

## **Unite written response to ‘Equity and Excellence: Liberating the NHS’**

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

Unite 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, healthcare science, applied psychology, counselling and psychotherapy, dental professions, audiology, optometry, building trades, estates, craft and maintenance, administration, ICT, support services and ambulance services.

### **1. Executive Summary**

1.1. The White Paper, ‘Equity and Excellence’, proposes to transform and privatise the NHS so that services are geared towards fulfilling financial and business contractual relationships and outcomes, rather than meeting health needs. This will lead to increasing health inequalities and Unite believe it ultimately puts at risk the concept of a universal, free health care service.

1.2. The creation of the NHS Commissioning Board is a ‘contracting out’ of the responsibility of the NHS by the Government; it is an attempt by the Government to be at ‘arms length’ distance when the quality and range of health services decreases because of the implementation of their proposals.

1.3. The cap on private income for Foundation Trusts exists to ensure that a hospital, clinic or service cannot be turned over mostly or wholly to fee-paying patients and users. The abolition of the cap opens the door to a two, or multi-tiered, service where people can be pay to be prioritised to receive quicker treatment, or receive a better standard of treatment.

1.4. The White Paper contains the proposal to make £20billion ‘efficiency savings’ by 2014, but these ‘efficiency savings’ are just cutbacks in ser vices.

1.5. The announcement of the Government's implementation of a pay cut for NHS and other public sector workers rode roughshod over the collective bargaining arrangements in the NHS and other parts of the public sector. Just some of the impacts of such an action will be high staff turnover, recruitment and retention problems as in the early 1990s and higher stress and workloads for employed staff. All of these will lead to lower quality of services, and through lower staff numbers, fewer health services in total.

## 2. Introduction - 'Liberating' the NHS: the privatisation of our NHS

2.1. The democratically decided policy of Unite is for a National Health Service that is publicly owned, publicly funded and publicly accountable, providing comprehensive and universal health services, free to all, before and after treatment. Unite supports an NHS where delivering high quality services to patients and users is paramount, and strongly believes in the equality of all patients, users and staff.

2.2. Unite believe the government White Paper is opposed to these aims and beliefs. The proposals in 'Equity and Excellence' threatens to sweep away the NHS as we understand it - a collective public service – and leave only a logo behind. Health services will be provided by a myriad of competing, businesses trying to maximise their profits. This will be brought about in three main ways;

- i. **Implementation of GP commissioning:** Consortia will put all local health services out to tender, and will then be able to award the contract to *"any willing provider"*. This means any private company can apply to provide services. The application of competition law will prevent these consortia from favouring those organisations that remain public sector, 'NHS' organisations.
- ii. **Bringing about the disintegration of the remaining public sector, NHS organisations:** the extension of the 'right to request' will mean a deepening drive to break apart NHS organisations and transfer them section by section to the private sector. This is not altered by the softer sounding moniker 'social enterprise'. Health services previously owned, operated and delivered by NHS Trusts will be turned into autonomous, private sector businesses needing to win service contracts and patient income to survive and vulnerable to take-over from multinationals.
- iii. **Carrying out the role of 'commissioner':** the bringing together of 'consortiums' of many and varied GP practices, the time pressures on individual GPs and the complexity of the health business market being set up – for example, requiring knowledge of the complex British and European law and regulations concerning contracting and competition, means that the practical solution for many of these consortiums will lay in contracting out the commissioning function itself to a private, management consultancy.

2.3. Yet despite the sweeping, fundamental change being threatened by the government there is no proper public consultation. There has been no proper explanation to the public of the full ramifications of what is proposed in 'Equity and Excellence'. This written consultation has been conducted over the summer period, and its outcome already presumed – as evidenced by the Chief Executive's letters to the service.

2.4. Unite believe that the Government's proposals will;

- Decrease the quality and range of health services available to people,
- Contribute to increasing health inequality,
- Increase healthcare costs,
- Reduce accountability.

2.5. Just some of the impacts of such an action will be high staff turnover, recruitment and retention problems as in the early 1990s and higher stress and workloads for employed staff. All of these will lead to lower quality of services, and through lower staff numbers, fewer health services in total.

### 3. Putting patients and the public first?

3.1. Developing a 'patient centred' NHS requires staff having sufficient time to spend with each patient and user. Healthcare staff who may not have direct interaction with patients and service users, but nonetheless play a vital role in the delivery of healthcare, need to be able to devote sufficient time to conducting their role properly and thoroughly. At the heart of achieving this is the need to address escalating staff workloads. Yet within the White Paper is the proposal to make 'efficiency savings' of £20billion by 2014.

3.2 In a Unite survey of our health sector membership in 2009 nearly half of respondents (48%) to the Unite stated that when they work additional hours they are normally unpaid. This is in line with results from the NHS Staff Survey which found that 53% regularly work unpaid hours above their contracted hours (41% up to 5 hours more, 9% 6-10 hours more and 3% more than 11 hours)<sup>1</sup>. Compared to the previous year 46% stated that their workload had increased a lot –overall 83% replied their workload had increased either a little or a lot. Just 4% had experienced a workload decrease of any kind. This fits in with high individual workloads in the NHS Staff Survey over recent years.<sup>2</sup> The impact of this growing

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<sup>1</sup> See Q1c, National NHS Staff Survey 2008 found at [www.cqc.org.uk](http://www.cqc.org.uk)

<sup>2</sup> In the 2007 Healthcare Commission Staff Survey respondents were asked if they agreed or disagreed with the statement "*I do not have time to carry out all my work*", just 3% strongly disagreed with the statement and therefore strongly felt they *did* have sufficient time to perform their role. This figure remained at 3% in 2008. In 2007 a total of 26% disagreed with the statement, and nearly half of respondents – 47% - agreed that they did not have enough time to fully perform their role. In 2008 46% agreed with the statement that they did not have enough time to carry out all their work – the total percentage disagreeing with the statement – i.e. did have enough time to perform their role - was just 27%.

workload is clear; both on individual NHS workers and those receiving NHS services. When asked for the impacts of their increased workload, the top 3 answers were that individuals experienced "increased stress levels resulting in a detrimental effect on [their] relationships within and outside work" (48%), "increased stress levels resulting in a detrimental effect on [their] health" (40%), and that there was a "negative impact on patient/client care" (24%). This has led to 43% considering leaving because of stress and workload levels. 'Efficiency savings' and privatisation will make this worse. '

### Efficiency savings and staff workload

3.3. Delivering health services is labour intensive and therefore cost savings and 'efficiencies' are often made at the expense of the number of staff, and where services have been contracted out, the terms and conditions of staff. 'Efficiency savings' often translate into simple cutbacks in services and staff, rather than genuinely engaging staff about how to services and work can be redesigned effectively. For example, NHS Sheffield Primary Care Trust has previously employed a consultancy firm to find efficiency savings, who recommended cutting the Whole Time Equivalent Health Visitor numbers from 95 to 84.86. Union members reported that the company carried out 'time and motion' studies and were unwilling to recognise the role of Health Visitors in child protection. This example comes from a time when the 'NHS competitive market' and 'efficiency savings' were on a comparatively small scale compared to what is about to be unleashed by the government's proposals. Unite are already receiving reports of many staff performing vital roles who are being told their jobs are at risk. These 'efficiency savings' are simply cut backs in services.

### Privatisation

3.4. Privatisation, and the drive to make profits and reduce costs as much as possible, will lead to reduced staff numbers. This will mean the ending of some health care provision and increased staff workloads for those employed. Unite believe that reduced costs also threaten to come at the expense of staff terms and conditions.

3.5. If we take cleaning as an example because cleaning services have been subject to privatisation since 1983 we can see the trends that emerge - approximately 40% of hospitals now have contracted out cleaning services<sup>3</sup>. Since the introduction of compulsory competitive tendering in 1983 the levels of cleanliness in hospitals has declined. Cardiff University research<sup>4</sup> has cited a range of evidence to support this, and the decline in standards has been accepted by clinicians, academic researchers and the Department of Health.

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<sup>3</sup> BBC, 2008 – see <http://news.bbc.co.uk/1/hi/health/7372992.stm>

<sup>4</sup> Steve Davies, Cardiff University, 'Making the Connection: Contract Cleaning and Infection Control', (2009) and 'Hospital Contract Cleaning and Infection Control', (2005).

3.6 There have also been significant recruitment, retention and sickness absence problems and high staff turnover with contracted out cleaning services. All of these will be contributory factors in lower standards of cleanliness and create barriers to cleaning staff being part of the wider health team. The government's mass privatisation programme will replicate these serious problems across what was the NHS and across the future delivery of health services.

### Accountability

3.7. Throughout the White Paper there are frequent references to accountability. Simply publishing information does not hold an organisation accountable. Unite believe the proposals will erode democratic accountability and structures through which local people can change the direction of local health policy and action, the services that are delivered, by whom and how they are delivered.

3.8. The 'choice' that is contained within the proposals is not needs based or patient based – it is a narrowly defined, market based choice. The actual choice about who to commission – and therefore the determination of what is available in a local area – lies with the GP Commissioners. Unite does not believe that there will be meaningful democratic oversight of this power as discussed in our response to the proposals outlined in 'Equity and Excellence: Democratic Legitimacy'.

## **4. Improving health outcomes?**

4.1. The mechanisms for improving performance and enhancing quality in the White Paper are solely about the monitoring, enforcement and payments of contracts with health service providers. Combined with a 'light touch' regulation this is a recipe for disaster that will lead to tragic results. The Mid-Staffordshire Inquiry Report is instructive in what can happen when an organisation becomes focused on financial rather than clinical outcomes. Yet focus on financial and business outcomes is at the heart of the system the government is proposing to establish and reinforce across what is currently the NHS.

4.2. Unite does not believe the Government's proposals for the future of healthcare will drive up quality standards in health services. On the contrary, as the proposed system is one of privatisation, and services becoming businesses competing in a market environment, there will be a decline in quality. As well as considering the impact of privatisation on cleaning services we can also look at the impact on social care. The Commission for Social Care Inspection reported in 2005 that in providing care for older people in care homes, and home care services, private sector providers were more likely not to meet minimum national standards. Further, it also reported that a consequence of competition amongst private

sector care providers is that to lower costs there are examples of staff not being paid for the time and expenses involved in travelling between care visits<sup>5</sup>.

4.3. As well as leading to cost-cutting - including a reduction in staff and an increase in the workload of remaining staff - a 'health system' comprised of contracted, competing businesses will lead to an incentive to 'cherry pick' or 'cream skimming' the most 'profitable' patients (i.e. those who are simplest and cheapest to treat), pushing the more complex cases (and therefore more expensive to treat) to the back of the queue.

4.4. In respect of the NHS Outcomes Framework the phrase that is missing is "national minimum standards" that people should expect. There is no detail on what will happen if a contracted provider does not achieve a 'goal' – (assuming that the goal is incorporated into a contract as a standard to be reached rather than an aspiration) – the logic of the market/contract system is that the provider in question is not paid. This will make local health services worse for the local community and is another example of why health is a public good that should be delivered collectively, not a privatised commodity.

4.5. As the contractor relationship that the White Paper wishes to roll out across health services is a funding model based on activity carried out, there is a serious concern that there will be no funding to assess and address unmet need.

4.6. The emphasis on generating business revenue will lead organisations to assess how they can raise funds and improve profitability. Moves such as removing the private income cap for Foundation Trusts will allow organisations to prioritise attracting and treating fee paying patients. We are witnessing the opening of the door to a two, or multi-tiered service, which will increase inequality. The business market the Government proposes is based on short term profit and volume of activity - it does not incentivise or reward public health programmes whose benefits are not financially rewarding in the short term, and is not concerned with assessing or funding unmet need in a local community.

## **5. Autonomy, accountability and democratic legitimacy?**

### NHS Commissioning Board

5.1. The creation of an NHS Commissioning Board epitomises how the NHS as we currently understand it will end, to be replaced by a series of complex contracts to be monitoring, enforced and wrangled over. But the creation of the NHS Commissioning Board is also a 'contracting out' of the responsibility of the NHS by the Government; it is an attempt by the Government to be at 'arms length' distance when the quality and range of health services decreases because of the implementation of their proposals.

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<sup>5</sup> Former Commission for Social Care Inspection, 'Time to Care, 2006  
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### GP Commissioning

5.2. Groups of GPs will be handed £70-£80billion to contract healthcare services for their patients from “any willing provider” - in other words from the private or ‘third’ sector. This contracting function is itself likely to be contracted out to a private management or health company such as McKinsey, Bupa and others. The business development director at the private multi-national health company Tribal has said that the government plans “could lead to the denationalisation of healthcare services in England”.

5.3. Further, the actual power when it comes to deciding what services are needed, and who should deliver, resides with the GP Consortia, not the Health and Wellbeing Boards the government is proposing. This means that there is no effective accountability structure or democratic oversight of this decision making power, which as Tribal have helpfully pointed out, the accumulative impact of which will be the privatisation of the NHS.

### Foundation Trusts

5.4. Despite the rhetoric on choice it is notable that every organisation will have to become a Foundation Trust, and no organisation can remain as an NHS Trust, even if this is what the local community wants. The problems with the proposals surrounding Foundation Trusts in particular are summarised below.

- ‘Freeing Foundation Trusts from constraints’: this is part of the drive to the bottom through the removal of minimum standards, and also paves the way for Foundation Trusts to become social enterprises – this is a form of privatisation in contradiction to the White Paper saying that “Foundation Trusts will not be privatised”.
- As mentioned above, the cap on private income exists to ensure that a hospital, clinic or service cannot be turned over mostly or wholly to fee-paying patients and users. The abolition of the cap opens the door to a two, or multi-tiered service, where people can be paid to be prioritised to receive quicker treatment, or receive a better standard of treatment which should be standard for all.

5.5. As part of the government’s commitment to removing ‘unnecessary barriers’ to new providers it also states its belief that “in future all individual employers will have the right, as Foundation Trusts have now, to determine pay for their own staff”. It needs to be noted that despite lobbying on their behalf, Foundation Trusts do not have this right. AfC is the minimum for staff in the NHS, and allows FTs some narrow scope for variation, but within limits set out by the AfC agreement. This section is a clear attack on national, collective bargaining for staff and is a clear indication of what was highlighted above – efficiencies and cost savings are often found at the expense of staff pay, terms and conditions. The

removal of national collective bargaining will be sought in order to drive down costs and maximise the profits of companies winning contracts to deliver services.

#### Monitor and competition law

5.6. The establishment of a regulator specifically to ensure that organisations are fiercely competing with each other and that competition law will be applied is the clearest illustration that what the government is proposing is the total destruction of the collective provision of a public good – universal, public healthcare, free for all before and after treatment.

#### Collective bargaining and fair pay

5.7. The government has set out its policy in the Budget and the White Paper that staff are to face a pay freeze – a pay cut in real terms – over the next few years. The Government's imposition of a pay cut on NHS and other public sector workers is based on myths about the state of pay in the private sector and is not based on any rationale of improving public services. This policy is not just the continuation of a pay policy that sought to hold down pay, which NHS workers have been subject to over the past few years, but it is a policy that seeks to tighten the screw on NHS workers and cause a further two years of falling living standards.

5.8. Just some of the impacts of such an action will be high staff turnover, recruitment and retention problems as in the early 1990s and higher stress and workloads for employed staff. All of these will lead to lower quality of services, and through lower staff numbers, fewer health services in total.

5.9. The announcement of the Government's implementation of a pay cut for NHS and other public sector workers rode roughshod over the collective bargaining arrangements in the NHS and other parts of the public sector.

### **6. Cutting bureaucracy and enhancing efficiency?**

6.1. The privatised and marketised health system that is being established will have to create a massive and expensive layer of bureaucracy. Privatised healthcare tends to cost more - the break up of NHS services into lots of different private sector competitors operating in a market is a huge financial drain. This competitive market needs to be 'managed' and has a large number of transaction costs, such as legal fees in drawing up and monitoring contracts, invoicing and billing for services, advertising for patients and service users and money spent on trying to win contracts. Professor Alyson Pollock has estimated that the marketised healthcare system may cost up to £20billion a year – this is wasted money that should be spent on patient care. PFI currently costs 8.3% of a hospital's budget, compared to 5.8%

for conventionally-built hospitals. Privately run GP centres cost 7 times more per patient than standard NHS centres<sup>6</sup>.

6.2. The government has promised to increase NHS funding in real terms in England over the coming few years, though the yearly increases will be less than in recent years. But the reality is that NHS services and staff are going to be tightly squeezed over the next few years. The NHS has been charged with finding £20billion 'efficiency savings' from now until 2014/15. At a local level we are already seeing job losses and the deletion of staff posts.

6.3. The White Paper claims that management costs will be reduced by 45% between now and 2014/15. Yet we know that 'GP commissioning' model creates the need for a plethora of people simply to negotiate and manage contracts. Unite has many members who have a 'clinical management' or 'clinical leadership' role - these roles are falling victim to the driving down of management costs. Unite are also concerned that administrative, ICT and other support staff without whom healthcare services could not function are being unfairly targeted for cuts – **all staff are 'frontline staff'**.

## 7. Conclusion

7.1. Unite believes that the proposals in the White Paper, 'Equity and Excellence', represent a shift in gear to the privatisation so far seen in the NHS. The impact of these proposals will be far reaching – the speed at which they are being introduced and implemented, without any democratic mandate from a public that has not been properly and genuinely consulted with.

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<sup>6</sup> Research from the NHS Support Federation, <http://nhscampaign.org/>

**Monday, 04 October 2010**

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