# Health unions briefing for MPs

July 2006


## Introduction

The purpose of this briefing document is to update MPs on recent developments within the health service in England, which have significant consequences for the future of the NHS and the patient experience.

Profound changes are taking place in the NHS with no debate in Parliament and without full and proper consultation with major stakeholders such as staff and their representative organisations, community and user groups.

Across England, NHS organisations are being forced to make cuts which affect patient services. Trusts have been told by the Government that they have to pay off their debts by the end of the year and are having to cut jobs and services in order to meet this target.

At the same time, the government has introduced a range of untested proposals to open the NHS up to US-style market forces. We do not believe that handing over the provision of services to private providers and allowing individuals and shareholders to make a profit from taxpayers is in the best interests of the NHS or the people who rely on it now and in the future.

The pace of change is alarming. Many reforms are being implemented without being tested or evaluated to assess their effectiveness or otherwise. In addition, NHS staff, on whom health services depend, are currently finding it impossible to keep track, let alone contribute to policy initiatives. As a consequence, service delivery is being affected adversely. Recently we've heard the Department of Health has decided to abandon its plans to extend the 'payment by results' system of tariffs due to serious consequences to children's hospital services. We have also heard from the Health Select Committee that the Independent Sector Treatment Centres ( a huge £5 billion investment by the Department of Health) have failed to demonstrate that the predicted benefits of contracting out operations to ISTCs are any greater than if they were done within the NHS.

This briefing provides a summary of health service reforms taking place about which MPs may not be aware. It is the start of a number of briefings which will be made available to MPs over the coming months. We want MPs to be aware of what's going on nationally, and to provide you with the tools to help you raise questions locally so that you can be accountable to your constituents. The joint trade unions want to assist MPs to gain a fuller understanding of the reforms currently taking place which will enable them to mobilise locally, to challenge the pace of reform and to raise questions with Ministers and the Secretary of State on their constituents' behalf.

## Recent developments

Developments include:

- ongoing financial difficulties, which are leading to redundancies, loss of posts and deterioration of services

- the Department of Health inviting organisations to bid to provide commissioning services to Primary Care Trusts

- publication of a framework which promotes commissioning of health and social services from a broad provider base, including an expanded NHS Foundation Trust sector, the private sector and third sector organisations

- privatisation of NHS Logistics

- proposals to expand the foundations trust sector, to include all hospitals and ambulance trusts and providers of community health services

- the indication that PCTs who directly provide services will be required to separate their commissioning and provision functions to facilitate competition and a level playing field with alternative providers

- publication by the Department of Health of the Third Sector Taskforce report, calling for a step-up in the amount of health and social services being provided by voluntary and community organisations and social enterprise

As was the case last summer, when the then NHS Chief Executive Sir Nigel Crisp published *Commissioning a Patient Led NHS* shortly before the recess, a number of the consultations associated with these developments will be taking place over the summer.

When placed in the context of other developments in the health service, such as payment by results and the growth of Independent Sector Treatment Centres, such initiatives can be seen to have an accumulative effect which will radically change the character of the NHS. Services will be fragmented and patients will be on the receiving end of discontinuities of care and contractual unevenness.

All of us see the case for reform along the lines set out in the *Our Health, Our Care, Our Say White Paper*, and the need to constantly innovate and provide better services to patients and provide value for the taxpayer. In some respects we represent a vested interest – we do have concerns about the impact of these changes on our members' working lives. But we also comment as health service professionals with experience of what can and cannot work and a vision of health services run on the basis of collaboration and co-operation, rather than market style transactions.

## The current context

### *Deficits*

A large number of NHS Trusts are still struggling to deal with deficits. This is not an isolated problem. As the recent annual report of the NHS demonstrates, nearly one third of all trusts are in debt. There have been a growing number of compulsory redundancies in trusts across England. Although these have, largely, been dealt with through freezing posts and natural wastage, there are a whole range of measures taking place such as closure of departments and severe cuts in education and training, which will have a huge impact on standards of care and services to patients, both in the short and long term.

Community nursing services are experiencing specific problems, especially in health visiting and district nursing. These services, which are not subject to 'targets' are having posts frozen and cut, and newly qualified trainees in these community practitioner professions as well as speech and language therapy are unable to find jobs commensurate with their qualifications.

A recent survey of medical directors carried out by the BMA found that 37 per cent of medical directors were planning to reduce services due to financial difficulties. Deficits have also produced situations in which patients have had to wait for operations, even when doctors and theatres have been free to carry out surgery. Some trusts have changed their thresholds for treatment, meaning that people with comparatively minor conditions receive less care than they would have done.

It has become commonplace to blame these deficits on poor management. However, this is not borne out by recent Public Interest Reports from the Audit Commission, which have singled out only a few NHS institutions for specific management failings. Where there have been local problems, there is little evidence of a structural management problem replicated across the country.

More significant than management failings have been the costs associated with marketisation of the NHS, which, in addition to the initiatives set out above, are operating through the use of Independent Treatment Sector Centres, Payment by Results and PFI.

In order to address these problems, we call on the Department of Health to set realistic time scales that would allow deficits to be tackled through managed efficiency savings rather than indiscriminate cuts.

## *Independent Sector Treatment Centres (ISTCs)*

The first wave of ISTCs has placed severe financial pressure on PCTs. The uneven playing field established between them and NHS providers means ISTCs being paid in full by PCTs regardless of contract delivery. In one example, South West Oxfordshire PCT paid £255,000 to the company Netcare, despite their having only carried out £40,000 worth of operations and assessments. The commercial costs and risks are effectively transferred back to the public sector. The new centres have been able to select the cases they take, leaving the NHS with the more complicated and costly ones, but without any additional funding to cover a more mixed intake of patients. Rather than providing additional value for money resources, the ISTC programme has been designed to create a sustainable market for private sector providers. PCTs have been forced to sign up to contracts, even in places where there is spare NHS capacity.

## *Payment by Results / tariffs*

Despite having been only recently introduced, the move towards Payment by Results (PbR), with money following the patient for each procedure, is already having a detrimental financial effect on both PCTs and NHS providers. The Audit Commission has highlighted financial instability for PCTs as the most significant risk of PbR. Under the previous block contracts, trusts were guaranteed a certain income, which enabled them to plan ahead more effectively. A trust would know the services it had been commissioned to provide and be able to calculate, and plan the provision of, the resources need to provide these services. With PbR this is not the case – a hospital can build new wards and then find they do not have the patients to fill them. Where hospitals are built using PFI, cost implications are likely to be particularly grave because the fixed tariff fee for each item of treatment takes no account of the inflated overhead costs that come with large scale PFI building schemes.

Another significant failing of the system is that it does not take account of multiple pathologies or complex medical conditions, a consequence of which has been the government's decision, made on 18 July, that PbR will not be expanded next year, as had initially been planned. This followed lobbying from the children's hospitals, warning the government that they would have to cut services because the fixed tariff fees they received

through PbR were not sufficient to meet the true costs of treating patients. When making this announcement Lord Warner said that he 'will not be specific' about how PbR will develop in future.

### *PFI*

Health unions have been warning against the use of PFI and NHS LIFT (Local Improvement Finance Trusts), in the building and servicing of hospitals for many years. Far from being a cheaper way to run projects, PFI is allowing private companies to cream off profits while hospitals are saddled with high levels of ongoing debt. A recent example is the Norfolk and Norwich hospital, where the hospital's PFI consortium company took £115 million out of the scheme and replaced the money in the project with borrowed funds. The Public Accounts Committee criticised this re-financing deal for 'lining the pockets of the investors' while the hospital has been left to deal with a large deficit and has taken on more risk. Similar issues are arising in relation to LIFT projects. LIFT grant exclusive 15-year contracts which are themselves open ended framework agreements. Once the LIFT partner is agreed they have exclusive contracts to supply all current and future developments in the area, without the need for competition.

### *Arms Length Body Review*

A further development with significant consequences has been the Arms Length Body Review, which was established with the aim of identifying savings in the NHS to meet the targets set by the Gershon Review.

The Arms Length Body Review has resulted in a whole range of organisational dislocation. Not least among these has been scrapping the NHS University, which was essential to the whole endeavour of workforce modernisation necessary to deliver the service enhancements envisaged by the government.

It has also led to the establishment and privatisation of the Business Service Authority (BSA), which includes Dental Practice Board, the NHS Pensions Agency, the Prescription Pricing Authority and NHS Logistics Authority. These agencies were previously highly efficient, cost effective public services run by public sector staff with the interests of patients and the NHS at their heart. NHS Logistics is an award-winning service. No acceptable business case has been put forward to support its outsourcing. As a result of the potential outsourcing, groups of Logistics staff are due to embark on industrial action.

NHS Direct is potentially the next NHS employer to experience industrial action because of unnecessary redundancies and reconfiguration.

## Key developments in July

#### *OJEU Contract notice*

A notice of invitation to apply to provide a range of services to PCTs was re-issued in the Official Journal of the European UNION on 14 July. This followed the Department of Health withdrawing an earlier version of the invitation, following representations from health trade unions within the Social Partnership Forum. The substance of the original invitation remains unchanged.

- there is an assumption that PCTs will be commissioners, not providers

- the Framework Agreement, which organisations are invited to bid for, would facilitate private companies becoming 'official suppliers' of a range of services including, identifying population health needs, data collection and analysis, designing care pathways and implementing and managing contracts. Many of these tasks are currently undertaken by PCTs themselves

***Commissioning Framework***

The Department of Health published the first part of the commissioning framework, focused on commissioning NHS acute services on 13 July. The framework documentation describes a process whereby PCTs and practices commission health and social services from a broad provider base, including an expanded NHS Foundation Trust sector, private sector providers, third sector organisations and PCT direct provisions. The framework identifies competition between providers as a central driver of service improvements and therefore does not support the opportunity for developing capacity and expertise in-house at PCT level

The accompanying commentary says that the Department will be working with Monitor to explore the possibility of extending Foundation Trust Status to 'providers of community health services'. The document suggests these 'Community NHS Foundation Trusts' as a way forward where staff are directly employed. More information is promised following discussions with national stakeholders. The document also suggests that NHS Foundation Trusts will be entitled to bid to provide primary care services. This comes alongside other recent commitments to make all NHS trusts and ambulance trusts foundation trusts. The deadline for responses to specific questions set out in the document is 6 October 2006.

***Our response***

Our response will reflect our strong conviction that competition between providers will be wasteful and lead to fragmentation of services. If we are to deliver the government's goal of achieving more care outside of hospitals we have to build on the many best practice examples of where health and social care providers work together in a collaborative way.

We will also be seeking further clarification regarding the direct provision. Despite assurances given last year following widespread dismay at the publication of *Commissioning a Patient Led NHS*, the direction of travel outlined in that document has remained and intensified. Whilst PCTs will not <u>have</u> to divest themselves of services, the status of community health staff who are currently directly employed by PCTs requires urgent clarification.

We will also be seeking clarification on whether, under these proposals, private sector and third sector organisations will have access to managing and raising revenue from public sector assets.

There are references in the documentation to a continuing role for PCT direct provision. But at the same time, there is also a requirement for PCTs to ensure that there is a split between their commissioning and providing roles within the context of commitments to a level playing field for alternative providers, competition as the driver of improvements and expansion of the third sector.

***Third Sector Taskforce Report***

The Third Sector Taskforce was established by the Department of Health in 2005 to address the obstacles to third sector providers becoming mainstream providers of health and social care services. The taskforce, the membership of which did not include any of the mainstream health trade unions and professional organisations, has published a report on 11th July entitled *No Excuses: Embrace Partnership Now – Step Towards Change* setting out recommendations to encourage PCTs to commission the third sector to provide services.

The report, which was launched by joint chair of the working group, health minister Ivan Lewis, calls on commissioners and providers to step out of their respective 'comfort zones' and collaborate to develop genuine diversity of provision and support new providers entering the market. The Department of Health have said that the report and feedback from it will feed directly into the new commissioning framework for health and social care delivered in the community (this will be the second part of the overall commissioning framework). Deadline for comments on the recommendations included in the documents is end of October 2006.

***Our response***

Our response will acknowledge that the third sector clearly already plays an important role in contributing to patient care and developing and complementing new approaches to patient care in a joined up way.

The government itself has used the example of charities such as Advocacy Partners, who work in partnership with the London Borough of Merton to provide advocates to listen and provide advice and encouragement to elderly patients when they are discharged from hospital. We agree that this provides an excellent example of how the third sector can make a real difference. The service they provide joins up with the service provided by the hospital as part of an integrated care pathway. The same can be said of the services provided in some areas by Help the Aged and the terminal care provided by the hospice movement.

However, we believe that an important distinction needs to be made between those social enterprises, charities and voluntary organisations that emerge organically and which bring additional expertise and resources and those that are engineered for the purposes of creating a market for health and social care, which is one of the aims of the White Paper. Whereas the former clearly brings additional patient focused services, the latter threatens:

- collaboration as a system of competition pitches organisations against each other and instead of sharing expertise to transform and improve services, they begin to look at ways of undercutting their "competitors" to win the contract. Competition for the same business also risks an uneconomic duplication of the same services
- not-for-profit organisations' independence, ability to innovate and advocacy role as they are encouraged to take over statutory service provision. In addition, not-for-profit organisations may take on contracts that they cannot afford to deliver for the price of the contract, leading to poorer services and untrained, underdeveloped and unmotivated employees. There would also be increased risk of vulnerability of not-for-profit organisations through take over by large multinationals

- fragmentation of services, as providers extricate themselves from more complex and costly care, as has happened in relation to Independent Sector Treatment Centres, and the government rely more and more on the inadequate resources of the third sector (total non for profit sector currently only amounts to one per cent of GDP)

- patient safety, as a result of the fragmentation of services

- fewer opportunities for training and clinical placements. This is because training is predominantly provided by the NHS, which will be competing against other providers. It is improbable that the NHS will be able to place staff with its competitors for the purposes of staff training.

- pressure on PCTs to divest themselves of services and the subsequent impact on staff morale. Although not an explicit requirement, the White Paper makes it clear that from 2007 all PCTs will be expected to review the services that they commission

and provide and put in place governance procedures that facilitate services being put out to tender.

East Elmbridge and Mid Surrey provides one recent example of a PCT seeking to divest itself of direct provision to a new social enterprise - Central Surrey Health. The organisation has been established to provide the nursing and therapy services currently supplied by approximately 700 PCT employees. This is an example of the processes that the Department of Health wants to put in place throughout every PCT in the country. Staff have overwhelming rejected it: 80 per cent of participants who took part in an indicative ballot of staff were opposed to transferring their employment from the PCT to the social enterprise. This is despite the huge resources put into it from the Department of Health which should have made the move more attractive. The Department of Health is yet to resolve the issue of staff pensions being protected in these enterprises. We have major concerns about the future of service delivery regarding standards and continuity. It is clear that if small social enterprises are eventually subsumed by global corporations, this will cause further instability in reconfigurations.

The expansion in the role of the third sector, particularly where this arises in respect of transfers of staff from the NHS to the third sector, also raises fundamental questions about the status of the third sector in respect of the 15 per cent cap on healthcare provided by the private sector.

***Patient and public involvement***
A new set of arrangements for public and patient involvement in health and social services was published on 13 July. The new arrangements have been developed to reflect changes in the health and social care system. The Commission for Patient and Public Involvement in Health and patient forums will be abolished. Local involvement networks will be established for every local authority area with social services responsibilities. The networks will gather information on public need and gauge opinion via focus groups, make recommendations to commissioners and providers and be a means by which commissioners, Overview and Scrutiny Committees (OSCs) and regulators access local views. Under the new arrangements OSCs will shift their focus to commissioners – scrutinising the decisions that the PCTs and practice-based commissioners have made on behalf of the community. Deadline for comments on this document is 7 September 2006.

***Our response***
Our response will suggest that important decisions about whether services should be outsourced should be made by the local community.

## Next Steps

High level activity will be taking place across England with all health trade unions working together and the TUC is leading on a major lobby of Parliament to take place in the autumn.

Health will be a major focus at the TUC Congress 2006 through motions and a fringe meeting and the same will apply at Labour Party Conference.

In addition we are looking to organise a major national demonstration in the new year.

The TUC and health unions are calling urgent meetings with the Secretary of State and the Prime Minister.

Health service unions are committed to campaigning for reform that is consistent with the very highest levels of care underpinned by an ethos of collaboration and co-operation across the health service. We believe that it is incompatible to run a health service based on the principles of social solidarity on the basis of market transactions and competition. We will be developing national campaigns along these lines over the coming weeks and months.

At a local level we intend to work with local MPs to campaign for the best possible services in their constituencies.

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