Eastern UNISON eye

UNISON Eastern Region Health Committee ● Autumn2016 For UNISON members only

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UNDERFUNDED NOT OVERSPENT!

It's common knowledge that the NHS is being starved of the funds it needs to meet the growing needs of a rising population. Even Tory MPs are pointing to the rising pressure on services.

NHS Providers, which represents trusts and foundation trusts, has been publicly banging the drum on this for weeks.

Its chief executive, Chris Hopson has spelt out a grim series of options in the likely event that no further funding is forthcoming from Theresa May's government. He warns:

"No trust board wants to depart from the key principle of NHS care being available to all based on clinical need not ability to pay. But, faced with this clear, national level gap, the logical areas to examine would be:

● reducing the number of strategic priorities the NHS is currently trying to deliver [such as seven-day services]

● formally rationing access to care in a more extensive way

● relaxing performance targets

● closing or reconfiguring services

● extending co-payments or charges

● or reducing or more explicitly controlling the size of the NHS workforce which accounts for around 70% of the average trusts budget."

In other words 'Hopson's choice' is effectively whether to abandon NHS principles … or cut the NHS to vanishing point. It's a choice between being hung or garrotted.

No choice

But without extra funding there is no choice: many of the cutbacks outlined by Hopson can already be seen taking shape in Eastern Region, where so many trusts face massive deficits, CQC warnings, 'special measures' – and even a "success regime" that is lashing together Basildon, Southend and Mid-Essex hospitals.

Endangered species? Cash-cutting plans often mean axing A&E units

NHS spending is being deliberately reduced as a share of national wealth year by year, reversing the ten years of increases from 2000.

● CCGs in Essex have been at the forefront of moves to ration access to IVF and other services.

● CCGs across the country have been discussing plans to "reconfigure" and centralise health services, which could result in tens of thousands of patients facing longer journeys and delays in accessing the care they need.

● NHS Improvement, the regulator, has announced new limits on the staffing levels in struggling trusts, discarding all of the warnings, guidelines and evidence from the Mid Staffordshire nightmare and the Francis Report.

All this is driven by the austerity regime unleashed on the NHS and public services by George Osborne and the coalition government in 2010, and continued by the Tory government in 2015.

We were told austerity was needed to tackle the deficit after the banking crisis: but the deficit increased. In fact the cuts in local government and the freeze on NHS spending are part of the ideological Tory drive to cut public spending and reduce or privatise the remaining public services.

Used as an excuse

Deficits and "overspending" in the NHS are now being used as an excuse to scale down services: but these problems have been created by the deliberate policy of barely increasing NHS funding above inflation for six years, while cost pressures increase by up to 4% per year.

Our mental health, community and hospital services are not overspent: they have been consciously underfunded. NHS spending is being reduced as a share of national wealth year by year, reversing the ten years of increases from 2000, leaving Britain one of the lowest spending countries in Europe.

UNISON supports the TUC campaign for an immediate and urgent funding boost as part of the government's plans to re-set their spending plans.

Ministers must lift the pressure to make unrealistic efficiency savings which are causing problems for patients and cuts to services.

We need a long-term settlement for the NHS, a commitment to public funding that will help the NHS plan properly and create a sustainable health and social care system for the future, and allow it to invest in the staff who are the heart of the NHS, with fair pay, improved training, and safe staffing ratios.

October 21: lobby MPs against axing bursaries

The government's plans to scrap NHS bursaries in England will leave student nurses, midwives and allied health professionals with more than £52,000 worth of debt.

The fear of debt will discourage many people from becoming health-care professionals, exacerbating the current recruitment crisis.

This will have disastrous repercussions for patient safety. There have been some signs that the Conservative government has misgivings about the policy, but is still planning to go ahead with it, at the moment.

This means it is a good time to put pressure on MPs.

If you agree this policy doesn't make any sense, get behind the campaign and tell your MP what you think by joining the national NHS bursary constituency lobby day on Friday 21 October.

This is the best opportunity we have to change the minds of unsympathetic or unaware MPs, and ensure friendly ones continue to actively oppose the scrapping of NHS bursaries.

Please make sure you read the Everything you need to know about lobbying guide for more information, especially the section called 'talking to your MP' before you get to the meeting.

This is your chance to show your MP that scrapping NHS bursaries will have a really detrimental impact on every-one who lives in their constituency.

■ Key facts to help persuade or challenge Conservative MPs: see page 2

Not yet a member of UNISON? JOIN NOW – back page

The big squeeze on NHS funding

Almost all NHS trusts and a few local Clinical Commissioning Groups (the local bodies holding the budgets for most health care) are facing enormous deficits.

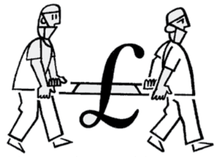
But the Department of Health budget, and even many local health economies are in balance – because of reserves held back by CCGs, and billions more held in reserve by the Department of Health, much of which each year since 2010 has been ***paid back*** to the Treasury, even while local services face cuts.

There is no real reason why the Tory government could not simply decide to spend more money on the NHS, rather than pursue the current brutal austerity regime, imposing a 10-year real terms freeze on budgets while costs increase.

Osborne's aim was to reverse the dramatic increases in spending each year from 2000-2010, when Labour decided to increased NHS spending as a percentage of national wealth (GDP).

NHS spending has already been reduced from a high of well over 8% to 7% of GDP and is heading back to the dismal days of the 1980s and 1990s, in which spending of just 6.5% of GDP brought us massive waiting lists and inadequate services 20 years ago.

This spending crunch is not the result of global forces but of domestic political decisions by British governments to cut back public spending – and of course at the same time maximise the opportunities for private hospitals and clinics to hoover up more paying customers frustrated by the queues.



UK spending on health is now the lowest of any comparable European country

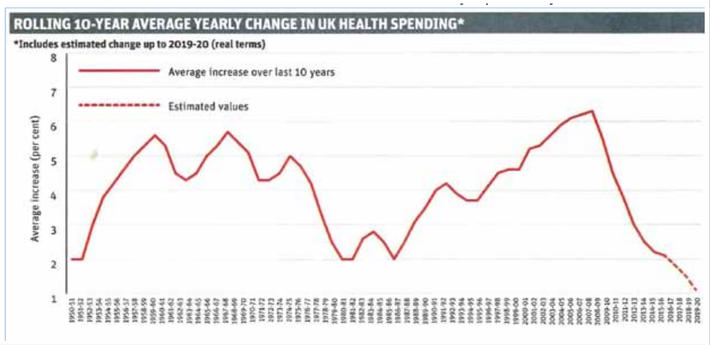
The squeeze is also designed to open up debates on alternative ways to fund the NHS or even move towards a form of insurance system – like the USA.

Netherlands - health spend per head (£) 4,060

Germany - health spend per head (£) 4,003

France - health spend per head (£) 3,356

UK- health spend per head (£) 3,052



HCAs - nurses on the cheap

Healthcare assistants (HCAs) working in the NHS are doing the jobs of nurses without the equivalent pay or education, according to a report from UNISON.

Two in five (39%) say they have not received the training necessary to provide the care expected of them such as looking after dementia patients, according to the report 'Care on the Cheap'.

Less than half (45%) of HCAs feel the tasks they are asked to do – including giving patients medication, doing heart checks and inserting medical tubes – are appropriate to their level of competence.

The findings are based on a survey of nearly 2,300 HCAs across the UK working in primary and secondary care including GP practices, emergency departments and in the community.

The report highlights how HCAs are being treated as 'glorified skivvies' and often left unsupervised to plug gaps in NHS care because of nursing shortages, according to UNISON. Yet more than two thirds (68%) say they are not given sufficient access to training and development.

Failure to allow HCAs to reach their full potential is letting down not only staff but the patients they care for, says UNISON. Instead of investing in the whole HCA workforce, the government has chosen to focus on creating a new 'nursing associate' role, a move that UNISON does not believe will solve the NHS staffing crisis.

UNISON is calling on the government to review the HCA role, including a rethink over pay and career progression, and the introduction of national standards defining exactly what their responsibilities should cover.

UNISON deputy head of health Sara Gorton said: "Healthcare assistants are undervalued, increasingly overworked and not getting the support they need at work.

"Their responsibilities have increased massively– from feeding patients to now carrying out skilled medical procedures. They are essentially doing jobs previously done by nurses yet this is neither reflected in their pay nor in their career opportunities, so they're struggling to make ends meet.

"Many could earn more stacking supermarket shelves than they can looking after patients. It's nursing on the cheap and patients ultimately suffer as a result."

Key reasons to oppose scrapping NHS bursaries

(from front page)

Students and graduates will be worse off

While students may receive more funding during their studies, students and graduates will be financially worse off in the longer term because their total debt will have increased significantly making it harder for them to meet the ever growing cost of living.

London Economics say a representative student undertaking a full-time degree in nursing professions will see their total debt (comprising maintenance and tuition fee loans) increase from approximately £6,930 to approximately £48,788 on graduation.

While a newly qualified nurse may only repay £90 in the first year, this figure will increase as they go up the Agenda for Change pay points.

The scrapping of NHS bursaries will equate to a pay cut of over £900 per annum (or 3%) for a nurse on a mean average salary (£31,080).

Fewer healthcare professionals, not more

Far from encouraging 10,000 additional training places by 2020, cutting NHS bursaries will discourage many people because of the fear of debt.

According to London Economics, the 71% increased costs that students and graduates will bear will in all likelihood reduce education participation by 6-7% - equivalent to more than 2,000 students in the first year.

The House of Commons Committee of Public Accounts said in its report Managing the supply of NHS clinical staff in England that 'the changes could have a negative impact on both the overall number of applicants and on certain groups, such as mature students or those with children'.

Lost income and no savings

The government's proposal states that it will ensure sustainable funding for universities. However London Economics found that higher education institutes will be worse off by approximately £57-£77 million per cohort.

Contrary to the government's claims, there will be no cost savings to the Exchequer because most nurses will not earn enough to repay the entire loan and the decline in numbers entering nursing will increase Agency staffing costs.

London Economics say the cost savings to the Exchequer are more likely to be approximately £88m per cohort than the £534m stated by the government: but they also estimated that there will be an additional £100m cost incurred by Trusts per cohort – wiping out any potential cost savings.

Tory voters say NO!

A YouGov poll of 1,656 adults, undertaken between 13 and 14 June 2016, found that there was very little public support for removing NHS bursaries and replacing them with tuition fees and loans.

More than three-quarters (77%) of voters who took part in the YouGov survey believe the government must carry on paying the tuition fees of student nurses and others studying to become NHS health professionals.

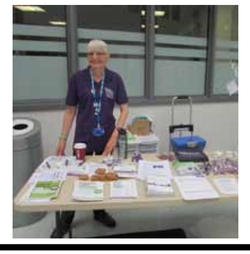
72% of survey respondents who voted Conservative in last year's general election are of the same opinion.

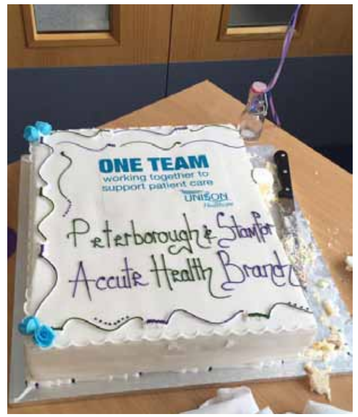
One NHS, One Team!

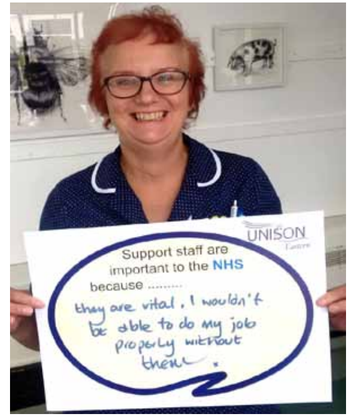
UNISON health branches across the UK celebrated NHS support staff by holding 'One Team for Patient Care' themed parties during the NHS birthday week in July.

It was all to celebrate the valuable contribution that NHS support staff make every day – and to challenge efforts to divide the work-force into "front-line" and "back-office, demeaning the role that over 500,000 non-clinical staff play in making services tick.

Events in our region included Peterborough and Colchester.







Carter Review targets "back office staff"

The Review into efficiency in the English NHS by Labour peer Lord Carter of Coles claims savings of as much as £5 billion a year could be made from procurement by 2020. But many of these 'savings' would affect UNISON members' jobs.

The review was published by the government in February, and UNISON was quick to challenge a number of its "potentially alarming" recommendations, which include the outsourcing of pathology, pharmacy and support services to achieve cuts.

Research

Since then, the union has been working with researchers to investigate the likely impact on staff, particularly those working in trusts' corporate and administrative functions.

"Key management figures in the NHS and in English hospitals value the work of administrative staff in relieving clinical staff of administrative tasks and in making hospitals more efficient," says UNISON head of health Christina McAnea.

This "chimes very strongly" with UNISON's One team for patient care campaign.

"Without these staff the NHS would grind to a halt, with nurses and others having to spend more of their time filling in forms or tidying wards than directly with patients," she added.

UNISON's researchers particularly wish to draw attention to the past problems of privatisation in the NHS, which has consistently failed to produce either quality outcomes or cost savings.

"Major opportunities exist for UNISON to influence the way the Carter recommendations are carried out," said Ms McAnea.

"The union will continue to stand up for our members working in pathology, pharmacy and support services, who could be most affected by Carter."

Our convenor wins TUC award

Darren Barber, branch secretary at the Queen Elizabeth Hospital in King's Lynn, Norfolk and regional convenor for UNISON Eastern, was honoured with the TUC organising award.

When he started at the hospital, union membership was at an all-time low. But now, membership has grown from 365 to 810 and the number of active UNISON stewards from two to 14.

Nominating him for the award, UNISON noted said his work means the union "is now an active and dynamic force within the hospital, providing a wide range of organising support and opportunities for members and staff."

He is particularly proud of the work he did with the trust to get it out of special measures, benefitting both health workers and patients.

"One of the biggest reasons, more than anything, why everyone should be in a union – it doesn't matter what workplace you're in" he adds, "if we're one voice we can get rid of austerity."

A proud Darren Barber at the TUC with (L to R) Deputy Regional Convenor Becky Tie, Regional Head of Health Tracey Lambert, and Regional Secretary Glyn Hawker.

STPs: Good idea, or top-down NHS reorganisation?

Since January England's NHS has been carved up into 44 "footprint" areas, in which commissioners and providers are supposed to collaborate together.

That might appear to be good news, if the complex, costly and divisive competitive market system entrenched by Andrew Lansley's Health & Social Care Act was being swept away, and a new, re-integrated NHS was empowered to work together again to improve services.

But that's very much NOT the case: instead the main task of the "footprint" areas is to balance the books of each "local health economy" – taking drastic steps where necessary to wipe out £2.7 billion of deficits built up by trusts last year.

Each area has to draw up a 5-year Sustainability & Transformation Plan (STP), to be vetted by NHS England.

And while they do so, all of the legislation compelling local CCGs to open up services to "any qualified provider" or put them out to tender remains in full force. The private sector is still snapping up contracts.

The legislation is being ignored, in what amounts to a coup launched led by NHS England chief executive Simon Stevens.

Stevens is the man who urged Tony Blair's government to experiment

"Give it to us straight. How long have we got?"

with private sector providers for the NHS, and then spent nine years at the top of US health insurance giant UnitedHealth.

Sweeping powers

The 44 leaders appointed by Stevens to lead planning in the "footprint" areas are to be encouraged to overcome the "veto powers" of individual organisations to stand in the way of controversial changes.

In many areas STPs are likely to be used a a means to force decisions on the disposition of hospital services, with some services downgraded, downsized or closed despite local opposition..

Only 7 of the 44 Draft STPs have so far been published, and the remainder along with the approved final version will not be made public until the autumn, with some dragging on to the new year.

But we know enough to predict that many A&E departments and hospitals will be closed or downgraded, while Hospital capacity will be significantly reduced in return for empty promises of investment in "care in the community".

Such promises are largely worthless, since the STPs are seeking to reduce spending, and Simon Stevens has admitted there is little or no capital for any new facilities.

The objective capping of budgets and eradication of deficits will lead to more attempts to restrict local access to healthcare, cut capacity, ration treatment and reduce staff.

'Mad' process

Concern is growing over the way all this is being done. Julia Simon until recently the head of NHS England's commissioning policy unit and its co-commissioning of primary care programme director, has warned that forcing health and care organisations to come together so quickly to draw up the complex plans was likely to backfire: the way it had been done was "mad".

Up against tight deadlines, organisations were likely to make unrealistic financial forecasts and claims about benefits to patient care, she warned.

Speaking to GPonline at a London healthcare conference, Ms Simon said "Everyone will submit a plan, because they have to.

"But it means there is a lot of blue sky thinking and then you have a lot of lies in the system about the financial position, benefits that will be delivered - it's just a construct, not a reality."

She also warned that hastily drawn-up plans would lead to financial problems: "Ultimately it means bankruptcy in some areas."

"I haven't seen any genuine patient and public engagement yet. It's mad." She argued that the speed at which STPs were being asked to draw up plans was "actually shameful, the way we have done it."

GPonline also reports NHS Clinical Commissioners co-chair Graham Jackson stating that the timeframe and secrecy around STPs had been ridiculous.

STPs face the prospect of stiff resistance to cuts. A packed recent public meeting in Ely is just part of the growing anger at plans that could end some outpatient services and close Minor Injuries Units in Cambridgeshire's remote Fenland area.

Where's the evidence these ideas will work?

The same set of arguments ("case for change") in the NHS have been well rehearsed in proposals up and down the country. Time and again in SW London we have also been told:

- The threat of huge deficits caused by rapidly increasing demands on the NHS, and budgets not keeping up, is real and growing.
- Prevention is better than cure
- Better social care would reduce the demand for acute care
- Acute care can be further rationalised and concentrated to improve quality and efficiency
- There is no time and no point in delaying essential decisions needed to do something
- Anyone that doesn't agree is a luddite, out of step with modernity and reality
- All doctors agree.

The public are fed these arguments consistently, and even opposition figures have been muted when faced with the power and the weight of propaganda mustered in support.

Footprint	Population (million)	No of CCGs	Projected gap to address
Cambridgeshire & Peterborough	0.9	1	£250m
Norfolk and Waveney	1	5	£234m
Suffolk and North East Essex	0.9	3	£422m
Bedfordshire, Luton and Milton Keynes	0.9	3	Not released
Hertfordshire and West Essex	1.4	3	£234m
Mid and South Essex	1.2	5	£216m (to 2018/19)
Totals	**6.3**	**20**	**£1.356 bn**

But once you look at the arguments and practical implications in detail it all starts to unravel.

- The UK and England in particular, spends significantly LESS on both health care and on social care than comparable countries. It is a myth that modest increases in the NHS budget are unaffordable. Budgets need to increase in line with demographic pressures.
- Public health budgets have been cut. But in any case any immediate spending on increased prevention will take years to bear fruit, and efforts would be better directed at improved school dinners, imposing sugar taxes and tackling slum living conditions.
- The argument that spending more on social care will prevent acute episodes has proven to be unproven in the UK context. It is based on some limited success in America – where they spend 140% more on health care but 50% less on social care. In Europe, where more is spent on both social care and health care, there are more doctors, more beds and more interventions than the UK.
- In fact the UK already has the most concentrated acute sector in the world, which has been acknowledged by the Nuffield Trust: and England has the greatest concentration of all.

Further rationalisation is extremely difficult without cutting services.

- The NHS is complex and UK geography varied. There are no simple blueprints of reform that can be unfurled. History and geography cannot be rewritten.
- Plans need to be studied in detail, in advance and full support provided from stakeholders before decisions are made. The rulings of the Independent Reconfiguration Panel are a partial but revealing testament to the revisions and reversals that are more often necessary than not.
- Huge reconfiguration proposals in SW London and NW London have had to be held up because plans are so weak; costing more than the benefits promised and based on entirely unjustifiable confidence that capacity can be reduced before there is proof demand can be reduced by 'out of hospital' care.
- What has become clear is that there are conflicts of interest and vested interests that are attempting to bounce Parliament, local authorities and health organisations into prior agreement to plans that have not even yet been made public.
- All doctors do NOT agree: most doctors have never been asked, and many GPs, on whom plans depend, are already over-worked and leaving. The UK suffers already from blockages caused by not having enough doctors, health care, or diagnostic capacity.
- The march of technology may well enable more and more safe care to be provided in localities – but it doesn't all point towards concentration of hospital care into a handful of massive centres with little local access.

Can you speak E**STP**eranto?

The language of STP-land

Here's a handy phrasebook for UNISON activists

A

Accountable: (adjective) reporting to an unrepresentative quango

Accountable Care Organisation (compound noun)**:** Body that is not accountable to patients and doesn't care. Cash limited. 'Gateway' policy, bringing dangers of decline into top-up payments and private insurance.

B

Better (…): (adjective) Private sector involved

C

Care Quality Commission: (noun) a fig-leaf to conceal falling standards or use as a scapegoat when problems go public

Centralise (verb): Close local services – prelude to for long journeys and queues

Clinical Commissioning Group (CCG): (noun) device to make GPs carry the can for unpopular decisions drawn up by private sector

Clinically-led (adjective): [Accountants' plan] fronted up by a few stooge medics

Clinical Senate: (noun) toothless, pointless body invented to placate marginalised hospital consultants

Clinician: (noun) one of the handful of doctors and nurses who agree with proposals

Compelling (adjective): Claim for evidence that won't be revealed

Cost envelope: the white or manila scrap paper on which financial projections are worked out in wine bars by management consultants

D

Demand management (compound noun): Mechanism for denying people treatment

Downgrade (verb): Begin closure by instalments

E

Engagement: bullying or bribing local councils into signing up for STPs

Evidence shows: (baseless assertion) I'm making this shit up

F

Footprint: "Local" area of up to 2.5 million people to be carved up by STPs

I

Independent : (adjective) (1) private sector (2) body stuffed with my supporters Innovative: (adjective) private sector

Integrated: (adjective) fragmented orgabisations linked by contracts

L

Local (adjective): (a) within a radius of 60 miles (b) any size, no matter how big, but not national

Local health system (compound noun): random, dysfunctional geographical collection of largely bankrupt organisations

Local Hospital (noun): Medium sized clinic on remnant of the site of a general hospital

P

Personal health budget: (noun) device to sack skilled care coordination staff and dump responsibility back onto patients to fend for themselves in a failing market

Ploughed back into patient care: (misleading phrase) ploughed into private sector

Private Finance Initiative (PFI): (noun) issue that allows Tories to blame Labour for their implementation of the Tory policy while they carry on signing new PFI deals

Public health (noun): (a) Device for blaming public for their ill-health and NHS under-funding (b) useful abstract topic to pad out opening pages of NHS consultation documents (c) vanishing and neglected specialist skill

R

Reconfiguration (noun): dismemberment, cuts: - see 'Centralising'

Referral management: (noun) replaces patient choice with bureaucrats' (or private sector) choice

Responsive: (adjective) private sector

Robust: (adjective) private sector

S

Seamless: (adjective) fragmented, chaotic, disappearing

Social care (noun): You're on your own: phrase for chaotic privatised remnants of historic social provision of care.

Success regime (noun): Boot camp to bully bosses of failing organisations. Income stream for management consultants and lawyers

STP: Plan to Slash Trash and Plunder local services in pursuit of cash savings

Sustainable: (adjective) (1) much cheaper (2) private sector

V

Viable: (adjective) private sector

Vibrant: (adjective) private sector

The cash limit was too tight for lead provider contract in Cambridgeshire & Peterborough: now there's even less cash in the pot

Mummy, what's an ACO?

Many STPs will plan to establish Accountable Care Organisations (or Partnerships), the new magic incantation from Simon Stevens Five Year Forward View that is seen as the way to go.

ACOs are an American model, in which a (public or potentially private) provider accepts a contract paying a fixed amount per head of a given population to provide an agreed package of services. If they can do so inside the budget they can make a profit: but they take the risk that if the money runs out, they will carry the excess costs.

These schemes have been losing a packet in the US because a number of them have taken on delivering the low grade 'bronze' subsidised insurance plans to people on low incomes; and these people tend to get sick, and run up costs of treatment – which is not what the insurance companies want or expect. Many have gone bust.

How could all this apply to England?

The nearest equivalent we have seen so far was the Cambridgeshire CCTG plan for a single £150m a year contract for Older People's and Community Services. It was very controversial. They put it out to tender: but a number of the key private bidders withdrew as the contracting process went on, arguing that there was not enough money in it.

The contract eventually went to two local foundation trusts: and within 8 months the contract collapsed – because there was not enough money in it.

In Staffordshire attempts to develop a cancer care contract have also struggled because most private bidders pulled out, and once the contract had been allocated even the local NHS trust pulled out … because there's not enough money on the table to sustain services.

These schemes don't save money – especially if they are to draw in the private sector.

They are just a new type of cash limit. So if there's not enough cash in the pot, there won't be a sustainable service. Nor will ACOs be accountable in any real sense to the communities they are supposed to serve.

Hunt's flagship American hospital fails safety tests

A US hospital proclaimed by Jeremy Hunt (right) as 'perhaps the safest hospital in the world', and which has been paid a hefty £12.5 million for a 5-year contract to help improve patient safety in England has just failed a safety inspection.

A *Daily Mirror* report picked up the findings of the Joint Commission that monitors safety in US hospitals, which in May issued a "preliminary denial of accreditation" to the lavishly funded hospital, whose chief executive earns a monster $3.5 million per year, compared with the much more modest reward for even top NHS managers.

Virginia Mason hospital was found wanting on no less than 29 separate counts. Since resources are clearly not the problem, it seems more than likely that the deeply flawed US system and the perverse incentives created by the culture of commercial medicine are to blame.

It's astonishing that Jeremy Hunt should have thought the lavishly-funded (and now evidently not very good) Virginia Mason could be in any way compared with the NHS in the midst of a decade-long funding squeeze from George Osborne. He has obviously not looked at it in any detail.

On 2014 figures, Virginia Mason with just 336 beds and revenue of $1 billion, has fewer beds, one fifth the number of patients, but almost double the staff and more than three times the funding of the struggling Princess Alexandra Hospital.

Only Cambridge University Hospitals FT, one of the largest trusts in the country, has a bigger budget than Virginia Mason, but that has to stretch to cover 50% more staff, almost three times more beds, more than five times the number of admissions and three times more emergency attendances than the US hospital that is supposed to be showing NHS managers the way forward.

Norfolk & Norwich Hospital has a smaller budget but three times more beds and more than ten times more admissions than Virginia Mason, with five times more emergency attendances.

And Peterborough's PFI-burdened hospital has less than half the budget, but twice as many beds and far more A&E cases and admissions to deal with.

There's no doubt any NHS manager desperately struggling against the odds to deal with soaring deficits and rising caseload would give their right arm for the resources lavished on this clearly less efficient and less successful US hospital.

How they compare: resources and workload at Virginia Mason compared with some eastern Region hospitals

	Virginia Mason	Norfolk& Norwich	Cambridge University Hospitals	Peterborough & Stamford Hospitals	Princess Alexandra, Harlow
Revenue (£m)	650	441	708	248	190
Staff	5,500	7,000	8,395	4,000	2,881
Beds	336	967	893	623	428
Admissions	15,436	179,000	133,000	86,000	72,000
ER/A&E visits	23,000	112,000	106,000	75,000	101,000
Outpatients/ physician visits	853,000	738,000	727,000	469,000	284,000

Luton fight to protect agreements

Staff at Luton and Dunstable Hospital Trust rallied outside their workplace against proposed changes to their sick leave policy.

The trust uses the "Bradford Factor Calculator" formula to gives staff a score by looking at the frequency and length of absences.

And while the trust has one of the best sick leave records in the region, employers want to cut the number of times workers can be off sick before they are brought into a sickness capability meeting.

UNISON says staff at the hospital are "coming to work sick or taking painkillers to avoid hitting this trigger and being brought into a formal process that can lead to dismissal,"

Regional organiser Shane Hall says the union is "always happy to work with the trust to look at constructive ways that it can support genuinely ill members of staff back to work.

"But fast-tracking people through a formal process that can lead to dismissal only places undue stress and anxiety upon already ill and vulnerable members of staff.

"Does the public really want to enter a hospital where staff are coming to work ill to avoid triggering a meeting that could lead to their dismissal?"

North Essex STP link with Suffolk

The linking up of North East Essex with Suffolk in a common STP footprint seems designed primarily to drive the takeover of the troubled Colchester Hospital University Foundation Trust by Ipswich Hospital, a lowly NHS trust.

The complications of a full merger mean that this is being avoided, but as yet there seem to be no firm plans – or certainly none that are being shared with the trade unions.

There is equally little communication from local trusts or the CCGs on the wider Sustainability and Transformation Plan, although they have let slip that the target is savings of £422m by 2020 – a major challenge.

Clearly some of those in charge of NHS England and the CCGs believe that the best way to achieve such ambitious savings is by minimal transparency – keeping all of the proposals secret until they are revealed at the end of this month as a fait accompli.

West Essex hived off to Herts

There have been fears over the future of Princess Alexandra Hospital in Harlow, struggling with heavy debts, a critical CQC report, and inadequate capacity.

These fears have not been eased by its incorporation into an STP footprint based in Hertfordshire rather than the "success regime" of its Essex neighbours. The trust's website has been out of action for a prolonged period

Princess Alexandra was the first trust to declare that it would close beds it could not staff properly rather than run up inflated costs for agency staff.

Could even more be closed as the STP seeks savings of £234m by 2020?

Little sign of success in Essex quest for cash savings

Despite grand promises of concerted action, we are still waiting to see any results from the "success regime" introduced to tackle the chronic deficits of trusts in Mid Essex, Basildon & Thurrock and Southend, now an STP footprint.

One of the more obvious results so far is senior managers dividing their time between more than one trust, and more and more meetings – with no clear benefit.

NHS England's Essex area director Andrew Pike rolled out little more than the usual bland waffle when he gave an update to the local press back in March:

"If we can get hospitals to go on with their efficiency programmes, and if we can reduce the amount of people going to hospital, you are releasing money to invest in primary care because hospitals are paid for each person going to hospital."

Of course all this would be fine if it worked. The question is HOW?

A new HR Transformation Manager for the success regime has been appointed, no doubt tasked with tackling one of the six priority areas singled out as objectives – developing a "flexible workforce that can work across organisations and geographical boundaries."

Again the question is how.

Questions over recruitment and retention of staff, resources and terms and conditions also spring to mind, along with the fact that in the absence of a merger of the three trusts such objectives can be complicated to achieve.

It's clear to UNISON that without proper engagement with staff and the health unions the success regime will wind up talking to themselves with little effect.

The regime is cagey about any engagement with the unions. A copy of the letter sent by the regulator NHS Improvement to STP leads was only released to the unions six weeks later.

Clare Panniker, chief executive of Basildon & Thurrock Foundation Trust has attempted to play down the ambitions of the success regime, limiting it to three initial objectives – some clinical reconfiguration to concentrate some specialist services onto fewer sites; greater integration of corporate services across the three trusts, and consolidation of clinical support services.

There seems to be little appreciation of the likely less than enthusiastic reaction to any of these proposals from staff and the local public whose services are affected.

Consultation

A consultation on changes was supposed to be taking place at the end of this year, but the regime is nowhere near ready for this.

They are holding a series of "pre-public meetings" telling people who turn up the reasons for what they might do, without saying what it they have planned.

Given the aim of saving money and the lack of capital for any new developments, it's a safe bet that among the things they will have little or nothing to say about will be any concrete plans for the "priorities" of 'same day services and urgent care in communities' to reduce unnecessary visits and admissions to hospital, or 'joined up community-based services' – GPs, primary, community, mental health and social care – around defined localities or hubs.

It may be a bit early to brand the success regime a failure: but its main successes so far are confined to creating new management titles and posts.

Short sighted cuts and conflicting policies

Norfolk & Norwich trust boss feels like "piggy in the middle"

The Norfolk and Norwich University Hospital NHS Foundation Trust, with its costs still inflated by the continued burden of payments on a PFI-funded hospital, has missed out on £14.4 million of funding after it could not agree its "control total" with the government.

The FT is now been consigned to "special measures" to tackle its chronic deficit, with a requirement for £20m of savings. "Special measures" includes a change of Finance Director and submitting to the unwanted intervention of teams of highly-paid and often useless management consultants, as well as responding to edicts from the trusts regulator, now known as NHS Improvement.

NHS Improvement recently announced that hospital trusts in deficit should not seek to maintain staffing levels more generous than the bare minimum 1 nurse per 8 patients recommended by the Francis Report after the Mid Staffordshire Hospitals service failures a decade ago.

NHS England has also unveiled a so called "financial reset" which required the 44 'local health economy' footprint areas drawing up Sustainability and Transformation Plans (STPs) to identify any units where clinical service viability and financial stability was at risk from excessive reliance on more costly agency and locum staff.

Where this is the case, trusts are urged to find ways to "consolidate" and centralise services (and close the offending units) –all in the name of sustainability.

But at the same time STPs are seeking to speed the discharge of patients from hospital by developing a closer integration with local government-run social care and social services. Small wonder that the Norfolk & Norwich FT finds itself bemused at the need to close a 24-bed ward that had been set up in just this way with joint funding from Norfolk County Council to enable patients who no longer needed a front-line acute bed to be discharged despite a lack of adequate numbers of places in nursing homes.

The county council money has now apparently run out: none of the local CCGs is willing to pick up the funding and ensure a continuity of services – yet it is the acute hospital trust that is taking the public blame for closing the Henderson Unit at Julian Hospital in Norwich, in line with its own "special measures" regime.

"Your job is to encourage the Chief Executive if he seems to weaken"

Chief Executive Mark Davies has told the local Eastern Daily Press he feels like "piggy in the middle" as the hospital makes tough decisions like this. he has also had to put the progress of two projects on hold as a result of the hospital being in special measures – an Ambulatory Care and Diagnostic Centre project to expand capacity for outpatient and day surgery services, and the relocation to another part of the hospital of the Children's Assessment Unit (CAU)..

The relocation of the CAU was a recommendation of the Care Quality Commission - which monitors, inspects and regulates health and social care services.

Mr Davies said: "We have one regulator saying we have to save money and one saying we need to improve services. So we live in a completely contradicting environment at the moment.

"We are sort of a piggy in the middle. We were left with no choice but to close the service down...it is a sad thing for us."


Hi, I'm Mr Special and he's Mr Measures

CCG bosses in a queue for the exit

Clinical Commissioning Group (CCG) bosses are falling like ninepins across Norfolk and Waveney as a controversial Sustainability & Transformation Plan is drawn up under a heavy veil of secrecy, seeking savings of £234m by 2020.

The most recent announced departure is that of Dr Sue Crossman, chief officer of West Norfolk CCG, which has been rated as 'requires improvement' by NHS England, and faced with generating savings of £9.8m to balance the books.

It follows the resignations of chief officers in Great Yarmouth and Waveney CCG, and North Norfolk CCG over the summer.

Despite leaving West Norfolk in deficit, Dr Crossman has apparently been invited continue to work with NHS England on innovation programmes. She claimed that she is leaving the CCG "in a strong position" – leaving a new chief officer to sort out the deficits and carry through the STP.

STP: bad news for Bedford?

News over the summer that a controversial plan to relocate maternity services from Bedford Hospital to Milton Keynes has been "put on hold" will not be enough to ease suspicions of the furtive Bedford Luton & Milton Keynes (BLMK) Sustainability & Transformation Plan.

The STP brings together 16 NHS and local government organisations – but also centres on work by Optum, the British subsidiary of US health insurance giant UnitedHealth.

The STP lists at the top of its priorities "Information and public engagement," but has not even revealed the amount of money they hope to save in order to balance the books.

Nor does it reveal the significance of the ominous "Health Care Review" which has been expensively rumbling along for several years, offering different unpalatable "choices" on whether Bedford or Milton Keynes should remain as a major hospital with full A&E and other services – with the prospect of 18-mile extra journeys for patients living near whichever hospital that is downgraded.

The STP apparently aims to develop a "detailed business case" with a 10-year financial plan, based on "optimal new care model design and structure" – assisted by Optum.

This is unlikely to be good news for Bedford Hospital (which has already lost its Hyper Acute Stroke Unit) – or for Luton and Milton Keynes, which will struggle to cope with the additional caseload if patients are diverted in their direction.

There is little or no capital on offer to expand or build any new facilities.

But of course UNISON members at Bedford Hospital should know all this: the final slide of the STP "progress checkpoint" says that the plan involves "Engagement of staff at every stage".

UNISON will do its best to keep staff informed, and continue to resist any reduction or downgrading of in services in Bedford, Luton or the BLMK footprint.

Mental health still desperately short of beds

Campaigners in Ipswich protested against the generous pay-offs for managers displaced in the merger of mental health trusts in Norfolk & Suffolk, while services are struggling.

Although there are some signs that quality of care has begun to improve, the most recent Board papers show Out Of Trust referrals – sending patients sometimes hundreds of miles for treatment for lack of local beds – are increasing again after a brief reduction. The fight for both parity of esteem and fairer allocation of resources for mental health has to continue.

Plans rest on a £1 billion bail-out & Cambridgeshire CCG

Peterborough-Hinchingbrooke trust merger: Nagging doubts remain

A swift scan through the Full Business Case for the "acquisition" of Hinchingbrooke Health Care Trust by Peterborough & Stamford Hospitals Foundation Trust shows that the document is substantially reorganised from the Outline Business Case, published just a couple of months ago.

The chapter titles are changed, with new chapters added. Appendices from KPMG PA consulting and Deloitte reveal that the merger process so far has been an expensive one in terms of management consultancy.

At first sight much of the primary content of the OBC appears unchanged.

The case rests on continued long term and substantial Department of Health subsidies (totalling almost £1 billion) to cover over the 30-year PFI-driven deficit in the balance sheets of PSHFT. The OBC assumed £10.8m of 'transitional funding' to PSHFT would be put together with a £4m payment to HHCT.

When this is added to the PFI subsidy of £25m a year, it's clear that the vision of eradicating the PSHFT deficit rested largely on the ready supply of extra money from elsewhere in the NHS – to the tune of £39.8m a year. It's not clear whether this assumption has been completely revised: the term 'transitional funding' does not appear in the FBC.

The FBC assumes that it's possible to merge the two financially strapped trusts and maintain all the services on all 3 hospital sites while also saving £9m a year through "back office" economies.

Appendix 5 to the FBC sets out the various plans to merge and integrate services in PSHFT and HHCT. Many of these appear to be positive proposals, with the maintenance of Emergency Departments at both Hinchingbrooke and Peterborough, and minor injuries services at Stamford, and a fully integrated and sustainable 7-day Stroke service across both sites.

Oncology services would also remain at all 3 hospital sites", with plans to expand existing services.

However the "future vision" of an integrated critical care service is "unclear at present" and it seems the continuation of two ITUs is only grudgingly proposed because "other service configurations require this".

It's made clear that services "would be dependent on wider STP decisions on service reconfiguration including ED, obstetrics, acute medicine and emergency surgery".

In other words, while the merged trust might promise to retain services, the STP could propose to reconfigure them away from Hinchingbrooke.

Any service can only continue if supported by commissioners. the merged trust would no more be the master of its own fate than the two trusts separately.

But the mechanism of the STP process is if anything even less accountable and transparent for local people than the CCG.

If the assurances are adhered to in practice by the commissioners, then it's clear that the merger would offer a lifeline to an otherwise beleaguered HHCT, which since the abrupt departure of Circle has had an uncertain future. However UNISON's concerns over the impact of attempts to "save" £9 million a year from "back office" services – by which they appear to mean primarily administrative and clerical staff – remain as they were in response to the OBC.

And the question marks over the financial assumptions of the merger are increased by the stark contrast between the projected balance sheets in the OBC and the far worse deficits projected in the FBC which shows deficits before tax sharply higher each year.

While the potential benefit of safeguarding the future of HHCT, and therefore minimising the threat to services and jobs could be a reason for UNISON to accept the case for merger, any endorsement of the merger would be conditional on the commissioners giving guarantees that the proposed integrated services will be funded to continue.

Fenland fight to hang on to MIU and OP services

Local politicians from east Cambridgeshire and Fenland have been forced into challenging controversial plans by Cambridgeshire & Peterborough CCG to close minor injuries units (MIUs) at Doddington, Wisbech and Ely, and possible cuts in outpatient services.

The threat to the MIUs was flagged up over the summer by a whistleblower who leaked a confidential internal report to NE Cambs MP Steve Barclay, who argues that 33,000 patients a year use the units and could wind up having to trek in to Cambridge, Peterborough or Kings Lynn to seek treatment.

His challenge was echoed by the Mayor of Ely, the leader of fenland District Council and other councillors. One described the proposed closures as "Utter madness". CCG chief officer Tracy Dowling's attempt to placate an angry public meeting in Ely by asking if they felt the CCG had at least been "honest" was met by cries of "no" as the meeting ended.

The CCG's director of urgent and emergency care, Ian Weller, has admitted that the closure of all three MIUs has been the "only option" put forward by the CCG which is looking to save money to bridge a growing financial shortfall. But the CCG insists that no decision has been taken until a 'review' of potential options concludes next March.

Mr Barclay has linked these proposed changes to the CCG losses of £16 million as a result of the collapse of their elaborate contract for Older Peoples and Community Services.

The loss of local urgent care and outpatient services would cause particular problems for many older patients and those on lower incomes who would be dependent on lengthy, awkward and uncomfortable journeys by public transport if they do not have access to cars. Cambridgeshire County Council has pointed out that the catchments of the three hospitals include areas of deprivation, and closures would impact on the most vulnerable.

However there does appear to have been some concessions made by the CCG to concerns raised by local councillors and MPs over the potential loss of local outpatient services, with new contracts in place to continue services at Ely and Doddington into 2018. The same pressure needs to be maintained until the CCG sees sense over the threatened MIUs.

Tory MPs in these rural areas where local services are at risk have increased bargaining power in shifting Theresa May's government with its majority of just 12 in the Commons: they must not be allowed to forget it.

After the fiasco – recriminations continue

The ridiculous Cambridgeshire and Peterborough CCG plan for an under-funded 5-year lead provider contract for Older People and Adult Community Services (OPACS), which we reported at length in our last *Eastern Eye*, collapsed, predictably, within eight months.

The disastrous Strategic Projects Team that masterminded this and a series of other costly fiascos has also been scrapped, and a series of inquiries have been held, each of which has studiously avoided using the word "incompetent" to describe the irresponsible actions of the CCG.

An independent report, sponsored by UNISON and other unions, and published by Cambridgeshire Keep Our NHS Public, breaks from this reticence in its title 'Let Down by Everyone – A Tale of Incompetence.' Its opening point is that the contract that was signed did not even stipulate a final price or agreed specification of what was being commissioned.

But within the NHS recriminations and consequences keep coming back to the surface. A follow-up report for NHS England, written for them by PwC (since no managers seem to write their own documents any more), unsurprisingly criticises the CCG for not buying in enough "advisor input".

The CCG, the SPT and the trusts whose "limited Liability Company" triggered an unbudgeted 20% cost for VAT keep blaming each other – but have any lessons have been learned?

"Extra" pay for nurses would be taken from their pensions

E&N Herts trust plan puts staff pensions at risk

Unions protested outside Lister Hospital in Stevenage against an offer of cash incentives by East and North Hertfordshire NHS trust, which is offering higher salaries to new starters and existing staff in a bid to fill 200 nursing vacancies – as long they opt out of the NHS pension scheme.

UNISON says this is morally wrong, and against the law (Section 54 of the Pensions Act prevents employers from 'inducing' staff out of a pension scheme or encouraging them not to join one).

It discourages workers from planning for their retirement, and could potentially undermine the NHS pension scheme itself – affecting hundreds of thousands of staff.

The union has already reported the trust to the NHS Pensions Board and the Pensions Regulator, and is now awaiting their response.

This is not the first time a trust has attempted to save money by targeting staff pensions, says UNISON. A similar offer earlier this year by Oxleas NHS trust in south east London to nurses was abandoned following union pressure.

UNISON's head of health in the East of England Tracey Lambert said: "This deal, which applies to newly qualified and existing staff, is clearly a cost-saving measure. If offering staff more money not to join a pension scheme isn't an inducement, then it's difficult to see what is.

"Many trusts are under huge financial pressure as a result of the squeeze on NHS funding, and have difficulties filling vacancies.

"And we know after years of frozen pay or below inflation increases many staff could be tempted by the short term promise of extra cash, without recognising the long term cost.

"Saving on pension costs to subsidise higher rates of pay isn't the way forward. Every worker deserves financial security in their retirement and staff shouldn't be encouraged to put short-term gain ahead of long-term security.

"It's morally wrong to condemn a generation of mainly female staff to poverty in their old age."