Unite-Amicus response to Lord Darzi's 'Healthcare for London: A Framework for Action'

This response is submitted by Unite the Union - Amicus Section. Unite is the UK's largest trade union with 2 million members across the private and public sectors. The union's members work in a range of industries including manufacturing, financial services, print, media, construction and not for profit sectors, local government, education and the health service.

Unite – Amicus section is the third largest trade union in the National Health Service and represents approximately 100,000 health sector workers. This includes seven professional associations - the Community Practitioners and Health Visitors' Association (CPHVA), Guild of Healthcare Pharmacists (GHP), Medical Practitioners Union (MPU), Society of Sexual Health Advisors (SSHA), Hospital Physicists Association (HPA), College of Health care Chaplains (CHCC) and the Mental Health Nurses Association (MNHA) – and members in occupations such as allied health professions, health care science, family of psychology, counsellors and psychotherapists, the family of dental professions, audiology, optometrists, opticians and building trades, estates, craft and maintenance.

Executive Summary

- Unite-Amicus believe the proposals are founded on a lack of understanding and knowledge about the wide breadth of roles within primary care. The document does not clearly spell out the implications of the proposals and this has a detrimental impact on the quality of the consultation and people's ability to engage in discussion around the future of NHS London.

- Unite-Amicus are concerned the proposals will lead to a worsening of access to primary care and believe there are several important flaws and problems in the costing, staffing and resource assumptions on which the proposals are based.

- Unite-Amicus are concerned at the 'gaps' in the Framework document, and believe there needs to be clarification on how these proposals link in within other health policies and service trends.

- Unite-Amicus believe that the Framework document is in keeping with the national policy drive, with reforms underpinned by a process of transferring healthcare assets and services from the public sector to the private sector. Unite-Amicus opposes such an agenda.

Introduction

1. Despite Lord Darzi's assertion that recommended changes are based on a "thorough, practitioner-led process, and rooted in evidence"[1]. Unite-Amicus does not believe the proposals meet these criteria, as explained in detail below.

2. This response has been drafted in close consultation with Unite-Amicus London Region Health Sector representatives. Unite-Amicus members are practitioners, and within Unite-Amicus there are specialist sections which have dual roles as professional bodies and as a trade union – yet they have not been consulted. Unite-Amicus also understand that separate professional bodies representing other groups of members have also not been consulted. In addition, Unite-Amicus reject the often artificial division which is made between staff and service users; staff are also service users. As professionals they have a wealth of valuable expertise and knowledge to contribute that can be crucial to ensuring services are re-designed effectively and efficiently. Unite-Amicus also have approximately 100,000 members who live in the London area and are therefore users of NHS London services.

3. Unite-Amicus believes it is clear the London Strategic Health Authority and a majority of Primary Care Trusts are assuming these proposals are to be implemented. This calls into question the validity of this consultation exercise. Currently NHS London is heading towards a giant experiment in the provision of health care for Londoners - with all of the risks this entails – and Unite-Amicus would urge a pause for thought and some caution on the part of NHS London, and a genuine engagement with users and staff.

4. As outlined below, for a number of reasons these proposals may result in worse access to health care for many, including the most vulnerable groups within our community, and Unite-Amicus believe that far more thought is required on the question of ensuring equitable access for all. Unite-Amicus also seek the commitment that adequate funding to new services will be in place *before* old services are closed, that there is a robust and transparent evidence-based examination of the viability of many aspects of the proposals, and continued public sector provision of NHS services.

5. Unite-Amicus also note the proposals are for longer working hours, and for unsocial working hours for staff, and commitment is sought these aspects of the plans will be withdrawn. Long working hours for staff are not compatible with the delivery of high-quality health care; staff need to be well-resourced, motivated and alert.

Framework Overview

6. On the surface of the Framework document there is much to support - Unite-Amicus fully support the principles Lord Darzi outlines;

- That services based on individual needs and choices
- Localise where possible, centralise where necessary
- Truly integrated care and partnership working, maximizing the contribution of the entire workforce
- Prevention is better than cure
- A focus on health inequalities and diversity

[1] Framework document, Summary, paragraph 2, page 4

Unite-Amicus are clear that services tailored to individual people, and as part of this people can exercise choice over the type and how they receive treatment or services, and this should not be used as an excuse for privatisation.

7. Unite-Amicus particularly welcome the stated commitment to a preventative model and the emphasis on tackling health inequalities. Unite-Amicus believe NHS London should be ready to meet future challenges and deliver improved care from cradle to grave. All of these are given as stated aims in the Framework document. Unite-Amicus have repeatedly stated, at a local and national level, support for many of the principles in the Framework document. However, Unite-Amicus do not believe that the proposals will successfully deliver these outcomes, and indeed may undermine progress towards to achieving them.

8. It takes significant time for the reader of what is a lengthy document to extract and understand the **content** of what is being concretely proposed as actions – rather than the principles that are stated as lying behind these recommendations and proposals. Unite-Amicus is concerned about how opaque some of the actual proposals are and what remains unsaid in the Framework document – including the rather significant question of which London hospitals will be closed or run down. The comments below outline these critical concerns as well as responding to what is included in the Framework document.

The NHS is more than doctors

9. Unite-Amicus and members have been greatly concerned by the lack of knowledge demonstrated in the Framework document of the professional roles that exist across the breadth of the NHS outside of the acute sector.

10. Unite-Amicus is deeply frustrated and saddened at the continued need to make the point that there is more to the NHS than doctors. Yet the model of care that emerges from the Framework and Technical Paper is quite clearly a medical model. It is assumed that in primary care 75% of staff time is spent in face-to-face contacts, and that primary care consultations last for 15 minutes. It is even suggested that 15 minutes may be an over-estimate, given the current 7 minute duration of primary care consultations[2].

11. The care offered by Unite-Amicus members bears no resemblance to the model proposed here; relating to human beings and changing behaviour cannot be done in 15 minute appointments. This care involves careful child protection and preventative work done by Community Nurses members, Speech and Language Therapists (SLTs) working with people over time to help them with communication and swallowing difficulties and Sexual Health Advisors influencing sexual behaviour. Psychology is a further example of where time is required to build relationships with the person being seen. This level of detailed and personalised care cannot be delivered within the proposed model, where a series of 15-minute appointments are sufficient. The proposals demonstrate little understanding of the complex professional roles of Unite-Amicus members, no understanding of the level of preparation for individualised appointments, or of the need for careful liaison to ensure 'joined up care' for patients or clients with complex conditions. This is particularly disturbing given that one of the main stated aims of the proposals is to deliver personalised care. Further, there is no recognition of the travelling time involved in home visits which has direct resource implications.

12. Unite-Amicus believe the model of healthcare outlined in the proposals will not deliver high quality care, and believe that references to 'primary care' within these proposals mainly refer specifically to GPs. Yet the data modelling within the Technical Paper appears to generalise assumptions across all clinical staff. This impression is reinforced by the examples and language throughout the Framework document.

[2] Data taken from pages 28 and 33 of the Technical Paper.

13. Members who are Speech and Language Therapists have been offended by the proposals and the lack of knowledge of their profession. This is illustrated by the (hopefully apocryphal) story of seven-year-old ‘Coral’ – a child with cerebral palsy who suffers from recurrent aspiration pneumonia arising from swallowing problems. In the ‘current’ NHS, she sees her GP or is taken to A&E when she is ill. In the ‘future’ NHS, she will be taken to the urgent care centre, and the doctor will know her history from her Electronic Patient Record. Unfortunately it occurs to no one – in the current or future NHS – that intervention by a specialist Speech and Language Therapist might stop this little girl getting aspiration pneumonia in the first place. The ignorance of the specialist health care offered by Unite-Amicus members is profound and concerning.

14. The Framework document is characterised by a lack of reference to staff other than doctors. For example, if references to key groups of community and primary care practitioners are counted in a document that is purporting to outline a positive way forward for the NHS the following is found; Health visitors are mentioned 4 times, School nurses, Speech and Language Therapists and community mental health nurses are mentioned once each. Psychologists are not mentioned at all. The wide range of scientific and technical staff that enable key decisions such as diagnosis to take place are close to invisible, as are the estates and myriad of support staff without whom the NHS would be unable to function. By contrast, GPs are referenced 198 times, consultants 67 times, while the generic word ‘doctor’ is used 35 times.

15. The Framework document proposes the complete reorganisation of healthcare in London, yet rests on the basis of a fundamental misunderstanding – or ignoring - the role of many NHS professionals, and how they perform those roles. When clinicians express concern at these plans, it is not because they ‘understandably fear change’[3]. For Unite-Amicus members’ concerns at these proposals arise from understandable and well-founded fears of redundancy, a decline in terms and conditions and the further erosion of the vital services they provide. Addressing these fears requires a genuine willingness to engage with representatives of *all* the clinicians in the NHS, *and* the multitude of staff in non-clinical roles whose work is of equal importance, not ‘clinical champions’ as proposed.

Where will care be offered?

16. Unite-Amicus believe that despite the stated principle of ‘Localise where possible, centralise where necessary’, the substantial changes proposed will actually result in making access to primary and secondary care harder.

Polyclinics

17. It is asserted there is a ‘stark need’ for “a new kind of community based care at a level that falls between the current GP practice and the traditional district general hospital”[4]. The proposed solution is polyclinics, where in future “the bulk of healthcare activity will take place”[5]. These will offer not just GP services, but a wide range of health services, providing the infrastructure for a shift of care away from hospital settings and a ‘one-stop-shop’ for people with long-term conditions[6]. This will involve a wide array of staff that can be accessed at each polyclinic - such as consultant specialists, nurses, dentists, opticians, therapists, emergency care practitioners, mental health workers, midwives, health visitors and social workers[7] The shift of much healthcare out of hospital settings means that in the future ‘the bulk of healthcare activity will take place in polyclinics’[8]. Further, each polyclinic will serve a population of around 50,000 and there will therefore typically be between three and five polyclinics for each London borough. There will be two locations for polyclinics – they will be co-located with every hospital, and will act as the ‘front door’ to A&E, and will also be in free-standing locations in the community[9].

[3] Framework document, page 118, paragraph 41
[4] Framework document, page 10, paragraph 16.
[5] Framework document, page 107, paragraph 71.
[6] Framework document, page 11, paragraph 22.
[7] Framework document, page 92, main table.
[8] Framework document, page 107, paragraph 71
[9] Framework document, pages 92 and 93, main tables.

18. Unite-Amicus believes this raises issues which have either not been fully acknowledged in the Framework document, or not properly recognised and thought through, outlined below.

Reduced access for those who most need healthcare

19. Overall, access to healthcare will be reduced. Unite-Amicus fully support the concept of healthcare *'closer to home'*. Polyclinics are not compatible with this ideal. The proposals in reality *centralise* health care services that are currently available in settings close to home.

20. Polyclinics are intended to *replace* the existing network of GP surgeries and health centres. Although reference is made to the possibility of a 'federated model', where existing GP practices access common services from a separate polyclinic, this is seen as operating only 'initially' while the polyclinic model is developed[10]. The modelling in the Technical Paper assumes 70% of GPs will be polyclinic-based. The intention is therefore that physical access points to primary care – GPs, practice nurses, various clinics – will be sharply reduced. Older people and disabled people typically use primary care services much more frequently than younger people – as illustrated in the Technical Papers own figures - and those without disabilities. Travelling one or two kilometres is potentially a challenge to some members of our local communities who are older, and those with impaired mobility. Young children are also regular users of primary care – not just for GP appointments, but for baby clinics, immunisation and so on. Travelling to polyclinics on public transport can be significant challenge for a parent or guardian who may have a number of children with them.

21. High poverty levels continue to exist amongst vulnerable service users and therefore increased travelling distance may increase cost barriers to accessing services for some groups of people. While much is mentioned about reducing health inequalities in London, it is not clear what concrete actions are being proposed that will reduce inequalities and how the proposals link in with the comprehensive plan to reduce health inequalities published by the Mayor of London in 2007.

22. Access to polyclinics for appointments currently offered in hospital settings may be easier (although this benefit will be reduced by the co-location of polyclinics with every hospital). However, 80% of patient contacts are currently in primary not secondary care. An overwhelming majority of NHS users do not *need* the specialist care, diagnostic tests, minor surgery and so on that will be offered from polyclinics.

23. Reduced access is a major concern for those of us who work in and are committed to primary care. This is potentially a model of service provision that will sharply reduce access to primary care for the people who most need it, and Unite-Amicus strongly urge it is not implemented as reduced access directly leads to worse patient care.

Poor understanding of primary care

24. As outlined above, a major concern in these proposals is that a very limited understanding of primary care is displayed and built into the assumptions upon which the proposals are based. People accessing primary care services need high quality care, and often need reassurance and support from health practitioners they know and trust. It is rare to need emergency surgery or an MRI scan on the spot.

25. There is a risk that in the re-design of the NHS in London some of the aspects most valued by people are lost. There is always is scope for improvement and Unite-Amicus members are frequently at the forefront of implementing innovative practice that improves patient care. However, Lord Darzi himself notes that the only aspect of GP services Londoners are dissatisfied with is the provision of

[10] Framework document, page 93, paragraph 21

out of hours care[11] Unite-Amicus question the rationale for overhauling the entire GP network to solve a self-contained problem such as this.

Low volume procedures

26. The low volume of some of the procedures to be offered from polyclinics raises questions about cost, viability, and the standard of clinical care. Projected data is given in the Technical Paper[12] which estimates that each polyclinic will provide 6 or 7 elective surgery procedures a week. For emergency surgery, the figures are even lower: 19 minor procedures per year, while paediatric emergency surgery procedures are estimated at only 10 a year. It makes little sense, clinically or on cost grounds, for these procedures to be offered in a polyclinic setting.

27. The BMA has commented on the wider issues around moving specialist provision out of hospitals. Concerns are not simply around cost and clinical standards, but also the risks to secondary care, safety, the risks to secondary services, and the possible loss of convenience to patients as low demand will limit the frequency and availability of specialist provision in community settings.

Reduction in outpatient appointments

28. Darzi proposes that many outpatient appointments should be carried out by GPs or nurses[13], and encourages commissioners to reduce outpatient follow-ups that ‘have no clinical benefit’. Unite-Amicus believe there are risks inherent in this approach *unless* decisions are made on clinical grounds, by clinicians, and – where necessary – on a patient by patient basis. Unite-Amicus is aware that cost-driven ‘skill mix’ is leading to a reduction in the level of clinical care in areas such as health visiting and district nursing; Unite-Amicus is aware this trend is spreading rapidly into the services provided by Allied Health Professionals. Unite-Amicus believe this is damaging to patient care. Unite-Amicus and our members do not wish to see the extension of skill mix in the manner proposed here. Commissioners simply do not have the clinical skills to make these decisions.

Diagnostics

29. Lord Darzi proposes that “point-of-care pathology and radiology” will be offered in polyclinics[14]. Unite-Amicus seeks clarification on how the Darzi proposals link up with reforms currently taking place. Trends in London are for a greater centralisation of pathology services. Private sector providers are also now seeking to offer services from a small number of high-volume centres. Plans for localisation would necessitate a sharp reversal of this. The start-up costs of offering pathology and radiology services from every polyclinic will be substantial. Moving a large number of skilled staff out of hospital settings into polyclinics may threaten the provision of diagnostic facilities in the acute sector. Very few tests can actually be performed at the point of care and the majority are still done centrally. However Unite-Amicus members do work to deliver point of care testing and improve on it but resources are limited and an increase in this work will affect the delivery of centralised testing. *If* sufficient funding is made available, *if* change is implemented in a carefully planned way, and *if* change is clinically driven, these issues can be overcome. There is no evidence however that these challenges have been considered.

Buildings

30. The most obvious practical difficulty is the accommodation for polyclinics. Darzi comments, “One specific estates challenge will be the development of polyclinics. Suitable sites for polyclinics will need to be found. To do this we advocate working with local authorities…”[15]. The process may not be quite so straightforward. These will be large buildings, typically with 43 consulting rooms, and an additional 1000 square metres for waiting areas, office space and healthy living centres[16]. The space required for diagnostic facilities is somehow absorbed into the tariff costs for diagnostics. The

[11] Framework document, page 21, paragraph 33
[12] Framework document, page 25, table 10
[13] Framework document, page 67, paragraph 161
[14] Framework document, page 92, main table
[15] Framework document, page 125 paragraph 90.
[16] Information from the Technical Paper, page 28, paragraphs 88 and 91

Framework document outlines the need for pharmacy, optician, dental and social care facilities to be located in polyclinics. These are not mentioned in the Technical Paper. Buildings of the size likely to be required to house facilities for ‘one-stop-shops’ will need to be built, or substantial investment made to modernise and convert existing premises. Yet the Technical Paper does not mention capital costs. Unite-Amicus have serious concerns about where this money will come from – such as existing health budgets, and the potential use of PFI schemes which are well-documented as not providing value for money[17].

Longer working hours – and worse working hours – for staff

31. Unite-Amicus have strong concerns about the staffing assumptions in the proposed healthcare model, specifically the assumption that staff will work 40 hours a week[18]. Current NHS working hours are 37½ hours a week as stipulated by the Agenda for Change negotiated agreement. Unite-Amicus believe the working week should be reduced to 35 hours, in the interests of staff health and well-being and work-life balance, and the corresponding positive impact this would have on staffs’ ability to deliver high-quality healthcare. Unite-Amicus are unaware of any proposal to increase the working week, and would oppose a suggestion on the basis it would be detrimental to staff and the service they were able to deliver. Unite-Amicus believe it is unacceptable to simply include such an assumption in a Technical Paper appendix. Further, the suggestion is at odds with Lord Darzi’s referral to the need for “healthier, happier NHS staff”[19].

32. The proposals also seek to implement unsocial working hours for a much larger group of staff than is currently the case. The Framework document outlines the proposed opening hours for polyclinics as being between 18 and 24 hours a day, 7 days a week[20]. All community services will be offered for a minimum of 12 hours a day, and it is proposed that “Interactive health information services including healthy living classes” are required to be available 18 to 24 hours a day. While Unite-Amicus fully support services being more accessible there are several problems with these specific proposals. Such services being open for such long hours will involve a drastic change to staff working patterns, yet they and their trade unions, including Unite-Amicus, have not been consulted. If services are to be open for longer hours then investment to recruit large numbers of extra staff would also be necessary. Finally, there is the question of value for money – there is no clinical need for routine healthcare to be available 24 hours, unlike emergency medical care. Unite-Amicus strongly suspects that such primary care clinics at times such as 6am or midnight – which is what the proposals imply – will be greatly under utilized. Unite-Amicus believe a significant problem with NHS services having accessible hours must rest with employers and the long-hour culture in Britain, where workers feel they cannot take an hour or so off from a working day to visit a healthcare professional.

Private sector to run polyclinics

33. Unite-Amicus is not opposed to change, believing a future high-quality health service lies with a reformed NHS - but one which is integrated, properly and publicly funded and publicly owned. Recent Government policies and the proposals in the Framework document have been eroding this. Unite-Amicus believes competition, and commercialising and privatising the NHS do not deliver the quality, personalised care and reduced health inequalities that Unite-Amicus supports. Instead, these policies lead to fragmented services, threaten worse terms and conditions for staff and divert vital funds away from service delivery and into profits. Unite-Amicus note that the Framework document is clear the door is open for the private sector to own and manage polyclinics.

A reduction in health inequalities?

34. A critical issue in London is the need to reduce health inequalities, which Lord Darzi suggests can be addressed through his proposed polyclinic model. Unite-Amicus strongly agree that health inequalities need to eliminated, and Lord Darzi correctly notes there are fewer GPs per head in parts

---

[17] Private Finance, Public Deficit: A report on the cost of PFI and its impact on health services in England, Allyson Pollock and Mark Hellowell, 2007
[18] Technical Paper, page 27, paragraph 85
[19] Framework document, page 55, paragraphs 82 and 83.
[20] Framework document, page 92, main table

of East London than elsewhere in London[21]. However, as outlined above, Unite-Amicus believe there is a risk that polyclinics will reduce the accessibility of primary care, and therefore will not help reduce health inequalities and may worsen them. As Unite-Amicus have consistently argued, increased fragmentation and privatisation through the development of a system of multiple providers simply operating under the badge of the NHS will worsen accessibility and health inequalities.

35. The Government has already prioritised the introduction of private sector GPs in areas of high social deprivation. Anecdotal evidence from Unite-Amicus members suggests a poorer quality of care where private sector GPs have been introduced. A contract has been recently awarded to UnitedHealth to run three GP surgeries in Camden when they proposed to spend £75 per patient for every £100 a local GP - who also sought the contract - would have spent. This underlines Unite-Amicus concerns.[22]

36. These issues coalesce into a strong risk that patients and services users from socially deprived areas will suffer a double whammy of less access to care, and possible lower quality care when it is accessed. Unite-Amicus propose that a solution to the low number of GPs in East London is to encourage PCTs to employ salaried GPs in these areas, and to make these posts attractive through training and development opportunities, flexible working, access to childcare and so on.

37. There is a wealth of evidence to demonstrate that poverty levels are the major causes of health inequalities; a critical component of reducing health inequalities is addressing the large income gap that exists in society and addressing the systematic discrimination that still exist in society on grounds of gender, ethnicity, religion, sexuality and age.[23]

Care at home – part of the polyclinic model

38. Unite-Amicus and its healthcare professional membership fully support the call for an increase in the provision of healthcare in peoples' own homes; home visits offer the opportunity for respectful and personalised care in the setting where a patient feels most comfortable. Unite-Amicus also agree with Lord Darzi's comment that healthcare provided at home can help to reduce health inequalities for vulnerable groups such as disabled people and older people with long-term conditions.

39. Unite-Amicus are concerned that this does not appear to have been costed, and this will cause severe problems further along the line. Staffing costs represent a significant bulk of NHS spending[24], and home visits are costly in regards to staff time. For example, psychologists who are providing mental health care at peoples' homes will see many fewer patients than if they were based at a clinic. For routine care to be provided at peoples homes there will have to be a significant increase in the numbers of community nurses and Allied Health Professionals to provide that care. Home care is then not mentioned in the Technical Paper, so it has to be assumed that costings have been derived from clinic-based appointments. This shortfall in staffing levels is not overcome by the (unproven) assumption that seeing patients at home will reduce hospital admissions by 9%. Further, the staff involved in providing preventative care in a community setting will typically not be the same people or even same professional groups as those that provide acute care in hospitals.

Supporting infrastructure

40. Unite-Amicus suggest that as well as funding questions that remain unanswered, there remain questions which may be termed as relating to the supporting infrastructure. A huge expansion in home visits will mean a huge expansion in the number of staff who may be classed as lone workers; there are various health and safety issues that Unite-Amicus would expect to be addressed as a priority. For

---

[21] Framework document, page 127, paragraph 104

[22] Pulse 5th February 2008 and the Evening Standard, 29th January 2008

[23] 'Reducing Health Inequalities – issues for London and priorities for action', Mayor of London, August 2007, 'Monitoring Poverty and Social Exclusion 2007' and 'The persistence of Poverty across generations, 2006, both from the Joseph Rowntree Foundation, 'Being the gay one: Experiences of lesbian, gay and bisexual people working in the health and social care sector', Stonewall (for the Department of Health), 2007 are just a few examples. There have also been numerous reports from the former equality bodies – the Equal Opportunities Commission, Commission for Racial Equality and the Disability Rights Commission.

[24] –For example, see the Department of Health evidence to the Pay Review Body 2008

example, the government delivering on its promise to provide all workers with an 'identicom' card. Further, Unite-Amicus would suggest that transport issues need to be addressed, for example, securing free public transport for NHS workers carrying out their role from the GLA, free car parking during work hours and the NHS providing bicycles for those who wish for them.

41. Further, clinical staff will be unable to deliver services effectively without access to a sound IT infrastructure and high quality administrative support. Lister[25] has argued that the projected administrative costs of polyclinics have been seriously under-estimated by Darzi. If estimates are correct there is a danger of polyclinics being unworkable or cuts being made in patient care to pay for adequate support staff. Unite-Amicus seek urgent clarification on this issue, as such a possibility is totally unacceptable.

Urgent Care Centres

42. Urgent Care Centres are not referred to systematically in the Framework document, and it therefore takes time to work out where these will be based, and what they will be for. These will be centres that offer urgent advice, care, treatment or diagnosis – offering a similar range of services to polyclinics, with the addition of emergency practitioners and will co-ordinate out-of-hours GP provision. The intention is for some to be based in the community and others as the 'front-end' or 'front door' to hospital A&E units. Ambulance stations will be located at Urgent Care Centres[26]. They are GP-led and are not A&E units – unless they are attached to hospitals they will have no on-site access to inpatient beds, specialist medical support, high dependency or intensive care facilities. Careful reading of the document suggests that the community-based urgent care centres will be based in polyclinics[27] – but this is not entirely clear. For example, the proposed opening hours for community-based urgent care centres seem to be shorter than those proposed for polyclinics. It is unclear why an extensive network of new centres should be necessary just to deal with the dissatisfaction of Londoners with out of hours GP provision[28].

43. Possibly the real answer emerges when Darzi describes urgent care centres as 'highly-accessible alternatives to A&E'[29] and then discusses achieving a balance between provision and cost. If urgent care centres are seen as a 'front door' to a fully-fledged A&E unit, with decisions on patient access to A&E facilities made on a sound clinical basis, then Unite-Amicus have no difficulties with the proposal. If – as is implied in the document – urgent care centres are to become the 'alternative' to A&E units then this is more problematic. There is a wider agenda of closing A&E units, and Lord Darzi's proposals themselves suggest downgrading A&E units at local hospitals. Part-time GP-led centres are unlikely to be a substitute for the network of A&E units that currently exists across London.

Secondary Care

44. An enormously complex range of different organisational forms have been proposed: local hospitals; elective surgery centres; major acute hospitals; specialist hospitals; hyper-acute hospitals; trauma centres; and Academic Health Science Centres. Aspects of Lord Darzi's plans should be welcomed, while others will cause shortfalls in income that will result in hospital closures, and within the wider context of public sector and NHS policy are also likely to lead to greater levels of privatisation. This will be detrimental to levels of care. As with the rest of the Framework document, the actual implications of proposals only become clear once the Technical Paper is analysed.

The end of District General Hospitals

45. The 32 District General Hospitals currently in London are where most Londoners access inpatient treatment they may require and any necessary out-patient follow-up. Under the proposals

[25] "[Lord Darzi's] projected total 'administrative overhead' would leave just £326,000 for IT services, admin and clerical staff and management to run a £20m a year operation, equivalent to just 13 clerical staff on £25,000 a year nowhere near the level of managerial and support staff that will be needed", Dr. John Lister, 'The Darzi Report: The critical gaps', August 2007
[26] Outlined in the Framework document, pages 62-63
[27] For example, page 88, Table; page 91, paragraph 17
[28] Framework document page 62, paragraph 125.
[29] Framework document, page 62, paragraph 130

this network of District General Hospitals is to be dismantled[30]. It is doubtful that existing District General Hospitals would claim to have, for example, the oncology expertise of the Royal Marsden, or the specialist ophthalmology services provided at Moorfields. However, it does not automatically flow from this that the majority of District General Hospitals should be run down, and their A&E units lost or downgraded, intensive care and maternity care units removed, and paediatric inpatient services transferred elsewhere.

46. A majority of District General Hospitals will be redesigned as 'local hospitals', with the range of facilities summarised in the Framework document[31]. Local hospitals will lose their intensive care units - although some high dependency beds will remain - and offer emergency surgery only during the day. These hospitals will not have any paediatric inpatient beds – children brought to the A&E unit will be assessed and transferred elsewhere. Some local hospitals will retain their maternity units, but many will not. Patients who are too ill to be treated at one of these downgraded local hospitals will be taken to one of the 'major acute hospitals', of which there will be between 8 and 16 of these using Lord Darzi's figures, though the rationale for these figures remains opaque. Full A&E units, with 24 hour surgical teams, intensive care units and so on will *only* exist at these hospitals. This means that critically ill patients will necessarily travel much longer distances to access emergency treatment. This is concerning as recent research evidence indicates substantially higher death rates amongst some groups of patents in this situation.[32] There will be a sharp increase in the number of patients shuttled between hospitals, as any patient whose condition deteriorates significantly - or who requires surgery at night - will need to be transferred to a major acute hospital for emergency treatment before being 'repatriated' to their local hospital for rehabilitation.

47. As well as the risk to patients - the physician in the local hospital may not have the specialist skills to stabilise the patient, specialist diagnostics may be unavailable, the ambulance will need to travel through congested London, and there is not yet the dedicated critical care transport service that is assumed to exist – there may be increased distress to family members, who will have to travel much greater distances to visit their relatives. *Any* child requiring inpatient treatment – however routine this might be – will need to travel to one of the small number of major acute hospitals (or to a specialist hospital such as Great Ormond Street). The risks and practical problems around transport are essentially the same as those applying to adults. Additionally their parents will typically have to travel much further to visit children in hospital, and will find it harder to arrange care for any other children they may have.

48. There will be patients with some conditions for whom centralisation and highly specialist care are demonstrably beneficial. Surgery for children with cleft lip and palate is a strong example of centralisation of services that has already delivered improved outcomes. However, the extreme centralisation of acute care proposed here is not demonstrably beneficial - and could well lead to worse outcomes overall. Unite-Amicus believes there needs to be much more detailed work, led by clinicians, on those groups of patients who will require specialised care.

49. The financial system that now underpins the NHS means each hospital effectively operates as a stand-alone small business, generating income through providing services. It is difficult to see how District General Hospitals will survive when it is proposed that many of the services they currently provide will be located elsewhere – as outlined above – this will leave many financially unviable. This may lead to unplanned closures, which will be chaotic in the provision of care and cannot be supported. Also, selecting sites for polyclinics on the basis of ensuring some local hospitals remain financially viable[33] appears to be a perverse rationale for choosing those sites; this is taking into account what the funding system dictates, rather than local circumstances and wishes. Unite-Amicus would suggest a review of the funding system is more appropriate.

[30] Framework document, page 71, paragraph 186 and page 87, paragraph 7.
[31] Framework document, pages 96-98
[32] The relationship between distance to hospital and patient mortality in emergencies, and observational study, Emergency Medicine Journal, Nicholl, West, Goodacre and Turner, 2007
[33] Framework document, page 31, paragraph 96

50. Further, the organisational separation of elective and emergency surgery is not necessarily useful. The training of junior staff in routine procedures becomes more difficult. Patient safety – where unexpected complications may arise – becomes harder to ensure.

Specialist hospitals and Academic Science Centres

51. Unite-Amicus fully support the proposal to develop more of the excellent specialist hospitals that London currently has, and the development of a further two trauma centres. Unite-Amicus support in principle the development of Academic Health Science Centres, allowing the integration of clinical work, teaching and research.

A reduction in beds

52. The proposals for a net reduction in the number of hospital beds – despite a growing and ageing population – are buried in the detail of the Technical Paper. There are currently around 18,850 beds across London's acute and specialist hospitals and the intention is that by 2016/17 – making the assumption of 'baseline growth' – there will be 17,561. Under a 'low growth' scenario, there could be as few as 15,815 beds[34]. Unite-Amicus have strong concerns about this vision and are concerned that again this detail was buried deep within the document, rather than stated clearly and transparently.

53. As with polyclinics, it is proposed that even routine secondary care services should be offered for a minimum of twelve hours a day (for outpatient appointments, for example). This implies the presence of professional and support staff who currently work a standard working day. Any expectation that our members work additional unsocial hours must be negotiated and agreed.

Privatisation

54. Unite-Amicus believe that the Framework document is in keeping with the national policy drive, with reforms underpinned by a process of transferring healthcare assets and services from the public sector to the private sector. Lord Darzi is reported to have said 'We are not privatising primary care. '**The independent sector is a partner in the provision of primary and secondary care services.**'[35] Lord Darzi's national plans make clear the support for the private sector in service delivery, for extensive use of the private sector in a commissioning role and asserts, without evidence, that the private sector are the main source of innovation. The London proposals do not indicate he has a different view about the future of the NHS in London to nationally - the sub-text of the London plans is bundling healthcare into packages to be conveniently tendered and bid for. It has been outlined above how the private sector will be able to run polyclinics and GPs, which also opens up the private sector ability to access Practice Based Commissioning mechanisms – where they are able to commission other healthcare services from other commercial partners.

55. Independent Sector Treatment Centres (ISTCs) were originally introduced under the guise of the need to increase capacity, yet the evidence is accruing that in fact ISTCs have been under-utilised and have not been value for money[36]. The further 'unbundling' of elective procedures from other treatment increases the likelihood that this area will be further opened up to the private sector; it is also one of the most profitable areas as it involved routine procedures on low-risk patients. This leaves the NHS picking up more complex and costly patients, and reduces the opportunity for staff training.

56. A further route to private sector involvement is the proposal for 'End of Life Service Providers' – seen not as part of the NHS, but as having a contract with the NHS to coordinate and deliver end of life care[37]. It is profoundly disappointing that a valuable initiative to support Londoners in dying with dignity becomes instead a further opportunity for fragmentation and privatisation.

---

[34] Framework document, page 31, paragraph 99-100
[35] GP, magazine, Feb 2008, our emphasis
[36] 'Independent Sector Treatment Centres: evidence so far', BMJ, Allyson Pollock and Sylvia Godden, February 2008 and 'Confuse &Conceal: The NHS and Independent Sector Treatment Centres', Stewart Player an Colin Keys, 2008
[37] Framework document, pages 78 – 82

57. The US healthcare system is a prime example of how *not* to provide health care, the US spends 16% of its GDP on health yet 45 million Americans are not covered by health insurance at all, while millions more find that their insurance does not cover them when they need support. Large, multinational companies such as the giant US corporation UnitedHealth and Kaiser Permanente are viewing a market opening up in healthcare as an extremely lucrative business opportunity. These are not the principles that should underpin a healthcare system, and their involvement threatens the future of the NHS.

Co-ordination of services

58. Rather than the development of a single, integrated healthcare system the proposals deepen and widen the competition between different providers and services to secure their income stream and to employ qualified staff. Placing public services, not-for-profit organisations and private sector companies and other for-profit organisations in competition against each other undermines collaborative working practices and good communication across services. This is detrimental to patient and service user care.

59. Unite-Amicus agrees delivery of healthcare should be best value, but contests that this is what is being proposed. Unite-Amicus believes that by fragmenting healthcare services and locating them outside of the public sector the financial drive will be to deliver the *cheapest* healthcare. Commissioning takes place currently at local level – in PCTs, or even by individual GPs or small groups of GPs through Practice Based Commissioning. All the experts who put together Darzi’s Framework failed to spot the omission of a specialist speech and language therapist from the care of little Coral - why should an individual GP understand this? Even if he or she has heard of speech and language therapy, why should the GP understand that a speech and language therapist with highly specialist skills in the management of dysphagia will offer *better* clinical care than a cheaper private sector competitor with a glossy brochure? Why is it assumed to be automatic that the best service will be commissioned?

60. The influence of the market increasingly leads to more perverse influences on decision making than simple ignorance. Major private sector firms have been moving in to provide GP services for the last few years and are investing significant amounts of money in promotion and marketing material and roadshows. ‘Not-for-profit’ organisations are being invoked to make the overall policy of multiple providers more palatable – in truth it will be the private sector that will, and are, winning. A total of 14 large firms such as McKinsey, UnitedHealth, Bupa, and Tribal Group are on the Department of Health’s approved list of firms who PCTs can contract with to perform a spectrum of commissioning duties. If carried out in full this would mean multi-nationals and large private firms exercising up to 80% of the national health budget through taking on the commissioning function of PCTs, and being placed in the driving seat of choosing service providers and the range of services available.

61. London is not an exception to these policies; indeed if implemented Lord Darzi’s proposals means London would enter a period of massive upheaval as providers began a scrabble for assigned status – such as ‘Urgent Care Centre’ – and start a cut-throat fight for survival. This will be deeply damaging and Unite-Amicus do not believe the full implications of these policies have been thought through, or properly explained to the public.

62. Lord Darzi partially recognises the difficulties fragmented decision making causes, calling for pan-London commissioning and provision of some health promotion and prevention services, mentioning HIV services and care for homeless people[38]. For secondary care, it is argued ‘strong commissioning’ can somehow substitute for planning, stating, “There is a need commissioning to ensure that specialist care develops in a co-ordinated way”. Unite-Amicus believe that the market-driven vision of commissioning will not deliver the co-ordination of care services that is required. Instead, local authorities need to be able to properly plan and provide services, according to local

[38] Framework document, page 52, paragraph 69

needs in a co-ordinated fashion rather than embedding destructive, competitive market orientated incentives into the delivery of healthcare.

63. An example of the difficulties in co-ordinating and planning healthcare in the current policy context is Lord Darzi’s sensible and welcome suggestion that there should be a more efficient use of NHS buildings, stating that “In particular, we must ensure that all NHS organisations, including Foundation Trusts, are prevented from disposing of part of their estate without NHS London first considering whether that estate and the surplus generated from it, would be suitable for the development of new facilities and services, for example, polyclinics”. Yet it is clear from the current on-going argument at national level, Foundation Trusts very forcefully believe they are totally free from any NHS oversight or instruction.

Framework gaps

Children

64. It is absolutely remarkable that the proposals have not considered London children – there are groups on maternity and newborn care, staying healthy, mental health, acute care, planned care, long-term conditions, and end-of life care, but not the recognition that children are regular users of healthcare services and require services to be tailored in a particular manner. They are not simply ‘small adults’ - the occasional mentions of children add up to a patchy and problematic picture.

65. Parents will readily accept that children should be admitted to a specialist hospital for specialist care – but are far less likely to support paediatric inpatient care of all kinds being offered *only* from a few ‘major acute hospitals’. Recently there has been an emergence of a network of ‘children’s centres’ – supposedly one-stop shops for pre-school children and their families to access healthcare, education and play opportunities, social support and so on. There has been substantial capital investment in this programme. Yet it is unclear how these centres relate to other services, such as polyclinics, which are advocated in the proposals. Disabled children are conspicuous by their absence from this framework – a disappointing omission, given that health workers are striving so hard to create the ‘joined up services’ and family centred care that are needed for this group of children.

66. These points are in addition to the observation above that Unite-Amicus members who work with children – health visitors, school nurses, nursery nurses and so on – are barely mentioned in the proposals.

Social Care Funding

67. There are many references throughout the Framework document to social care. It is assumed by Lord Darzi that social care will be offered from polyclinics and urgent care centres, and that people with specific conditions will be offered integrated packages of health and social care. This is needed. Social care is now in deep crisis in this country, with the Commission for Social Care Inspection recently reporting that many cash-strapped councils restrict social care provision to people with ‘substantial’ or ‘critical’ care needs. The proposal is that the NHS might begin to commission social care itself[39]. However, the funding arrangements for this are not dealt with at all. There is no mention of social care anywhere in the Technical Paper. Any substantial provision of social care by the NHS would require a corresponding increase in funding. There *is* a need for improved social care in London, and a need also for closer integration of health and social care for those who access both. These improvements will only come about through careful, detailed work, backed up by adequate expenditure. Without this, we are likely to see a continuation of existing arrangements where councils and primary care trusts seek to pass the buck to one another, while the most vulnerable people in our society go without the care they need.

[39] Framework document, page 90, paragraph 19

Staff morale and workload

68. Unite-Amicus Health Sector members in London report a troubled NHS London, with constant re-organisation causing job and post losses. This causes increased workloads that need to be dealt with each day, alongside fears about the impact the break-up and privatisation of primary care will have on services, patients and service users. Privatisation of scientific and technical services within the NHS, a loss of training and development opportunities in recent years and the often crude use of 'skill mix' are also reported by members.

69. All of these factors combine with the impact of the pay cut in real terms, and the staging of that pay award, that staff received last year to result in extremely low levels of morale[40]. Morale is reported by health workers to have deteriorated in 71% of workplaces in the past year and 60% of NHS staff report that they have considered leaving their post over the last year.

70. The proposals made in the Framework document are for more upheaval with no staff engagement, a further erosion of services and privatisation. The lack of dedicated funding so far, and the omission of certain key areas from the expenditure estimates leads Unite-Amicus to be concerned that there will be further pressures and cuts to training and development and frozen posts. This will increase workload further, and again undermine the drive to high-quality services.

Conclusion

71. There are many very concerning aspects to these proposals. The method in which the implications of such proposals have not been clearly spelt out lacks accountability and transparency, preventing the public from being genuinely consulted and involved in a discussion about the future of their healthcare system. The plans set out greater commercialisation and privatisation of the NHS. They demonstrate a lack of understanding and grasp of the many and varied professional roles within the NHS, leading to proposals being founded on incorrect assumptions. The lack of genuine engagement and consultation with staff – who are the best placed experts to help re-design services which will deliver high-quality for patients and users – is damaging, and it is unacceptable that assumptions about very different working patterns are buried deep with the document. Unite-Amicus would support proposals that could develop a modernized and improved NHS. If these are to be developed, there must be genuine partnership working.

Kevin Coyne
Unite-Amicus National Officer for Health
Kevin.coyne@unitetheunion.com

33-37 Moreland Street
London
EC1 8HA

For further information please contact;
Siân Errington
Unite-Amicus Research Officer
Sian.errington@unitetheunion.com

[40] NHS staff survey: A research report for the joint NHS trade unions, Income Data Services, August 2007