**Healthcare for London:
A Framework for Action**

The Unite (Amicus Section) Response

London Regional Council

Unite is Britain's biggest union, with over two million members. The Amicus section of Unite organises around 100,000 members in Health – primarily in the NHS, but also in other health agencies such as the Medical Research Council. We represent many professional, scientific and technical staff in health, including the diverse healthcare scientists who provide essential support services; Allied Health Professionals such as psychologists, counsellors and speech and language therapists; pharmacists; estates staff across all healthcare settings; and hospital chaplains. Our specialist sections include the Community Practitioners and Health Visitors Association, representing health visitors, school nurses, and other community based nurses; the Medical Practitioners Union, representing doctors; the Mental Health Nurses Association and the Society of Sexual Health Advisors. Our members are the clinicians, scientists and technicians who will be expected to deliver health service reforms. They are characterised by their professionalism and their commitment to the provision of high quality services. Their expertise should not be ignored.

We note the assertion in the framework document that the recommendations for change are based on a *'thorough, practitioner-led process, and rooted in evidence'* (Summary, 4). We take issue with this assertion. Our members *are* practitioners, and have not been consulted in putting together these proposals. Our specialist sections have a dual role of professional body and trade union – but have not been consulted. The separate professional bodies representing other groups of our members have also not been consulted. Many of the proposals made by Lord Darzi are *not* evidence-based.

Our members are also Londoners. Unite is a general union, and our Amicus Section has around 100,000 members living or working in London. High quality healthcare matters for *all* of our members, and for their families. We cannot afford to see our NHS damaged.

It is clear that the Strategic Health Authority and a majority of Primary Care Trusts are simply assuming that these proposals are to be implemented, which must call into question the validity of the current consultation exercise. At present, we are on course for what is

effectively a giant experiment in the provision of healthcare for Londoners - with all of the risks this entails.

We urge caution in implementing these proposals in their current form. Our view is that these proposals may well result in worse access to healthcare for many, including the most vulnerable groups within our community. We believe that far more thought needs to be given to ensuring access. We seek commitments to adequate funding, to new services being in place *before* old services are closed, to an evidence-based examination of the viability of many aspects of the plans, and to continued public sector provision of NHS services. We also note that the proposals are for longer working hours and for unsocial working hours for our members, and we seek a commitment that these aspects of the plans will be withdrawn. If all of these commitments can be made, we look forward to working together to create the world class healthcare that is promised.

The 'Framework': Motherhood and apple pie?

The comment made at a number of meetings to discuss Lord Darzi's proposals has been that this is about 'motherhood and apple pie'. On a superficial reading of the framework document, there is little here with which to disagree. Darzi outlines five principles (Summary, 11) that most of us will support:

- 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

We particularly welcome the stated commitment to a preventative model and the emphasis on tackling health inequalities (although we struggle to see how the proposed framework can deliver on these promises).

The framework is supportive of 'improved care from cradle to grave' (Summary, 13) - none of us will disagree with that. The stated aspiration here is, *'We want to build an NHS for London that meets not only today's challenges... but also the challenges of the future'* (Summary, 4). Again, who could disagree?

It takes time, in a 134 page document, to extract the *content* of the proposals from the principles that supposedly lie behind them. The content that can be found leaves a great deal unsaid – including the rather significant question of which London hospitals will be closed or run down. Our response here is based as much on what is left out as on what is

included. It must be stressed that Unite (Amicus Section) has no disagreement with the principles outlined here, other than a concern that 'choice' has become the new code word for privatisation. Our concerns are not around the principles, but the likely impact of implementing the far-reaching changes proposed by Darzi. We are also genuinely surprised by the lack of knowledge of the professional roles of our own members.

The NHS isn't just doctors

It is astonishing that this point still needs making – but sadly it does. 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. Darzi even suggests that the 15 minutes may be an over-estimate, given the current 7 minute duration of primary care consultations. (These data are taken from pages 28 and 33 of the Technical Paper).

It would be convenient if 'talking therapies' fixed problems in a 15 minute appointment, or if sexual health advisors could influence sexual behaviour by writing a prescription, or if speech and language therapists could 'cure' speech and language difficulties through a short meeting. Unfortunately, the primary care offered by our own members bears no resemblance to the model proposed here. Relating to human beings and changing human behaviour cannot be done in 15 minute appointments. Similarly, the careful child protection and preventative work done by our community nurse members cannot possibly be delivered within the proposed model.

There is apparently little understanding from Darzi of the complex professional roles of our members. There is no understanding of the need for preparation for individualised appointments, or of the need for careful liaison to ensure 'joined up care' for patients or clients with complex conditions. There is certainly no recognition of the time taken to travel from one home visit to another.

The model of care envisaged here may suit the current drive towards productivity and efficiency savings that is so prevalent in primary care – but this approach could not conceivably deliver high quality healthcare. We suspect that when Darzi talks about 'primary care', he is thinking of GPs – but the data modelling within the Technical Paper appears to generalise this across all clinical staff.

Speech and language therapists who have read Darzi's report have been genuinely offended by the (hopefully apocryphal) story of seven-year-old 'Coral' – the 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 our members is profound.

The Framework document itself is characterised by the lack of reference to staff other than doctors. Primarily for amusement, we counted the references to key groups of our own

members. Health visitors are privileged to be mentioned 4 times. School nurses, speech and language therapists and community mental health nurses warrant a single mention each. Psychologists do not feature at all. Our wide range of scientific and technical staff are close to invisible, as are the estates staff and the myriad support staff whose hard work and commitment enable the NHS to keep working. By contrast, GPs are referenced 198 times, consultants 67 times, while the generic word 'doctor' is used 35 times.

While this exercise was done for fun, there is a serious point to be made. Darzi is proposing the complete reorganisation of healthcare in London. The proposals are made on the basis of no engagement whatsoever with representatives of most of the staff in the NHS. The proposals are also made on the basis of a fundamental misunderstanding of the work we do, and how we do it. When clinicians express concern at these plans, this is not because they *'understandably fear change'* (Page 118, paragraph 41). For our members, it is because we have a well-founded fear of redundancy, pay cuts, and the further erosion of the services we provide. The answer to the fears of our members is not the creation of *'clinical champions'*, as proposed here – but 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.

Where will care be offered?

Darzi proposes substantial changes in how and where NHS services are provided. Although the principle is, *'Localise where possible, centralise where necessary'*, our own concern is that the plans will – in practice – make access to both primary and secondary care harder.

We will review planned approaches to providing care.

Polyclinics

Darzi states that 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'* (Page 10, paragraph 16).This is an assertion, rather than an evidence-based statement, but there is not necessarily anything wrong with the proposal for new models of care.

The solution to the assumed 'stark need' is the polyclinic. The plan is an ambitious one. Polyclinics will offer not just GP services, but also *'antenatal and postnatal care, healthy living information and services, community mental health services, community care, social care and specialist advice all in one place. They will provide the infrastructure (such as diagnostics and consulting rooms for outpatients) to allow a shift of services out of hospital settings. They will be where the majority of urgent care centres will be located. And they will provide the integrated, one-stop-shop care that we want for people with long-term conditions'* (Page 11, paragraph 22).

The staff in each centre will include GPs, consultant specialists, nurses, dentists, opticians, therapists, emergency care practitioners, mental health workers, midwives, health visitors and social workers (Page 92, main table). The shift of much healthcare out of hospital settings means that in the future *'the bulk of healthcare activity will take place in polyclinics'* (Page 107, paragraph 71).

Each polyclinic will serve a population of around 50,000 (Page 92, main table). 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, acting as the 'front door' to A&E, and will also be in free-standing locations in the community (Page 93, main table).

There are some rather obvious practical challenges here, that either remain unacknowledged, or that have not been properly thought through.

Reduced access for those who most need healthcare
An immediate difficulty is that of access. 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 (Page 93, paragraph 21). The 'Technical Paper' modelling assumes that 70% of GPs will be polyclinic-based The intention is therefore that points of access to primary care – GPs, practice nurses, baby clinics, leg ulcer clinics and the like – will be sharply reduced. Older people and people with disabilities need ready access to primary care. They typically use primary care services much more frequently than younger or able-bodied adults. Travelling one or two kilometres is insignificant to many of us – but is potentially an enormous challenge to the most vulnerable members of our local communities.

The primary care needs of older people are starkly shown by the data included in the 'Technical Paper' (Page 5, paragraph 21). There are 2,735 primary care attendances per 1000 population amongst 15 to 39 year olds, compared with 7,466 attendances in 65 to 84 year olds, and 8,013 attendances in over 85s. Easy access to primary care is essential for older people.

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 (or, quite commonly, on *poor* public transport) is a significant challenge for a mother who may have two or three children with her.

Those of us who work in primary care are very familiar with the levels of extreme poverty that continue to exist amongst vulnerable service users. There is a significant proportion of Londoners who genuinely cannot afford to use public transport, even where it is available. The longer distances to access polyclinic care will be a real challenge to some patients

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

Darzi does mention transport twice (Page 90, paragraph 26; Page 125, paragraph 91) – but a quick mention resolves nothing. There is no evidence of any real awareness of the very detrimental impact that these proposals are likely to have on Londoners. There is a great deal of talk in the 'Framework' document about reducing health inequalities, but the plan for polyclinics will result in access to healthcare being *less* equal.

This is a major concern for those of us who work in primary care, and who are committed to primary care. This is a model of service provision that will sharply reduce access to primary care for the people who most need it. We strongly urge that this model of care is not implemented, as it will lead very directly to worse patient care.

We have other reservations about the polyclinic model:

Poor understanding of primary care

A major concern is Darzi's overall approach to the provision of healthcare. We know of Darzi's expertise in highly specialist surgical treatment. There has to be a strong suspicion that his understanding of primary care is limited. We strongly urge Lord Darzi to stand outside his local GP surgery or health centre for two hours, and chat to people going in. Find out why they are there, what is important to them, and why they value 'their' local practice and 'their' GP. Those of us who have campaigned against the closure and/or privatisation of GP practices in London know just how passionately committed people are to our existing provision. Those of us who *work* in primary care know why the majority of people access their GPs and practice nurses. People attending the GP practice are typically older people with aches and pains, or parents of small children with a rash or a raised temperature, or women needing a smear test. This may be less glamorous than surgery – but this, together with district nursing, health visiting and school nursing, and the specialist care provided by AHPs, is what day to day healthcare is all about. The people accessing these services need high quality care, and they often need reassurance and support from health practitioners they know and trust. It is rare for them to need emergency surgery or an MRI scan on the spot.

The risk is that we get so caught up in the excitement of redesigning the NHS that we lose the things that are most valued and most important in our existing healthcare provision. Of course there is scope for improvement, and our own members are frequently at the forefront of implementing the innovative practice that leads to better patient care. However, Darzi himself notes that the only aspect of GP services that Londoners are dissatisfied with is the provision of out of hours care (Page 21, paragraph 33). Discarding our entire network of GP surgeries and health centres is not a rational response to a self-contained problem.

Low volume procedures

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 are given in the Technical Paper (Page 25, Table 10). Estimates are 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.

The BMA (BMA, 2007) quite rightly comments on the wider issues around moving specialist provision out of hospitals. The concerns are not simply around cost and clinical standards, but also the risks to secondary care services, cost and safety, and the possible *loss* of convenience to patients as low demand will limit the frequency and availability of specialist provision in community settings. We strongly endorse the BMA's call for clinical engagement in order to ensure that only the most clinically appropriate care is moved into community settings. In the model proposed by Darzi, the vision starts to get in the way of commonsense.

Reduction in outpatient appointments

Darzi proposes that many outpatient appointments should be carried out by GPs or nurses (Page 67, paragraph 161), and encourages commissioners to reduce outpatient follow-ups that 'have no clinical benefit'. We believe that there are clinical risks inherent in this *unless* decisions are made on clinical grounds, by clinicians, and – where necessary – on a patient by patient basis. We are all too familiar with the way that cost-driven 'skill mix' is leading to a dumbing down of clinical care in areas such as health visiting and district nursing; we are aware that this trend is spreading rapidly into the services provided by Allied Health Professionals. We believe that this is damaging to patient care, and we do not wish to see the extension of skill mix – which is what this is – in the manner proposed here. Commissioners simply do not have the clinical skills to make these decisions safely.

Diagnostics

Unite (Amicus Section) is the union representing many scientific and technical staff in pathology and other diagnostic areas. Darzi proposes that *'point-of-care pathology and radiology'* will be offered in polyclinics (Page 92, main table). This may sound fine in principle, and certainly there is a limited number of such tests which pathology staff have worked to develop that have a high degree of clinical utility. For example, most diabetic clinics now assess the patient's glycaemic control over the previous 3 months by carrying out assays for glycosylated Haemaglobin whilst the patient is still in the clinic.

However, current trends in London are for the greater centralisation of pathology services (with private sector providers now seeking to offer services from a small number of high-volume centres). This is partly due to the need to maximise what are very expensive capital requirements in terms of specialist equipment (the largest such laboratory presently analyses some 5000 plus samples a day) and also a response to the now chronic shortage of qualified staff.

Plans for localisation would necessitate a sharp reversal of current trends. The start-up costs of offering pathology and radiology services from every polyclinic would be very substantial indeed. Also, moving a large number of skilled staff out of hospital settings into polyclinics very obviously threatens the provision of diagnostic facilities in the acute sector. *If* the money 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, though, that these challenges have been thought through.

Where will the buildings come from?

A very practical difficulty is where the accommodation for polyclinics is going to come from. 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...' (Page 125 paragraph 90). 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 (Technical Paper, Page 28, paragraphs 88 and 91). The space required for diagnostic facilities is mysteriously absorbed into the tariff costs for diagnostics (Technical Paper, Page 28, paragraph 91). The 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, so the actual intentions become very unclear.

Irrespective of the inclusion or otherwise of the facilities required for 'one-stop shops', buildings of this size, with the range of facilities required, are not simply sitting about. They either need to be built, or substantial investment needs to take place to modernise and convert existing premises. No mention is made in the Technical Paper of capital costs. Does the money come out of the budget for patient care? If not, where does it come from? Is this to be a re-run of the vast sums of money wasted on PFI? This remains unclear.

Longer working hours – and worse working hours – for staff

From a trade union perspective, there are strong concerns about the staffing assumptions. The Technical Paper assumes that each member of staff will work 40 hours a week (Technical Paper, Page 27, paragraph 85). Current NHS working hours are 37½ hours a week, and Unite believes that the working week should be reduced to 35 hours. We are unaware of any proposal to increase the working week, and would oppose this. Expecting London health workers to work an additional 2 ½ hours a week is of course unacceptable.

The proposals also seek to implement unsocial hours of work for a sharply increased number of NHS staff. Again, this is unacceptable. Any change to the working patterns of our members has to be negotiated and agreed with Unite. The Framework document outlines the proposed opening hours for polyclinics (Page 92, main table). All polyclinics will open between 18 and 24 hours a day, 7 days a week – with all the implications for support staff that go with that. All community services will be offered for a minimum of 12 hours a day. *'Interactive health information services including healthy living classes'* are, rather oddly, required to be available 18 to 24 hours a day. Who actually wants to attend a healthy living class at midnight, or at 6am? Maybe all the other health workers who are being made ill by their appalling working hours! Health workers accept that emergency healthcare will be available 24 hours a day, 7 days a week. For routine healthcare to be available on the basis proposed here is nonsense. There is no clinical need for this. We suspect this is more to do with meeting the demands of the CBI that UK workers should no longer be allowed to attend medical appointments in working hours.

Darzi refers briefly to the need for *'healthier, happier NHS staff'* (Page 55, paragraphs 82 and 83). We wonder if this aspiration is really compatible with the proposals around working hours.

Clinical staff will of course be unable to deliver services effectively without access to a sound IT infrastructure and high quality administrative support. Lister (2007) has argued that the projected administrative costs of polyclinics are seriously under-estimated by Darzi. If Lister's estimates are correct, there is a danger of polyclinics being unworkable and of services sliding into chaos, or of cuts being made in patient care to pay for adequate support staff. Neither is acceptable

Private sector to run polyclinics
Unite (Amicus Section) is opposed to the privatisation of the NHS. We believe that the fragmentation of healthcare provision and the introduction of the profit motive combine to produce worse patient care (and worse pay and conditions for staff). We note the ambiguity in these proposals about who will own and manage polyclinics. The Framework document comments, *'New polyclinics could be owned by the NHS and utilised by NHS staff and others. Or they could be owned by the independent sector – this could be a large GP practice providing some services and buying others in or it could be by a company interested in owning the asset but then letting it out to a service provider. Foundation Trusts may also be interested in owning and running polyclinics'*. We know from Darzi's 'interim report' on national healthcare of his strong support for the privatisation of primary care. Seemingly this will include private sector provision of polyclinics.

A reduction in health inequalities?
Darzi suggests that the polyclinic model will reduce health inequalities. We simply don't believe this. Many of our members are frontline health workers, and many of us work in areas of high social deprivation. We are certain that making access to routine healthcare more difficult is not the route to reducing health inequalities.

The claims made in the Framework document around reducing inequalities do not have a strong evidence base. We are told, for example, *'The scale of the polyclinics will allow them to improve accessibility by offering extended opening hours across a wide range of services. Scale should also make it more possible to provide the expertise necessary to improve accessibility for some disadvantaged groups, and to implement much more sophisticated telephone booking systems'* (Page 11, paragraph 23). Our own view is that problems of access are fundamental. An additional risk is that the degree of centralisation inherent in polyclinics will reduce the ability to offer culturally appropriate care on a local basis. We also believe that resolving the issues of privatisation, fragmentation, cuts and redundancies – now a central feature of London's NHS – are rather more significant than a sophisticated telephone booking system.

Darzi notes, absolutely correctly, that there are fewer GPs per head in parts of East London than elsewhere in the capital (Page 127, paragraph 104). Again rightly, he calls for this inequality of access to healthcare to be tackled. We agree. It is nothing short of scandalous that the most deprived areas of London have the worst healthcare (and that, historically, they have been under-funded compared with more affluent areas).

Unfortunately, socially deprived communities can be seen as a 'soft target' for experiments in healthcare. The Government has already prioritised the introduction of private sector GPs in areas of high social deprivation. Anecdotal evidence from our members in these areas suggests that a poor quality of care is commonplace. We also note the recent award of a contract to run three GP surgeries in Camden to United Health. A local GP who had sought to run the practices commented that United Health proposed to spend £75 per patient for every £100 that he would have spent. Privately provided healthcare is typically cheap healthcare. The reality of current policy is that worse healthcare in socially deprived areas will become even more intrinsic than it is now.

Darzi's proposal is that early polyclinics should be developed in precisely these areas (Page 127-128, paragraph 104). There is a strong risk that patients will suffer the 'double whammy' of worse access to healthcare *and* worse healthcare when they do access it. Our members tell us that these are the areas where a polyclinic model has the greatest potential to do harm. The solution to a 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, access to flexible working, access to childcare and the like). This very obvious solution would do more to tackle health inequalities than private sector provision *or* polyclinics.

Our own view is that any serious attempt to tackle health inequalities must look more deeply at the underlying reasons for these. The Black Report was famously 'buried' by the Thatcher Government on a Bank Holiday weekend in 1980. The report was considered too politically sensitive even to be publicised, never mind implemented. The report highlighted poverty as the major cause of health inequalities, and argued that the gap between rich and poor had to be narrowed in order for any real progress to be made. There is a need today for another Black Report – and a need for the political will to implement its findings. Darzi uses the word 'inequalities' throughout his report – but there is no serious attempt here to tackle health inequalities or the poverty that lies behind them. Sadly, 'Healthcare for London' is not a Black Report.

Care at home – part of the polyclinic model

Darzi calls for an increase in the provision of healthcare in peoples' own homes (e.g. Page 89, paragraph 11). Specific examples given are for increased home provision of antenatal and postnatal care, a sharp increase in the number of home births, and more systematic provision at home of services such as rehabilitation, mental health care, planned care for children, and palliative care for adults and children.

We agree completely. Home visits offer the opportunity for respectful, individualised care in the setting where a patient feels most comfortable. Our members, as health professionals, are supportive of this approach. We also agree with Darzi's comment that healthcare provided at home can reduce health inequalities for vulnerable groups such as people with disabilities and older people with long-term conditions (Page 89, paragraph 12).

However, there seems to be no awareness of the cost or staffing implications of this. Staff costs account for most NHS spending. Home visits are very, very costly indeed in terms of staff time. Put plainly, if psychologists are to provide mental health care at home – using one of Darzi's examples – they will see many fewer patients than if they are clinic based. If routine care is to be provided at home, there will need to be a significant increase in the numbers of community nurses and Allied Health Professionals providing that care. Home care is not even mentioned in the Technical Paper, so Darzi's costings derive from clinic-based appointments.

The assumption is made that seeing patients at home will prevent 9% of hospital admissions (Technical Paper, Page 2, paragraph 12) but this remains unproven. Even if this is the case, this does not overcome the shortfall in staffing levels. The staff involved in providing preventative care in a community setting will typically not be the same people (nor even the same professional groups) as those who provide acute care in hospitals.

Darzi comments *'NHS staff will be going into people's homes to help keep people out of hospital. Providing more care at home will have transport implications for NHS and social care staff, who will need to be able to travel quickly and (where travelling by car) park easily'* (Page 90, 15). We agree – but we don't know how this is to be achieved! The problem of poor transport in London cannot be so easily wished away. An immediate approach to the GLA to secure free car parking and public transport facilities for NHS staff in work time would be an exceptionally useful start – but even if this were to be achieved, the costs of healthcare at home would remain enormously high.

We strongly support more healthcare delivery at home – but this cannot come about just by hoping that it will happen.

Urgent Care Centres

References to urgent care centres are scattered around the proposals in a somewhat haphazard way, and it takes a little 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; they will have a similar range of services to polyclinics, with the addition of emergency practitioners; and will co-ordinate out-of-hours GP provision. Ambulance stations will be located at urgent care centres. The plans are briefly outlined in the Framework document (Pages 62 to 63). It is important to stress that these are not A&E units. They are GP-led, and – unless they are attached to hospitals – will have no on-site access to inpatient beds, specialist medical support, high dependency or intensive care facilities. 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 (Page 62, paragraph 126). Careful reading of the document suggests that the community-based urgent care centres will be based in polyclinics (e.g. Page 88, Table; Page 91, paragraph 17) – but this is not entirely clear. The proposed opening hours for community-based urgent care centres seem to shorter than those proposed for polyclinics, for example. 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 (Page 62, paragraph 125).

Possibly the real answer emerges when Darzi describes urgent care centres as *'highly-accessible alternatives to A&E'* (Page 62, paragraph 130), and goes on to talk about 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 we have no difficulties. If – as this paragraph implies – urgent care centres are to become the 'alternative' to A&E units then this becomes more problematic. We know of a wider agenda to close A&E units, and 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

The proposals are for an enormously complex range of different organisational forms: local hospitals; elective surgery centres; major acute hospitals; specialist hospitals; hyper-acute hospitals; trauma centres; and Academic Health Science Centres.

Some of the plans outlined by Darzi are positive, and should be welcomed. Others will lead to worse patient care, will almost certainly herald further widespread privatisation, and will cause shortfalls in income that will result in hospital closures.

The proposals are outlined for public consumption in the main Framework Document ('Future models of service provision', pages 87 – 112). The implications become apparent from the small print of the Technical Paper (Page 31, paragraphs 99-101).

The end of District General Hospitals

London currently has 32 District General Hospital Trusts. These hospitals are currently at the heart of secondary care. Most Londoners requiring inpatient treatment currently access this at their local District General Hospital. Most Londoners requiring outpatient follow-up currently attend their local District General Hospital. The system is not perfect, but by and large works well. It is a model of care that Londoners understand and support.

This network of District General Hospitals is to be dismantled. Darzi's argument is, *'We are clear that for the best care, more hospitals need to become specialist in particular aspects of healthcare. The days of the district general hospital seeking to provide all services to a high enough standard is over'* (Page 71, paragraph 186). This is slightly rephrased as, *'We... cannot have all 32 acute trusts in London seeking to provide the most specialised kinds of care... We need fewer, more advanced and more specialised hospitals to provide the most complex care…'* (Page 87, paragraph 7).

On this, Darzi may well be correct. We do not believe that our 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 follow from this that the majority of District General Hospitals should be run down, that their A&E units should be lost or downgraded, their intensive care units removed, their maternity units closed, and their paediatric inpatient services transferred elsewhere. This is precisely what is being proposed for a majority of District General Hospitals.

A majority of District General Hospitals will be redesigned as 'local hospitals', with the range of facilities summarised in the Framework document (Pages 96-98). Local hospitals will lose their intensive care units (although some high dependency beds will remain). They will offer emergency surgery only during the day, but not at night. 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 a 'major acute hospital'. There will be between 8 and 16 of these, using Darzi's figures (although the rationale for this figure remains opaque). Full A&E units, with

surgical teams 24 hours a day, 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 (with recent research evidence indicating substantially higher death rates amongst some groups of patents in this situation). 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 (Page 97, paragraph 33), before being 'repatriated' to their local hospital for rehabilitation (Page 98, paragraph 36).

There are obvious risks to patients here, as well as increased distress to family members. Darzi comments, *'Patients in the local hospital's care who deteriorate and need level 3 critical care will receive it as quickly as possible. They should be stabilised by an acute physician, and transferred by a dedicated critical care transport service'* (Page 98, paragraph 39). However, the reality is that the physician in the local hospital may not have the specialist skills to stabilise the patient, specialist diagnostics may be unavailable, the ambulance may get stuck in London's ever-worsening traffic en route, and we do not yet have the dedicated critical care transport service that is assumed to exist.

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. There are additional social issues, as parents will typically have to travel much further than now to visit children in hospital, will find it harder to arrange care for other children and so on.

The mantra used repeatedly in the Framework document is *'localise where possible, centralise where necessary'*. There will be some 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 secondary care proposed here is not demonstrably beneficial - and could well lead to worse outcomes overall. There needs to be much more detailed work, led by clinicians, on those groups of patients who will require specialised care.

Our existing District General Hospitals are therefore set to lose a great deal of their existing income. Minor procedures and many out-patient appointments will be transferred to polyclinics. Much emergency treatment will be transferred to major acute hospitals. Many hospitals will lose their maternity units and neonatal units. There is another income stream that will be transferred away from these hospitals: elective (planned) surgery. Routine surgery – e.g. cataract operations and hip and knee replacements - will no longer be carried out in hospitals, but in new 'elective treatment centres' (Page 99, paragraphs 41 – 43). 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.

Current NHS funding arrangements are such that every NHS hospital trust effectively functions as a stand-alone small business, required to sell its services in order to survive. Darzi proposes that most District General Hospitals in London will no longer be allowed to sell the services that enable them to be financially viable. It is difficult to see how many of

these hospitals will avoid bankruptcy and closure, unless there is also a fundamental review of NHS funding arrangements. The Technical Paper suggests that polyclinics will be located on local hospital sites *'in order to support the financial viability of local hospitals'* (Page 31, 96). This is a perverse basis for selecting the sites of polyclinic care, and unless NHS funding arrangements change, this will in any case not change the threats to financial viability of hospitals. Unplanned hospital closures will lead to chaos in the provision of patient care. Clearly we do not support this.

Specialist hospitals and Academic Science Centres

There are elements of the proposals for secondary care that we do support. London already has some excellent specialist hospitals, and the plan to develop more of these (Page 103) is one that we support. Darzi also suggests the development of a further two trauma centres (in addition to the existing centre of expertise at Royal London Hospital) (Page 63, paragraph 141). Again, this is something we absolutely support. We also support in principle the development of Academic Health Science Centres, allowing the integration of clinical work, teaching and research (Pages 104 – 105) – although our fear is that these could provide 'window dressing' for an NHS that is being run down behind the scenes.

A reduction in beds

The proposals for a net reduction in the number of hospital beds – despite a growing population and an 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 (Page 31, paragraph 100). The intention is that by 2016/17 – making the assumption of 'baseline growth' – there will be 17,561 (page 31, paragraph 99). Under a 'low growth' scenario, there could be as few as 15,815 beds. We have strong concerns about this vision. We also note that few readers will get as far as the second to last section of the supporting technical documentation to the Framework document.

Secondary care: staff issues

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

Lord Darzi is known to be a strong supporter of further privatisation of the NHS. In February 2008, he has been reported as saying to the publication 'GP', *'We are not privatising primary care.* ***The independent sector is a partner in the provision of primary and secondary care services.'*** (our emphasis).

Darzi's recent interim report on *national* plans to reorganise the NHS ('Our NHS, Our Future') highlights his enthusiastic support for privatisation. He calls for the immediate introduction of more independent sector GPs, and for the involvement of the private sector in primary care and in the management of long-term conditions. He claims that new private sector providers have *'helped extend choice, add capacity and spur innovation'* and states *'I believe that the innovative practice that independent sector providers can bring will help realise dramatic improvements for patients…'.* He even supports the privatisation of commissioning in his national proposals, calling for the *'extensive use within every SHA'* of FESC (the Framework for procuring External Support for Commissioners). This amounts to little more than an all-out assault on the NHS and the values of the NHS. This is the route to the rapid breaking up our health service, and allowing the private sector to grab the more profitable elements of it. Darzi's national proposals read very much as a hymn of praise to the private sector.

Are his proposals for London any different? Almost certainly the answer is 'No'. The plans are less overt in their support for privatisation, but there is little reason to suppose that Darzi enthusiastically supports privatisation everywhere in England *except* London.

The sub-text of the London plans is the sense that healthcare is being bundled up into the packages that will be most attractive to private sector bidders. We have commented on Darzi's support for the private sector to own and run polyclinics – an immensely profitable chunk of the NHS, given that Londoners will be accessing the bulk of their healthcare in this setting. Control of GPs will also give the private sector control of Practice Based Commissioning – so they will be enabled to commission other healthcare services from their commercial partners and subsidiary companies (just as they can with FESC).

Polyclinics are not the only route for privatisation. The excuse for Independent Sector Treatment Centres up until now has been that they are primarily about 'extending capacity'. The Framework document proposes that pretty much all 'high throughput' elective surgery will be 'unbundled' from other NHS provision, and delivered from 'elective centres'. These elective procedures (such as cataract surgery, and knee and hip replacements) are precisely the areas that the private sector has prioritised for involvement, cherry picking routine procedures and low-risk patients in order to maximise profits. There is very little doubt that private sector providers will be encouraged to bid for this work (and their existing experience in running high-volume low-cost units will give them an advantage). The NHS will be left to pick up more complex (and costly) patients and the ongoing expense of staff training – just as it is now.

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 (pages 78 – 82). It is profoundly disappointing that a

valuable initiative to support Londoners in dying with dignity becomes instead a further opportunity for fragmentation and privatisation.

Unite is opposed to the privatisation and ‘marketisation’ of the NHS. Our members in primary care are now seeing first hand the pressure for high-volume low-quality clinical services, as we are out-sourced to private sector providers, ‘Autonomous Provider Organisations’ or social enterprise companies. Our members in pathology are beginning to experience the job insecurity and attacks on pay, conditions and pensions that accompany privatisation.

The health system in the USA is a prime example of how *not* to provide healthcare. The USA spends as much as 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. We are now seeing American companies such as United Health invited to run chunks of our own NHS, while Kaiser Permanente is praised in the Framework document and was heavily promoted at Darzi’s ‘International Clinical Summit’ in November last year. This is not the way that our own NHS should be going.

There is a political agenda behind the proposals for London. The agenda is one of the continued break-up of the NHS, and the further involvement of the private sector. This is to the detriment of patients, of staff, and to the values and ethos that underpin the NHS itself.

Planning – or the market?

Darzi’s support for privatisation is well-established. He also supports the ‘commissioner-provider split’ that now dominates our NHS, and sees commissioning as a *‘very powerful lever for driving change’* (page 12, paragraph 29). It is quite clear that Darzi’s model of the NHS is a ‘free enterprise’ one. He comments on funding flows, stating *‘Commissioning can only drive change if it has a direct impact on the income of healthcare providers’*. The model is not about continuity of service provision. This is about commissioners deciding what they want, and deciding which one of many competing providers to buy it from. Healthcare providers will come and go, depending on their ability to sell their product. There is a broad equivalence here between buying healthcare and buying baked beans.

There are challenges. Commissioning takes place currently at local level – in PCTs, or even by individual GPs or small groups of GPs through Practice Based Commissioning. Let’s remember that 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 (Page 95). Why should an individual GP understand this? Even if he or she has heard of speech and language therapy and swallowing problems, 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 should the best service be commissioned? If it is, this is likely to be by chance.

The influence of the market increasingly leads to more perverse influences on decision making than simple ignorance. Major private sector GP providers have been moving in on the NHS for the last few years now, with a significant incentive being the control of Practice Based Commissioning Budgets. ‘FESC’ and any future initiatives to privatise commissioning will work similarly. We are now giving control of NHS budgets to private

sector companies, and allowing them to maximise their profits by commissioning healthcare from their commercial partners and subsidiaries. The driver for change here is a simple one – profit. It is actively unlikely that the best clinical service will be commissioned.

On the 'provider' side of the NHS – i.e. the people who provide healthcare - we are seeing an even greater level of chaos. NHS hospitals used to work together collaboratively, sharing best practice in the interests of patients. This has largely gone, as hospitals now compete with one another for business (that is, patients). Hospitals may decide to offer or withdraw clinical services on a purely commercial basis. Darzi's proposals will sharply increase the competition between hospitals, as we see a desperate scrabble to become a 'major acute hospital' or a 'trauma centre' – with the losers facing downgrading or closure.

The direction of travel of community healthcare services is towards very rapid fragmentation. There *is* competition between different providers, but a sharply growing number of these are not NHS providers at all. In a few years from now, provision may well be by a ragbag of private sector and voluntary sector providers, with Autonomous Provider Organisations and social enterprise companies acting as stepping stones towards full privatisation. There is little doubt that Darzi's polyclinic model will speed the break-up of NHS provision.

Whether we look at commissioning or service provision, the driving force in today's NHS is the market. The scope for planning and delivering healthcare based on patient needs diminishes as the role of profit increases.

Darzi partially recognises the difficulties that this causes. He calls for pan-London commissioning of and provision of some health promotion and prevention services, mentioning HIV services and care for homeless people (Page 52, paragraph 69). For secondary care, he believes that 'strong commissioning' can somehow substitute for planning, stating *'There is a need for strong commissioning to ensure that specialist care develops in a co-ordinated way'* (Page 87, paragraph 7). These are attempts to retrospectively impose some sort of order on an intrinsically anarchic system. Commissioning is a part of market-driven chaos, rather than a solution to it.

There is a real alternative, of course. The NHS market has been with us only since 1990, introduced by the Thatcher government. Labour opposed the NHS market in opposition, but has massively extended it in office. Prior to 1990, there was no 'purchaser provider' or 'commissioner provider' split. District health authorities *planned* the NHS care that patients needed, and they *provided* that healthcare. It wasn't perfect – but it was far more responsive to rational decision making than the free market that is now being created. The costs of bureaucracy were, of course, very much lower. If we are serious about meeting the diverse health needs of Londoners, planning and coordination are absolutely essential. Real modernisation might actually mean returning to a rather better way of doing things.

One tiny example shows just how powerless Darzi may find himself when it comes to implementing the occasional sensible reform. Darzi calls repeatedly for the more efficient use of NHS buildings, seeing these as an important shared asset and as sites for polyclinics and the like. He is very clear that NHS London should have the right to dictate to hospital trusts what they may or may not do with their buildings. One typical comment is, *'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' (Page 125, 89)..

There is a problem here. An astonishing row emerged in the media in February 2008. David Nicholson, Chief Executive of the NHS asked all hospitals to embark on a deep cleaning exercise to reduce hospital acquired infections. This followed the scandal of C. Difficile at Maidstone and Tunbridge Wells NHS Trust, where dozens of patients died unnecessarily. The Foundation Trusts responded with fury, condemning Nicholson for 'interfering' with operational decisions. In a matter of months, over half the hospitals in England will be 'Foundation Trusts' – still, nominally, NHS hospitals, but completely free of NHS control.

If the Chief Executive of the NHS can't make Foundation Trusts clean their hospitals, how can Darzi stop them selling off spare buildings as luxury flats? And if we can't stop Foundation Trusts flogging off their buildings, how can we have any hope of making them all work together to provide planned and co-ordinated healthcare that meets Londoners' needs? The Government has unwittingly created a monster here. The monster could still be tamed – but not without a genuinely radical turn towards public ownership and public control.

And more gaps in the Framework…

There are some surprising gaps in the Framework document.

Children

Darzi's proposals are supposedly based on the detailed recommendations of five working groups, looking at how to achieve 'improved care from cradle to grave'. Unfortunately, no one seems to have considered childhood an important stage on the lifetime journey of Londoners! So we have groups on maternity and newborn care, staying healthy, mental health, acute care, planned care, long-term conditions, and end-of life care (Page 43, paragraph 16). But children, once they are born, pretty much disappear from view. Unite members have been overheard wondering aloud if Lord Darzi has ever actually met a small child…

The occasional mentions of children add up to a patchy and problematic picture.

- 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'.
- We are now seeing the 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. But how do children's centres and polyclinics fit together? Or don't they? This is a fundamental question, as children are major users of primary care. Decisions need to be taken early on in the planning of service delivery. Darzi mentions the issue in passing, but does not explore it.
- Children with disabilities are conspicuous by their absence from this framework – a really disappointing omission, given the very positive work in recent years towards creating the 'joined up services' and family centred care needed for these children.
- And, as we have said, the tens of thousands of our members who work with children are very low indeed on Lord Darzi's radar.

Far more work must be done to think through the implications of these proposed changes for children. Our members are well-placed to contribute to this process.

Older People

There is little in this document for older people – other than more difficult access to primary care. We are also very disappointed by the impoverished model of health provision that views the needs of older people almost entirely in terms of 'end of life' care. There is a good deal more work to be done here.

Social Care Funding

There are many, many references throughout the Framework document to social care. It is assumed by 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. There is certainly a need for a major review of social care, in London and across England. Social care is in deep crisis in this country, with the Commission for Social Care Inspection recently reporting that many cash-strapped councils now restrict social care provision to people with ‘substantial’ or ‘critical’ care needs.

Darzi’s proposal is that the NHS might begin to commission social care itself (page 90, paragraph 19). 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 not come about through quick fixes, however, but 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.

The Existing Context

Our Health Sector members in London tell us that the NHS is London is in deep trouble. They describe a process of constant re-organisation, leading to job losses, pay cuts, and worse services. They report the increased workloads they deal with day to day, the financial pressures caused by last year’s staged pay award, and the impact of these things on their family and personal lives.

Members tell us of an NHS that is melting away. They describe the rapid break-up and privatisation of primary care, and their fears for the impact this will have on the care of complex patients. They tell us of the privatisation of scientific and technical services within the NHS. They tell us of the loss of training and professional development opportunities, and the crude use of skill mix, and the way these factors combine to ‘dumb down’ patient care. They tell us of managers (and politicians) who like to pretend that the NHS is going from strength to strength, while presiding over a system that it is being dismantled.

The day to day experiences of health workers feed directly into the lowest morale amongst health workers that we have ever known. This is summarised well in the joint union submission to the Pay Review Body for the 2008/09 pay round. Morale is reported by health workers to have deteriorated in 71% of workplaces. One of the main reasons for choosing to work in the NHS has always been the public sector ethos – but 60% of NHS staff report that they have considered leaving their post over the last year.

This is a background that Darzi has chosen to ignore. Why? Are these truths too uncomfortable? The proposals made by Darzi are for longer hours, more unsocial hours, more change, and more erosion of the public service ethos that continues to matter to NHS workers. For us, the NHS is not a logo at the top of a sheet of headed notepaper. For us, the NHS is a set of values and principles. The NHS represents the idea that we live in a caring society and *therefore* we look after one another – not from any profit motive, but simply because we care about one another. We do not believe that Lord Darzi understands that.

Conclusion

If Darzi said explicitly, 'I'm going to close GP surgeries and health centres, and close paediatric units and maternity units, and intensive care units, and run down your local hospitals' – if these things *were* said, then the proposals could never win public support. These proposals are disingenuous. The intention is that the mechanisms that will provide for cuts, closures and privatisation are put in place – but they are buried in a long and repetitive document, heavy on rhetoric, designed – we believe – to conceal the eventual outcomes.

The ultimate 'get out' for Darzi is that he never has to say which A&Es will be run down, and which maternity units will go. We are told, *'It is not the remit of this review to determine which of London's 32 acute Trusts are designated as major acute hospitals. We propose that is done by NHS London and Primary Care Trusts in a clear and transparent process'* (page 102, paragraph 47). And when Londoners protest at the loss of their local services, we will be told that we *were* consulted, and that most of us agreed.

There are positive aspects to these proposals. – but these are outweighed by plans that will harm the people in our community who most need healthcare. We also have the strongest possible concern over figures that don't add up, Darzi's poor understanding of primary care, the lack of understanding of the professional roles of our members, and the disregard for health workers when it comes to hours of work. We believe that the further privatisation of healthcare – inherent in these plans – will be damaging to the NHS.

There is still time for a thorough over-haul of these proposals, based not just on the 'show' of engagement but on genuine joint working and engagement with healthcare staff. We call for this as a matter of urgency.

Unite (Amicus Section) London Region
28th February 2008