshire – with rumours in the medical press that up to 15 percent of GP practices could be hived off in similar fashion to private companies such as United Health Europe or for-profit groups of GPs. The NHS nationally has also embarked on the disastrous experiment of privatising the delivery of home supplies of oxygen

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

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

But more alarmingly the consultation document also fails to tell us anything about the proposed new body that will control a combined health economy of more than £5.6 billion, span a population of 5.4 million people and cover an area of over 5,000 square miles.

The document says nothing about:

- How many members will sit on the new SHA,
- How they will be selected,
- On what basis, for how long, or by whom,
- Whether or not there will be any attempt to ensure geographical areas are represented,
- Any means by which this new super-quango might be held to account by any of the 5.4 million people whose health care services would be under their control.

- We are not even told *where* the new SHA would be located, or
- What mechanism – if any – would enable people to contact its members, lobby for policies, or protest against policies which are seen to undermine local services or fail to meet local demands.

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

The merger into a single West Midlands super-quango appears to represent a further *reduction* in democracy, accountability and connection with the views and needs of local people. To make matters worse, the clear impression is also given that regardless of any response that may be forthcoming the decisions are effectively a fait accompli – making a nonsense of the document's specious claim that "your views will be crucial".

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

The July 28 circular

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

But though it purported to re-shape the way services are commissioned "to reflect patient choices", we know that the last people to have been consulted – or have their views taken into consideration – were patients. Nor were NHS staff asked their views in advance on this new, unwelcome and major upheaval in the structure of the NHS. Despite Crisp's claim that the reforms are reshaping the NHS 'from the bottom upwards', we know that the opposite is the case: the reforms are being relentlessly driven from the top, allowing no time to hear or heed critical views from professionals or the public.

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

Most of the public and many staff are also utterly bemused and disorientated by the constant rounds of 'reform' that have stripped away the old local health authorities and recognisable regional health authorities, brought in a confusing and constantly changing system involving Trusts, Primary Care Trusts and Strategic Health Authorities (SHAs), and scrapped the Community Health Councils that once had a brief to stand up for local people, replacing them with a baffling array of toothless and pointless bodies that few people hear about or understand.

The PCTs that are now being reorganised are just three years old. Even on grounds of common sense we should ask – as the Commons Health Committee has asked – why such a massive new reorganisation is required so soon after the last one. But there are

other grounds for concern: the final objective of the latest policy switch is not one that UNISON or the wider public will support.

The policies set out in Crisp's July 28 circular 'Commissioning a Patient Led NHS' are important because they drive another critical nail in the coffin of an NHS based on principles of planning and social justice. Instead they open the door still wider to a health care "market" in which healthcare is reduced to a commodity, and NHS providers are forced to compete at every level with the private sector and rival NHS providers, with the losers going to the wall.

Purchaser-provider split

This notion of "commissioning" re-emphasises precisely the "purchaser-provider split" which was first controversially introduced to the NHS under Margaret Thatcher's reforms in the early 1990s, and established an 'internal market'. This system was correctly branded as "bureaucratic and wasteful" by successive Labour shadow ministers, and we recall Tony Blair's pledge in the run-up to the 1997 General Election to 'save the NHS' and sweep away the 'costly and bureaucratic' market system.

However the government's determination to go further in the introduction not only of an *internal* market, but of a competitive market which also involves a growing role for the private sector, has become steadily more apparent, and Sir Nigel's policies and circulars clearly reflected that underlying approach.

PCTs, which currently hold the purse strings for most health care services, employ upwards of 250,000 health workers, many of them delivering front line services including community and mental health care. Crisp's plan would mean that PCTs will have to be broken up, and reduced to commissioning only, with their role in provision of services "reduced to a minimum". It is not at all clear how this will be done: services may be hived off to existing Trusts, privatised, or handed to the voluntary sector.

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

Crisp's July 28 circular gave the SHAs less than 3 months to submit proposals – which would then be vetted by the Department of Health, and then put out to "consultation". The changes to PCT boundaries were to apply from October this year (2006): SHA boundary changes from April 2007, and the separation of all services to be completed by April 2008. This is no local policy tailored to local needs, but a rigid, national blueprint, driven from the top downwards.

Meanwhile in the same July 28 circular pressure was brought to bear on PCTs to ensure that the commissioning of all contracts for services is transferred to groups of GP practices – so-called 'practice based commissioning' – "no later than the end of 2006". It's not at all clear that GPs want this additional responsibility. Significantly, the new policy was the direct opposite of the Department of Health's own guidance just seven months earlier that

> "There are no targets: we simply have the aspiration that all practices will be involved in Practice based Commissioning by 2008".

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

Cash diverted out of NHS

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

The PBR scheme, which has begun on a relatively small scale, is due to be rolled out on a generalised basis to cover 60 percent of hospital Trusts' budgets from April – but it is already deep in crisis. The final weeks of Sir Nigel's tenure as Chief Executive were marked by a shambolic decision by the Department of Health that the basic tariff of reference costs, stipulating how much Trusts will be paid for each item of treatment, had to be withdrawn and rewritten at the last minute – leaving Trusts, PCTs and would-be Foundation Trusts completely in the dark. The situation has been aptly summed up in a *Health Service Journal* cover headline 'It's a total cock up' (March 2).

However UNISON is concerned that the PBR system itself is part of the same process of fragmentation that underpins the reorganisation proposals. The destabilisation – and enforced rationalisation – of existing NHS units is another important part of the government plan to create space for a growing and sustainable private sector, delivering care to the NHS … and funded from the beginning from NHS budgets.

We note that among the issues on the agenda for the two senior managers who have stepped into Sir Nigel Crisp's shoes at the helm of the NHS is the establishment of a "failure regime" that will facilitate a fast-track system for the closure of hospitals and services which "fail" in the new competitive market system. We also note the *Financial Times* summary of the agenda for the new permanent secretary at the Department of Health, whose role is described in terms of overseeing a rapidly declining number of NHS provider organisations as ever-more services are hived off to private companies or the voluntary sector:

> "… as head of provider organisations [the permanent secretary] is likely to be responsible for the dwindling number of NHS-run organisations.
> "Other NHS bodies will have become foundation trusts or independently contracted organisations run by the staff, with remaining provision coming from the private and voluntary sector." (*Financial Times*, March 8 2006)

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

The whole restructuring is designed to cut spending on NHS hospital care, diverting more patients to private providers, and encouraging GPs and PCTs to "free up" cash by developing alternative forms of "care outside of hospital". This too dovetails with the recent White Paper on the NHS, which proposed a mechanism that would enable PCTs to be compelled to put in-house NHS services out to tender, inviting bids from private sector organizations. UNISON notes that this is a one-way street towards privatisation: there is no corresponding proposal to enable patients or staff angered at the poor quality of privatised services to force PCTs or Trusts to bring them back in-house.

Excluded from any aspect of the planning or commissioning process, and facing a drastic reduction in income, many hospital Trusts will need to look to hefty cutbacks to prepare for an even tougher year in 2006-7. Exactly how this could result in a "patient-centred NHS" remains a mystery to all but Sir Nigel and his backroom band of pro-market advisors.

A Crisp introduction

The latest consultation documents all carry an identical introduction from Sir Nigel Crisp, and this constant emphasis on developing "a strong commissioning function" which flows from the July 28 must be seen as a polite way of reinforcing a competitive market system, in which PCT commissioners no longer provide services themselves but purchase them from NHS providers and the "independent sector".

Conspicuously, Crisp proposes the need for "stronger PCTs" but avoids any reference to them delivering services: instead he says their role is a restricted one: to "design, plan and develop" better services, "working to ensure that the NHS gets the best value for the public purse". In characteristic double-speak, Crisp goes on to insist that:

> "This new approach to commissioning is about giving the levers to make services more responsive to patients to those best placed to use them."

However it is clear that the "levers" will be handed to fewer, more remote organisations, with no mechanism existing or proposed to allow local people to influence their decisions.

And we should also note Crisp's reminder that the new approach is also about "enabling resources to be freed up" to "reinvest in new services". This is a coy way of proposing cuts not only in management but in existing services, and is a particular cause for concern in view of the uncertainty over who – if anyone – will take over some of the existing PCT-delivered services.

Crisp's introduction concludes by claiming that SHAs have been "discussing with their local communities" since his circular came out on July 28. Few people will recognise Crisp's view of the process so far, but even fewer will find any reason to believe that this process has either been led by – or in any significant way involved – patients or health workers.

Crisp argues that the plans offer an "exciting vision for patients" – but if he really believes patients are excited by the intricacies of his organisational restructuring of remote and unaccountable quangos into even more remote and less accountable quangos, then he really is deluded.

The SHA Chief Executives' Preface

The three existing Chief Executives of Birmingham & The Black Country SHA, Shropshire & Staffordshire SHA and West Midlands South SHA also offer a preliminary statement for the consultation process.

Their joint Preface claims that the aim of the reorganisation is to deliver

> "a step change in the way services are commissioned by front line staff, to reflect patient choices."

However they do not explain which – if any – patients have expressed a preference for this proposed new system in place of the existing structure of PCTs which is just three years old, and in some areas just beginning to show some positive results after the last major reorganisation.

Nor is it explained how the new system with fewer quangos covering larger populations can in any way hope to secure "better engagement with local clinicians in the design and commissioning of services".

Nor do they explain what – if any – additional choices would be available to patients as a result of this latest reorganisation, in which just one "option" is being proposed for the merger of SHAs, and only limited options, all involving the mergers of PCTs. Behind the brave words it is clear that the separation of PCT commissioning functions and the hiving off of existing PCT provider services could well reduce rather than widen patient choice, denying them the option of an NHS provider, and forcing them to choose between a limited range of profit-seeking private providers.

The SHA merger consultation

"Your views are crucial", claims a document offering no options or alternatives other than a merger of Birmingham & The Black Country SHA, Shropshire & Staffordshire SHA and West Midlands South SHA into a new super quango. There is no attempt to explain why or how anyone's views are crucial – especially in the context of decades of cynical "consultation" exercises in which the entire process was simply a charade, with any critical views suppressed or ignored.

The document goes on to offer a blatant lie:

> "The solutions proposed in this document will be unique to your area, and will reflect the needs, preferences and health priorities of your local communities"

In fact identikit proposals for wholesale mergers of SHAs and of Primary Care Trusts have been wheeled out across the country: even the wording of the main argument is almost exactly the same – only a few details and the local names and cover graphics have been changed, for example, between the West Midlands and the East Midlands consultation documents. Pages 1-8 of the West Midlands SHA merger document are more or less identical in content to pages 1-12 of the East Midlands equivalent: the opening pages of the PCT merger consultations are also crude cut and paste jobs from the Department of Health wording, with only minor changes. The drive has clearly been from the top and the centre rather than from local level.

The documents all parrot the chopped logic of an argument constructed from buzz-words and clichés. The section headed "Your NHS" goes on:

> "Why though is this so important? While most of us are passionate about the sort of services we receive in the NHS – the quality, speed and convenience of care – how many of us want to get tied up with organisational hierarchies and the mechanics of the service? …
> "The answer is simple. The changes proposed here will be [the] defining factor in whether the NHS can sustain the huge improvements it has already achieved and go on to realise its fundamental aim: to deliver a better, more responsive health service that gives people the control and choice they have a right to expect as patients." (page 7)

Roughly translated, this passage is simply a plea to hand even more power over to an enlarged and unaccountable SHA, which has already calculated that most local people don't want to get involved in policy decisions. And it argues that the apparently organisational changes that are the subject of the consultation are actually vital ("the defining factor") in the establishment of a new competitive market system.

We can also deduce from this that while the new system will destabilise NHS providers and force a new round of closures and privatisation, government ministers and NHS managers will be keen to attribute these changes to "patient choice".

Buzz words and empty phrases

The next section of the document "Achieving a patient-led NHS" also combines more buzz-words and empty phrases with a strong focus on "patient and client choice" – although the document is careful to stress the move towards "a wider range of services in convenient community settings", which in the current context of cash crises and failure regimes can be seen as an implicit warning of hospital closures dressed up as service reconfiguration.

The same section goes on to argue that:

> "The NHS has recognised it cannot do this alone. It will also need the support of local authorities and the voluntary and independent sectors …" (page 5)

It goes on to argue for the (unproven) advantages of Practice –Based Commissioning (PBC), which the document claims, without offering any evidence, is "one of the best ways to give patients more choice and say about their local services". Whether PBC actually empowers patients or simply lands more administration and financial responsibility onto GPs is an open question: UNISON is not convinced that the new system will deliver the promised advantages for patients. We do know that GPs, most of whom are not directly employed by the NHS, are among the least accountable of all NHS professionals for their actions or the standards of care they deliver.

The threat implicit in this wholesale reorganisation is spelled out more clearly in the next section of the consultation document, which sums up the meaning of 'commissioning' – showing it to be identical to "purchasing":

> "At its simplest, 'commissioning' is the term used to describe the processes by which the NHS spends its money" (page 5)

Gone are the days of relative security of hospital financing based on block contracts, says the document. What it does not explain is that the system of payment by results will leave each hospital unsure from month to month of what its annual budget will be, unable to guarantee the funds to invest in new or improved services, and fearful that new private sector providers or rival NHS Trusts will capture a share of their caseload, and leave a financial gap that will force a cut in jobs and services:

> "Practices will pay the national tariff for most hospital services, but crucially only for those services their patients use." (page 6)

GPs will therefore have a financial incentive to "develop and fund innovative community services as an alternative to hospital for some patients". But as they do so, they will be destabilising their local hospitals – and potentially forcing the closure of a service that is currently available to the whole of the local community not just to the patients on one GP's list.

No overall plan

Completely absent from this new, chaotic picture of individuals and individual GPs following their personal choices and preferences in a barely regulated, competitive market, is any notion of an overall plan to ensure that vital services required by all are maintained and that hospital services for those with chronic and complex cases that the private sector will not touch can still be sustainably delivered by the NHS. There is no discussion of any planning or coordinating role either for the enlarged PCTs or for the new super-quango SHA:

> "SHAs will continue to provide leadership and performance management in the NHS. They will be responsible for ensuring that key national objectives are delivered and that services are high quality, safe and fair. …" (page 6).

The section exploring the SHA's role "in more detail" also omits the "p" word except for "emergency planning". There is no reference to ensuring access and availability of vital health care services: instead we are told that SHAs will oversee the new health care market:

> "Work with regulators and external inspectorates to develop the local health community, including ensuring choice and plurality of provision…" (page 7)

UNISON notes that the section on "Protecting staff" consists of just three brief paragraphs at the end of a prolonged exposition of a new system that will put staff jobs and conditions at risk. We are in no way reassured by the tokenistic declaration that

> "In what is likely to be an unsettling time, it will be vital to ensure that staff are fully consulted on the local proposals and have the opportunity to use their experience and creativity in shaping new services." (page 7)

Interestingly there is one significant difference in the line of argument between the East Midlands SHA reorganisation document and our text in the West Midlands.

The East Midlands text is more up-front and honest in specifically admitting that the end product of the reorganisation and the separation of services would be a competitive market system in place of a planned NHS. The East Midlands document, in a passage replaced by even more bland evasions in the West Midlands text, explicitly describes the new system as a *market*, which would seek to:

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

UNISON believes that this is a more accurate summary of the end result of the changes proposed in the West Midlands. But of course we do not share this ambition: we do not believe that a competitive market in health care, especially one which offers privileged access for the private sector to a share of the NHS budget is in the best interest of patients or the long term future of the NHS.

The NHS can only ensure accessibility and availability of services to those patients who need them if it retains its character as a *public service*, publicly funded and publicly provided. Since it is part of a package of changes which explicitly seek to subvert that arrangement, UNISON must declare its opposition to the proposed new SHA arrangements in the West Midlands.

The West Midlands document plays the privatisation story low-key. It promises to "performance manage PCTs to develop a range of provider options for patients" (page 12) – which in context we know to be the development of a market including private companies.

It also proposes to encourage "the development of innovative and alternative services or service providers" (page 12). UNISON is in no way convinced that these are desirable objectives for the NHS: there is certainly no evidence that such policies will do anything but increase costs and inefficiencies of additional administration.

Services hived off

We note that while it pulls its punches on the full scale of the competitive market that could force closures and far-reaching changes in the NHS, the West Midlands document is clearly focused on the process that will see more NHS services hived off from PCT and Department of Health control.

In a section that does not appear in the East Midlands text, the West Midlands document outlines the role of merged Strategic Health Authorities, which it defines as managing the performance of PCTs and:

> "***For as long as necessary***, NHS Trusts" (page10)

Of course the theory is that all Trusts will become Foundation Trusts, which will be accountable not to the SHA but to Monitor, the independent regulator. However there remain concerns that some of the Trusts currently struggling in the run-up to the new competitive market may in fact face dismemberment and closure, as their elective caseload and the funds to deliver services are siphoned off to create the new independent sector.

It is perhaps even more amazing and even less convincing in this context that the West Midlands document should rashly promise that a single SHA spanning the whole region

> "would ensure delivery of consistent performance standards across the West Midlands" (page 10)

This would be a massive task if all of the providers were within the NHS, but given the drive towards a plurality of providers, and the sharply varying experiences already revealed in the quality of care available from private Treatment Centres, it seems most improbable that any new body could ensure uniformity of quality and standards.

But who will be in a position to check on the performance of the new SHA itself? We are especially concerned at the lack of any proposals to establish a scrutiny mechanism to enable this huge potential super-quango to be held to account. None of the very limited official NHS watchdog bodies – Patient Forums, PALS or local authority scrutiny committees – would have any jurisdiction over SHAs, and there appears to be no connection or accountability to regional assemblies. We are fundamentally opposed to giving such huge powers and budgetary discretion over billions in taxpayers' money to organisations with no defined chain of local accountability.

To cap it all, it is becoming increasingly obvious that the promised savings of £250m across England from the reorganisation of PCTs and SHAs will not be achieved. The Commons Health Committee estimated likely savings of at most between £60m and £130m – between a quarter and a half of the projected total. We know that in the West Midlands the plan to close 66% of existing SHAs are predicted to save just 53% of the current core budget of just over £14m.

We question whether all of these savings would be realised, and remain to be convinced that there would be any long term gain for health services from these painful and complex changes.

PCT mergers:

Birmingham & the Black Country

The SHA covers a population of 2.3m people and currently has 12 PCTs. The two options on offer would reduce this to 8 (leaving 3 PCTs in Birmingham) or to 6 (merging the Birmingham PCTs into one to cover England's second largest city.

Under either option the two Dudley PCTs would be merged into one, spanning a population of 302,000, as would the three Sandwell PCTs, giving a combined population of 298,000.

We note that the Commons Health Committee, examining the wisdom of these proposals, has noted the research evidence that shows that

> "increases in PCT size beyond populations of 100,000 patients do not necessarily generate substantial improvements in overall performance. … Health Authorities were large commissioning organisations, and their size does not seem to have made them effective organisations." (para 96).

In this context the plans for Birmingham, which would produce either a PCT with 400,000 population plus one of 341,000 and one of 285,000 – or a single PCT covering

1 million people – seem especially foolhardy, based on no firm evidence that they would improve any aspect of the service for patients.

It is worth noting that with PCTs as with SHAs the plans for merger are signally silent on the actual nuts and bolts of how many would sit on the new bodies, how they would be appointed and whether there would be any representation for local areas that currently have their own PCTs.

The Commons Health Committee points out that:

> "Each of the 302 PCTs in England has several Non-executive directors; a Patient and Public Involvement Forum; and a Professional Executive Committee of key local clinicians. While these structures clearly have a cost, they were introduced to add value. It is not clear why the Government is now unwilling to meet the cost of securing an enhanced level of local input into the NHS." (Para 117)

We agree with this criticism. The reality is that each of the mergers will sever the local links and working relationships that have been built up – while the new merged bodies will be unaccountable to anyone at local level.

The representation of patients' interests and the general public, already severely damaged by the abolition of Community Health Councils, will be further undermined by the merger of the fragile replacement bodies into even less popular and less active organisations.

UNISON therefore rejects both of the options for PCT reorganisation as a step backwards for patient and public involvement as well as a step towards privatisation and marketisation of the NHS.

Shropshire and Staffordshire

The SHA covers a population of 1.5 million and has a £1.5 billion budget. The plans proposed would reduce the number of PCTs from ten to just four or five – but again the arguments in favour are not very clear, and the unequal power of the new PCTs would be a potentially significant factor.

The least radical solution would merge the four North Staffordshire PCTs into one covering 578,000 people, merge the two south Staffordshire PCTs to create a catchment of 208,000, and merge the two PCTs covering Stoke, with 263,000 population. In either option Shropshire escapes without changes.

The more radical solution would see a single Staffordshire PCT covering 786,000 people, alongside a Stoke PCT just a third of the size.

Either way round the "reorganisation" process is moving from a situation where most PCTs are around the original target size to maximise local links and connections, to one where mega quangos with few if any links to the needs and view of local communities preside over services and very large commissioning budgets, with the danger that an ever larger share would be diverted to purchasing services from the private sector.

Given the severe financial problems affecting almost the whole of Staffordshire, all of which will be compounded by Payment by Results and the advent of new private sector Treatment Centres, UNISON fears that this merger process would simply cut links with local people and pave the way for far-reaching cuts and privatisation that could seriously undermine the gains and improvements that have been achieved at United Hospitals of North Staffordshire.

We see no benefits for patients or staff in either of the "options" and therefore declare our view against both.

West Midlands South

This SHA covers a combined population of 1.57 million, with a budget of £1.5 billion. It currently has eight PCTs, which it argues:

> "Have developed close working relationships with primary care, other local NHS organisations and district/borough council partners over the past three years. … In order to retain these benefits … it is proposed that any future PCT(s) would develop an empowered locality structure underpinning the overall strategic PCT."

As a result, West Midlands South is the only SHA to have outlined any attempt to remedy the worsening democratic deficit that will arise from the wholesale merger of PCTs. Indeed WMS appears to be the only part of the proposed new West Midlands SHA to have had any level of real debate on proposals, and the only one to present a range of options including the (discarded but often useful) option of "Do nothing".

Four options are discussed as possible contenders:

- Six PCTs, in which Wyre Forest and Redditch and Bromsgrove PCTs are merged in Worcestershire, and North Warwickshire PCT and Rugby PCT in Warwickshire, leaving the others unchanged.
- Four PCTs – merging all of the Worcestershire and Warwickshire PCTs into county-wide bodies (547,000 and 523,000 respectively), with Herefordshire and Coventry remaining unchanged (the favoured option)
- Two PCTs – one covering Herefordshire and Worcestershire, and one covering Coventry and Warwickshire.
- One PCT covering the whole SHA area – and clearly making a nonsense out of the very concept of local commissioning.

WMS again demonstrates that the latest round of reforms represents a major departure from the principles of local links and accountability that were argued by the government in establishing PCTs just four years ago.

The favoured option would result in county-wide PCTs that would effectively collapse any concept of local planning. Indeed even the most modest merger plans would lump together the two PCTs in Worcestershire (Wyre Forest and Redditch and Bromsgrove) which are still shouldering the costs and counting the lost local services as a result of the disastrous and still debt-ridden PFI hospital development in Worcester – a plan rammed through in the teeth of strong and well argued opposition by a county-wide Health Authority that felt able to ride roughshod over local views, as a new PCT will also be likely to do.

UNISON sees no merits in the new proposals outlined for WMS either for patients or for health workers who are already suffering the consequences of previous ill-judged decisions and facing another year of cuts, closures and impending privatisation.

Drafted for UNISON West Midlands by
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March 2006