

A stylized map of the United Kingdom, including Great Britain and Ireland, rendered in a light green color against a darker green background. The map is positioned in the center-left of the page.

UNISON health service  
group executive  
report on devolution  
in health

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# Background

The UNISON healthcare conferences in 2008 and 2009 agreed motions on the impact of devolution and the functioning of the health service group executive (HSGE). These motions demonstrate the importance of an HSGE response to the impact of devolution in terms of negotiating and bargaining, as well as organisationally within the service group.

The impact of devolution and the wider political relationships UNISON now has with the administrations in the four countries has a knock-on effect on political and industrial decisions taken at national level by the HSGE. For example, whilst Agenda for Change is a UK agreement, the 'four nation' employers have increasingly undertaken their own processes, and on occasion taken different positions, for example, on the 2007 pay award.

The HSGE has established an effective sub-group on devolution and the health service group has also fed into the overarching review of democratic processes, which has been examining the role of sectors, devolution and partnership between lay activists and full-time staff within UNISON.

# Introduction: political devolution and health policy

Political devolution began to take shape in the UK in 1997 when the newly elected Labour government produced its promised white paper on the subject. Two years later the Scottish Parliament, Welsh Assembly and Northern Ireland Assembly assumed their formal powers. The political situation in Northern Ireland meant devolution was initially short lived and then enormously complex, while the government's intention to pursue an element of political devolution to English regions collapsed when such a scheme was rejected in the north east in 2004.

There have been huge increases in funding across the UK NHS since 2000, which have produced major improvements in patient care in all four countries. But, given the nature of devolution, health policy is one of the main areas where powers have been transferred to the devolved nations with different priorities emerging in each. The devolved countries were quick to use their new powers to restructure their health systems, while in England, recent years have witnessed increasing levels of health spending devolved to the local level.

In England, greater freedoms for foundation trusts and local commissioners have shifted power away from the centre. Unlike in Scotland, Northern Ireland and Wales, the focus of the English service has changed frequently to concentrate firstly on standards, then targets and building capacity, followed by competition and choice, with the focus now moving towards quality and personalisation.

The English NHS is increasingly based on competition, contestability and choice. Scotland

has consciously moved away from market-oriented models and, along with Wales, has recently favoured a far more collectivist system, although there are attempts in Northern Ireland to mimic the English tariff system of payment by results.

A major feature of the system in Northern Ireland is greater integration between health and social care, while in Wales there is generally a better working relationship between health and local authorities compared with much of the UK. Major reorganisations are taking place in Northern Ireland and Wales to cut the number of health bodies.

Essentially we now have four distinct NHS systems within the UK, although on the 60th anniversary of the NHS in 2008, all four countries did sign up to a set of principles that the NHS should uphold, which ties in with the development of the first NHS Constitution in England.

In addition, pay determination through the NHS pay review body, the maintenance of the Agenda for Change agreement and central bargaining on terms and conditions and pay structure via the NHS staff council, remain a UK-wide activity. Whilst devolution has and does provide opportunities for bargaining on the edges of this UK agreement, the unity of UNISON as a UK union is essential to ensure both bargaining strength and to avoid the weaknesses of fragmentation to regional or devolved nation bargaining.

But after 10 years of devolution in the NHS, how have the four systems evolved?

# England

When the Labour government came to power in 1997, it pledged to end the NHS internal market and to restore the health service as a public service working co-operatively for patients, as opposed to a commercial business driven by competition. Once in office, it set about delivering on these commitments, abolishing many of the structures of the internal market and replacing them with a new emphasis on collaborative working and the collective planning of service provision. The 2000 *NHS plan* built on these reforms, setting out an ambitious 10-year vision for the future of the NHS, developed in partnership with patients, staff, and other stakeholders.

An early focus on targets and building capacity in England was used to reduce considerably waiting lists and waiting times, to the extent that in 2009 the government looked to guarantee the patient right of 18 weeks from referral to treatment (differing sharply from the long waits of up to 18 months under the previous Conservative administration). Along with the minimum wage, this is likely to be regarded as one of the Labour government's most significant achievements. (Waiting times have also been reduced in the devolved countries.)

Since 2002, however, the government has been putting in place a series of reforms that represent a fundamental change in policy direction. Increasingly, NHS health care is being provided by a diverse group of competing providers from across the public, private and voluntary sectors. In addition, NHS hospitals are being given independence from government, and are being turned into organisations that operate according to commercial principles.

The purchaser/provider split has been retained and intensified by devolving more than 85% of the NHS budget to local health bodies – primary care trusts (PCTs) – and making them responsible for commissioning or buying in care on behalf of their patient populations.

Following legislation in 2003, foundation trust status allowed NHS hospital trusts, and subsequently also mental health and ambulance trusts, to become independent of government control and acquire new powers and freedoms, allowing them to behave more like commercial companies. For instance, they have the power to borrow from the private sector, the ability to retain surpluses, and potentially have greater autonomy over pay and conditions packages. By mid-2009, more than 100 hospitals in England

had achieved foundation status; the majority of mental health trusts had too.

There has been an increasing use of the private sector to provide NHS health care, not as a temporary measure to meet short-term surges in demand, but on a long-term basis as part of the deliberate cultivation of a diversity of providers.

Patient choice of provider has been introduced. Since January 2006, all patients requiring planned hospital care have been able to choose, at the point of GP referral, from a range of four or more providers. Since May 2006, this choice has been widened to include a national 'menu' of NHS foundation trusts, which can include independent sector treatment centres (ISTCs) as well. From 2008, 'free choice' has meant that patients have been able to choose any healthcare provider that meets NHS standards and can deliver to NHS prices.

Underpinning these policies is the introduction of a new NHS financial system, payment by results (PbR), which was rolled out across parts of the NHS in 2005 and 2006. Under this system, rather than PCTs allocating hospitals pre-determined blocks of funding, providers are for the first time paid on a per procedure basis, using a centrally fixed system of national prices or tariffs. This is designed to facilitate competition, as money will follow the patient between providers, with hospital income and PCT expenditure both varying according to the volumes of patients treated. Furthermore, where a hospital loses patients, the drop in income that it experiences will generally be greater than its drop in expenditure, as the national tariff prices reflect average rather than marginal costs.

In July 2005, the government issued *Commissioning a Patient-led NHS*, announcing a reconfiguration of PCTs and strategic health authority (SHA) structures and functions, including community services currently provided by PCTs, such as district nursing, health visiting and occupational therapy. In terms of structures, the NHS has been reduced to 10 SHAs from 28 since July 2006 and to 152 PCTs from 303 since October 2006. Functional changes mean that PCTs and SHAs have to review their services and consider bringing in alternative providers to increase contestability. This brings the threat of the fragmentation of community health services and transfer of tens of thousands of NHS staff to new employers.

Following the publication of *Commissioning a Patient-led NHS*, the health secretary promised that PCTs would not have to divest themselves of their provider function. However, the government's January 2006 primary care white paper, *Our health our care our say*, included plans for a major programme for generating competition among providers and transferring NHS primary care services to the independent sector. The department of health's commissioning framework reaffirmed the split between the commissioning and providing roles of PCTs to better facilitate the arrival of alternative providers, with competition seen as the driver of improvements. Furthermore, the publication of adverts in July 2006 in the *Official Journal of the European Union* explicitly invited companies to prepare for PCT services to be put out to tender.

Since 2004, commercial and voluntary sector organisations have been able to provide GP services through contractual arrangements known as the alternative provider medical services (APMS) model. The world class commissioning programme was introduced to address a perceived skills deficit in commissioning by PCTs and a part of this includes the framework for procuring external support for commissioners (FESC), which provides commissioners with an approved list of private sector suppliers for assistance with commissioning.

The government also continued the policy of the Major government of using the private finance initiative (PFI) to build new hospitals. A primary care version of PFI called the local improvement finance trust (LIFT) has increasingly been used to build health centres.

There appeared to be something of a policy step change in mid-2007 when Gordon Brown became prime minister and Alan Johnson health secretary. It was announced that there would be no further central procurement of ISTCs and no more major structural reorganisation. An extensive review of the NHS by the doctor Lord Ara Darzi was also announced. This reported in summer 2008 but made no significant breaks with the marketisation agenda that had gone before.

Indeed in 2009, the primary care strategy of Lord Darzi led to a new drive for greater marketisation with the transforming community services agenda. This was compounded by the establishment of a co-operation and competition panel (CCP) to ensure

the development of health markets, and by a new commercial operating model for the NHS, entitled *Necessity-not Nicety*, to ensure that there are more opportunities for the private sector to break into health care.

Other key changes that came out of Darzi include the piloting of personal health budgets from 2009 – importing a consumerist idea of health delivery as used through individual budgets in social care. This is being sold, in part, as a way of integrating services better between health and social care. Similarly, new plans to pilot integrated care organisations will blur these boundaries.

In late 2008, a potentially momentous decision was taken – to permit top-up payments for cancer drugs, which could have far wider implications for NHS ideals. Meanwhile, prescription charges remain in place and have been increasing in England, although charges for cancer patients were abolished from 1 April 2009; over the next few years charges will also be abolished for patients with long-term conditions. A review was due to report to the government in the latter part of 2009 on how to define the range of long-term conditions that should be exempted from charges and how exemption could be brought in.

The past 10 years have also seen many changes to the various structures of patient and public involvement in the English NHS. Community health councils were replaced with patient and public involvement forums and the national commission for patient and public involvement in health. In turn these have now been abolished in favour of local involvement networks, but many questions remain as to whether the public has a proper role in scrutinising changes to the health service.

Similarly there are concerns about the regulatory framework. The Healthcare Commission was replaced in 2009 by the Care Quality Commission, which also brings together the regulatory regimes from social care and mental health. The focus is now very much on 'risk-based,' light-touch regulation despite the fact that there is now a far more fragmented system of health delivery with a greater number of providers operating. UNISON has also been critical of Monitor, the regulator of foundation trusts, which appears to be acting increasingly as an advocate for foundation trusts rather than a regulator – the Commons health committee was damning about Monitor's role in relation to the

Mid Staffordshire scandal, in which the Healthcare Commission uncovered appalling failures in care..

UNISON has built political resistance to many of these developments. Our lobbying around the private patient cap in foundation trusts has so far been successful and we have forced a review of the way in which the transforming community services agenda is being used as a vehicle for privatisation. The principles and rules of the CCP are also being reviewed as a result of UNISON pressure.

Following the combined actions of the NHS trade unions, under the umbrella NHS Together, one of the concessions wrung from the government in 2006/2007 was a far better system of consultation and engagement between unions, employers and government as part of the NHS social partnership forum (SPF). The SPF has developed into a forum, valued by all parties, for discussing the implementation of reform. Social partnership is increasingly a vehicle for us to modify many government policies to ensure that staff interests are protected and to promote partnership working and staff engagement at local level.

# Scotland

This report outlines the structure and operation of the NHS in Scotland, UNISON's own structures within the healthcare service group and how the union engages in the specific political and industrial structures in Scotland to represent healthcare members, as well as current policy issues emerging from devolution.

## Devolution and the NHS in Scotland

The NHS (Scotland) Act 1947 created a department of health for Scotland, working under the secretary of state for Scotland. Although formally a separate institution, NHS Scotland operated closely with the NHS south of the border to deliver a seamless service free at the point of use throughout the UK.

A major reorganisation in the early 1970s saw hospital boards and community services re-grouped into 18 area health boards, which largely removed the direct role of local government in health service provision. Although formally separate, the NHS in Scotland continued to be run broadly along the same lines as the NHS in England until the devolution settlement in 1999.

Since devolution, the NHS in Scotland has undergone major change – for example, the Conservative government's internal market was dismantled with the abolition of NHS trusts and there was a greater focus on partnership rather than competition.

## The current organisation of the NHS in Scotland

### Scottish parliament

In Scotland, cabinet secretaries and ministers are responsible and accountable to parliament for the overall running of the NHS in Scotland. The health and sport committee is the main committee dealing with the health aspects within the portfolio of the cabinet secretary for health and wellbeing and their deputies.

### Scottish government

The responsibilities of the cabinet secretary for health and wellbeing include: NHS; health service reform; allied healthcare services; acute and primary services; performance, quality and improvement framework; health promotion; sport; public health; health improvement; pharmaceutical services; food

safety and dentistry; community care; older people; mental health; learning disability; substance misuse; social inclusion; equalities; anti-poverty measures; housing and regeneration.

The Scottish government health directorate has responsibility for health policy, the administration of the NHS, community care and some responsibility for social work. The department is headed by the director general for health who is the chief executive officer of the NHS.

The Scottish government has a range of directorates responsible for ensuring progress is made on its five core strategic objectives:

- wealthier and fairer Scotland;
- healthier Scotland;
- safer and stronger Scotland;
- smarter Scotland;
- greener Scotland.

In terms of health care, the Scottish government states that it aims to help people sustain and improve their health, especially in disadvantaged communities, ensuring better local provision and faster access to health care. It provides a clear statutory and financial framework for NHS Scotland and holds it to account for its performance. Directorates that focus on this include public health and wellbeing, primary and community health, office of the chief medical officer, eHealth and health policies and strategies.

### NHS boards

The NHS in Scotland is predominantly run by the 14 area NHS boards, which are responsible for the planning and provision of health services for their local populations. The boards are accountable to ministers and thus to parliament. There are also a number of special health boards, which provide services on a national basis eg the Scottish Ambulance Service.

### Community health partnerships

Community health partnerships (CHPs) were created following the enactment of the National Health Service Reform (Scotland) Act 2004. CHPs are the successors of local health care cooperatives (LHCCs) and have been charged with the management of community health services. Acting as committees or

sub-committees of the board they are also supposed to:

- bring together those providing community-based health and social care services;
- feed local needs into board planning and resource allocation;
- provide a focus for integrating primary care and acute services;
- get involved in community planning to tackle poverty and deprivation in their area;
- be the main NHS agent for the implementation of the joint future agenda (aimed at developing closer joint working between the NHS and local authorities);
- be the main NHS agent for implementing the strategy for integrated children's services.

The exact responsibilities, make-up and funding of each CHP differ between boards. The forums are supposed to give local communities a chance to influence local services.

## Funding of the NHS in Scotland

Direct funding to health boards represents 78% of NHS Scotland's total £11 billion budget.

Levels of funding are determined by cabinet secretaries and ministers and approved by the Scottish Parliament. Since 2000, the majority of the health budget has been allocated to the 14 area NHS boards via the Arbuthnott formula. This formula aims to distribute money in a way that reflects varying need between boards. It is therefore based on measures such as population, morbidity, mortality and deprivation.

However, a new formula for allocating funding to NHS boards was to be introduced in 2009/2010. The decision comes after the NHS Scotland resource allocation committee (NRAC), the independent body charged with reviewing NHS board funding, submitted its final report to the Scottish government. The final report includes more than 30 recommendations, including a proposed revised formula to replace the Arbuthnott formula, as well as other recommendations on data developments, use of formulae in funding allocations, and the future maintenance of the formula.

## The history of Scottish NHS reforms since 1997

The following outlines the key policy developments in the Scottish health service since 1997.

### 1997-1999 – Dismantling the internal market

In 1997, the incoming Labour government inherited an NHS, which in the preceding years had undergone radical change at the hands of the Conservative government. This change was geared towards introducing elements of market economics into the NHS in a bid to curtail spending and improve efficiency. Such elements included the creation of NHS trusts and a purchaser/provider split, whereby fundholding GPs 'purchased' care on behalf of their patients from providers such as acute hospital trusts. This system received much criticism from opposition parties and the Labour manifesto pledged to abolish the internal market.

Carrying on the manifesto commitment in Scotland, the 1998 white paper, 'Designed to care', (Scottish Office, 1997) signalled the end of the internal market, GP fundholding and contracting for services. Trusts lost much of their autonomy, becoming responsible in an administrative sense for the provision of services, while policy-making rested with the area health boards. The purchaser/provider split became the strategic/service divide and primary care trusts were introduced to manage general practice and community services. GPs were given the go-ahead to come together voluntarily to form local healthcare co-operatives.

Health boards retained the strategic role of improving and protecting the health of their local population and were now considered to be strategic public health organisations. The competition of the internal market was to be replaced with a culture of partnership.

### 1999- 2001 – A new approach to public health

The new Labour government in Scotland and the UK also introduced a new approach to public health, and in February 1999, the Scottish Office published 'Towards a healthier Scotland' (Scottish Office, 1999). This white paper was notable in that it acknowledged health inequalities and the wider determinants of health, something of a departure from the previous political focus solely on individual responsibilities and lifestyles. The focus for health improvement was set out across three areas:

- life circumstances (eg employment, housing and education);
- lifestyles (eg smoking, diet and physical activity);
- health topics (eg cancer, coronary heart disease, stroke and mental health).

The shift in emphasis from lifestyles to life circumstances was also highlighted by a review of the national funding formula. The formula (known as the Arbuthnott formula) proposed that any distribution of funding to NHS boards should take greater account of need within the population, including morbidity, mortality and deprivation.

### **2001-2003 – Reforming governance and accountability**

In 2001, the Scottish health plan (Scottish Executive, 2001a) continued the dismantling of the internal market with changes to governance and accountability in the NHS. Health boards became ‘unified’ with NHS trusts, although this was primarily a change in the membership and role of health boards, as opposed to a unification of the actual structures. The unification was intended to provide a single focus of accountability for the performance of the local NHS system, and NHS boards were required to produce a single local health plan for the area. The health plan also announced the introduction of the performance assessment framework (PAF), which was to be used by the Scottish Executive to monitor performance and health improvement within each NHS board area.

### **2003-2005 – Single system working and community health partnerships**

The 2003 white paper ‘Partnership for care’ (Scottish Executive, 2003a) took previous reforms even further by announcing the abolition of NHS trusts entirely. The paper also proposed the establishment of community health partnerships as a means of making health services more accountable to local communities and better able to represent local interests within NHS boards.

The organisational changes outlined in the white paper were implemented via the National Health Service Reform (Scotland) Act 2004 and were seen as the final stage in dismantling the NHS internal market. The functions of the NHS trusts were incorporated into operating divisions of NHS boards, which became responsible for overseeing primary

and secondary care but which, unlike trusts, had no independent legal status. This left a single tier of governance and accountability in the shape of the 14 NHS boards.

The role and influence of local healthcare co-operatives (and thus, primary care) were also strengthened as they evolved into community health partnerships (CHPs). Although still in their infancy, it is envisaged that the CHPs will make the link between primary and acute care more seamless, with resources and responsibility for decision-making being devolved to them. In addition they have been charged with involving patients and a broader range of healthcare professionals in the decision-making process.

In 2004, the executive also published ‘Fair to all, personal to each’ (Scottish Executive, 2004), which set out new targets for waiting times and announced greater use of independent sector diagnostic and treatment services to bring down waiting times.

### **2005-2007 – The Kerr report and delivering for health**

At the same time, there was increasing public concern over service reconfigurations and the centralisation of services. Then health minister, Malcolm Chisholm, convened an expert group tasked with looking at how NHS services could be developed in the longer term. In May 2005, the national advisory group on service change published its final report (also known as the Kerr report). The group set out its vision of the NHS as: “Our vision for the NHS is that it should deliver safe, high quality services that are as local as possible and as specialised as necessary”.

One of the key themes to emerge from the Kerr report was the concept of shifting the balance of care closer to the community and away from acute services. This would partly be provided by ‘anticipatory care’ where care is geared towards preventing unscheduled admissions to acute care, but also by preventing future ill-health and improving the management of long-term chronic conditions. The executive issued its response to the Kerr report in the publication ‘Delivering for health’, which generally endorsed the Kerr report.

### **2007-2009 – Better health, better care**

Following wide consultation, Nicola Sturgeon, cabinet secretary for health and wellbeing launched

the Scottish government's strategy for a healthier Scotland, 'Better health, better care: action plan', on 12 December 2007. The central message of the action plan focused on new opportunities to develop a 'mutual' NHS in Scotland in which citizens see themselves as partners in the service, with rights and responsibilities, and where the people of Scotland are given the opportunity to take more control of their health and to be more active in deciding how NHS services should be run. The action plan outlined the actions the government would take to improve health and its key themes were: patient participation; improved healthcare access, and a focus on the twin challenges of improving Scotland's public health and tackling health inequalities.

## The current health policy framework in Scotland

Since devolution, a number of pieces of landmark legislation, in terms of health have been passed, such as the ban on smoking in public places and the provision of free personal care.

Scotland, as a nation, faces a number of challenges in relation to health. Although we are on average healthier and live longer, in large part as a result of six decades of the NHS, many health challenges remain. The ageing population profile means the pattern of demand for health care is changing.

There is a substantial degree of consensus between the main political parties (except for the Scottish Conservatives) on the main elements of Scottish health policy.

The Scottish government's main target for health is "to increase life expectancy" and its national health outcome is that "we live longer, healthier lives". The strategy is set out in Better health, better care. The action plan is not materially different to that of the last administration with its focus on reducing health inequalities, improving treatment and quality as well as improving the efficiency of NHS Scotland. The high level targets all recognise that NHS Scotland is only part of the solution to Scotland's enduring health problems and that a partnership approach is required nationally with other portfolios and locally through community planning.

Most importantly there has been no major structural change and the Scottish public service model based on co-operation not competition, as introduced

by the last administration, has been maintained. This administration is more strongly opposed to private sector involvement in NHS Scotland. The Scottish government's new version of public private partnerships, the Scottish Futures Trust, has yet to be fully developed, although we are monitoring the hub initiative that appears to follow closely the English LIFT/PFI model.

There have been only two health acts since 2007. The Health Boards (Membership and Elections) Act introduces direct elections to health boards. This was a long-standing UNISON policy to introduce an element of democracy to NHS Scotland, and MSPs from all parties acknowledged UNISON's key role in securing the legislation. The other was a reform of public health legislation. The previous (pre-2007) parliamentary session contained major health reforms including the NHS Reform Act and legislation banning smoking in public places.

Current legislation includes the Tobacco and Primary Medical Services Bill although a further bill on health care is in the legislative programme. Current private members' bills cover health issues including: palliative care; NHS parking; end of life choices and sunbed licensing. Secondary legislation can also be important, for example, the phasing out of prescription charges.

The health and sport committee includes health policy and NHS Scotland in its remit. The convenor is Christine Grahame and other members are Ross Finnie (LD), Helen Eadie, Rhoda Grant, Richard Simpson (Lab), Michael Matheson, Ian McKee (SNP) and Mary Scanlon (Tory). In addition to scrutinising the bills mentioned above, the committee is currently conducting an inquiry into mental health services for children and considering several petitions.

MSPs will also use motions and questions to raise health-related issues. Some of these will be debated in the chamber. The process is to circulate a motion to all MSPs and seek support. We sometimes use this approach as part of a campaign by asking an MSP to table a motion. Recent health motions cover GP drug dispensing, epilepsy week, pro-anorexia websites and breast feeding.

Petitions are another route into parliament for individuals and groups who want to raise an issue. This can be done online and the petitions committee will decide how to take forward a particular issue

usually by referring the matter to the appropriate subject committee.

### **Issues impacting on health**

Whilst the above covers health-specific issues, many aspects of UNISON Scotland's political strategy impact on health and government increasingly works across portfolios. The most important is obviously the Scottish budget, an issue that will dominate our work for the next few years given the recession. The Scottish government and parliament will be faced with some very difficult decisions in relation to health spending, starting with next year's budget bill.

Other issues include the Scottish government's efficient government initiative, with its focus on increased targets through absence management and shared services. Unequal pay, public service reform, violence against staff and occupational health all impact on health. The Calman Commission on devolved powers will also report this year and that may recommend new powers for the Scottish Parliament.

### **Key policy issues in Scotland**

The following sections briefly outline current key policy issues for the healthcare service group in Scotland. Full briefings on all of these issues are available from the policy and information team section of the UNISON Scotland website.

#### **Private finance initiative/Scottish Futures Trust**

After devolution, the Labour/LibDem executive continued to fund many hospital projects through the private finance initiative (PFI) and public private partnerships (PPPs), following on from the already commissioned Hairmyres and Wishaw General hospitals and Edinburgh Royal Infirmary. In addition, many private facilities' management contracts were still in operation although concerted efforts by UNISON branches had resulted in several coming back in-house over the period.

When the SNP government came into power in May 2007, it seemed to backtrack on its earlier opposition to PFI/PPP, saying it would continue with PPP in the form of the so-called non profit distributing (NPD) model. The SNP's much trumpeted Scottish Futures Trust, which had been promoted as an alternative to PFI, seems to have been set up in a way that will continue at least with NPD PPPs and it has not ruled

out traditional or standard PPP. UNISON has warned that the Scottish government is simply putting a gloss of public accountability onto PFI and PPP instead of addressing the scandalous waste of public funds these policies represent.

The new Forth Valley hospital is still being built through PFI, but the new government did announce plans to build a new Southern General Hospital in Glasgow with public funds, and proposals for this are continuing.

#### **Prescription charges**

Over the past few years there have been several attempts to introduce legislation to abolish prescription charges in Scotland, through private members' bills, but when the new SNP government came into power they finally passed legislation to phase out prescription charges, totally abolishing them by April 2011.

#### **Direct elections to health boards**

In March, 2009, the Health Boards (Membership and Elections) Bill was passed by the Scottish Parliament. This means that for the first time members of the public will be able to play an active part in the decisions made by health boards, which in 2009-2010 will spend a record £8.64 billion of taxpayers' money. Pilot sites for direct elections to health boards have long been UNISON policy and the union was very supportive during the bill's progress through parliament. NHS Dumfries and Galloway and Fife will pilot directly elected health boards in spring 2010.

#### **Healthcare and social care**

In Scotland, co-operation between health and local government has been driven by the joint future initiative. This identified closer working between health and social care staff, initially in projects working with older people, but now across most areas. In addition, as part of the efficient government initiative, shared services are being introduced, which could have serious long-term implications for UNISON members. Members could find their posts transferred to another employer, for example, a new body delivering a service to a number of health boards. European procurement rules mean that the provision of shared services could be opened up to tender and therefore to privatisation.

#### **Health spending**

An examination of health board finances in Scotland has identified that health board budgets are under a

great deal of pressure in 2009/2010, and as boards must have balanced budgets, there is concern that any overspends have to be met with cuts in other areas. As health inflation is usually higher than general inflation, recent inflation rises have been greater for health boards than for other areas. These increases have also coincided with changes in the formula for the allocation of funds to health boards and a new Scottish government with new priorities. Health boards also face additional pressures for funding caused by: a 48-hour working week limit under 'modernising medical careers'; 'agenda for change' successful grading appeals being more numerous than budgeted; waiting time targets and general cost pressure, such as increased fuel costs. The expected value of land sales will be affected by falling property prices. On top of this, boards have to make efficiency savings of 2%.

## Partnership working

The NHS in Scotland has predominantly worked in conjunction with trade unions and professional organisations to negotiate terms and conditions for staff. The employee relations climate which existed prior to partnership working could be characterised as one of conflict and confrontation. In July 1999 guidance was issued by the Scottish Executive, setting out the new partnership arrangements with which NHS Scotland employers were required to comply. Enshrined in the NHS Reform (Scotland) Act 2004 is the staff governance standard, which is the overarching policy for partnership working and employment practice and employee relations, outlining what each employer must achieve in relation to the fair and effective management of staff.

### Scottish partnership forum

The Scottish partnership forum (SPF) was set up in 1999 to support partnership working at a national level between staff, trade unions and NHS Scotland employers. Its agenda focuses on issues relating to services and patient care across the whole of NHS Scotland.

### The Scottish terms and conditions committee

The Scottish terms and conditions committee (STAC) is a partnership organisation that exists to negotiate terms and conditions issues collectively for NHS Scotland staff other than those who pertain exclusively to recognised separate collective bargaining arrangements. STAC is made up of an NHS employer side and a trade union and

professional representative organisation side, which each has its own secretariat. The committee is jointly chaired by a representative from each side. Meetings are facilitated by the Scottish government health directorates, which also provide an overarching administrative secretariat function.

### The Scottish workforce and governance committee

The Scottish workforce and governance committee is a standing sub-committee of the SPF, whose main function is to support the development of the workforce strategy.

UNISON in Scotland has direct representation on all of these bodies.

In addition to engagement on an industrial level, devolution has also brought a number of new opportunities for engagement within the political system. For example:

- Representatives of the Scottish health committee meet directly with the cabinet secretary for health and wellbeing.
- The Scottish Parliament's committee system gives UNISON the opportunity to provide formal evidence (written and oral) on legislative proposals and committee inquiries.
- The Scottish Parliament's petitions committee allows individuals, community groups and organisations to participate in the policy scrutiny process by raising issues of concern with the parliament (eg the 'food for good' charter).
- UNISON Scotland has regular liaison with the MSPs' group of UNISON members and directly contacts all MSPs with policy briefings etc on issues of relevance to membership.
- UNISON Scotland has directly supported MSPs' private members' bills – eg on NHS car parking charges.
- Representation through the Scottish Trades Union Congress and engagement through UNISON Labour Link and the Scottish trade union Labour Party committee also present further opportunities for political engagement on issues of concern to members.

It is fair to say that since devolution in 1999, health services in Wales have gone through three different phases of direction, each one coinciding with various election phases. In 1999, the first Welsh Assembly Government had a clear Labour majority and tended to reflect the traditional values of support for the NHS, despite it actually inheriting a market-driven competitive plethora of 28 NHS trusts.

Between 1999 and 2003, visible change to that competitive ethic became clearer in conservative stages and during the first four years the government failed to understand the benefits of a strong devolved policy towards NHS Wales.

However, during the second phase of a Welsh Assembly Government between 2003 and 2007, a direction began to be set in respect of moving from competition to collaboration, but this remained within a commissioner and provider setting. The health service inherited in 2003 was quite a fragmented creation consisting then of some 17 health trusts but 22 separate commissioning health boards, in effect a net increase from what had actually been inherited in 1999. However during the 2003-2007 period a few more radical policies started to emerge in terms of a deliberate strategy of public build for the NHS as opposed to PFI, a continued roll-back of those few NHS services that were still out in the hands of private contractors. However, significantly there was no obvious radical agenda from what was still a Labour majority government in Wales.

The third phase of the NHS under a devolved administration has, since 2007, clearly developed a radical, and some believe visionary, agenda, which saw the implementation of an NHS policy programme that was clearly different from what had gone before.

The 2007 Welsh Assembly Government was no longer a Labour majority; Labour was the largest party but had to enter a coalition government with Plaid Cymru, Wales' nationalist party. This coalition was underpinned by a document called 'One Wales', a progressive agenda for the government of Wales effective from June 2007. This can be accessed at: <http://wales.gov.uk/about/programmeforgovernment/strategy/publications/onewales>

In terms of health policy, a clear strategy was defined for:

- reviewing NHS reconfiguration;

- strengthening NHS finance and management;
- developing and improving Welsh health services;
- ensuring access to healthcare;
- improving patient experience;
- supporting social care developments.

In effect we had a health policy that could have been written by UNISON and it was a policy that reflected many of the discussions that UNISON has had with the Welsh Assembly Government since 1999. That policy has led to a current NHS reconfiguration programme, which was due to conclude in October 2009. This has seen the total eradication of the purchaser/provider split in favour of a more structured central planning system. As of October 2009, the health service in Wales was set to consist of six large health boards, one joint health and social care community organisation, one public health organisation, one ambulance service and one cancer trust supported by a possible all-Wales shared business services organisation. This led to a significant reduction in all management posts right across Wales, a process that is currently still ongoing. This organisational change has been radical but necessary to ensure a sustainable and affordable future for NHS Wales. All functions of the new health boards will be determined and overseen by a national delivery board chaired by the minister. UNISON has welcomed this progressive agenda and the eradication of numerous tiers of unnecessary and unaffordable bureaucracy.

This One Wales agenda has continued and will pursue further the public funding of hospital building programmes and reaffirm opposition to PFI/PPP. All outsourced cleaning, catering and other service (few as they were) have been returned in-house including those in a private decontamination facility. In addition, several hundred staff employed at one of the few inherited PFI hospitals have also returned to be directly managed by the NHS as NHS staff members, with a promise that the other two PFI facilities will at some earliest possible stage also return staff to the NHS.

The bargaining agenda has now evolved through successive governments and created an all-Wales NHS partnership forum, which negotiates on policy matters on behalf of NHS Wales staff. We have developed and will continue to develop all-Wales policies on discipline, grievance, dignity at work and

sickness management, which will operate universally across NHS Wales regardless of location. Ultimately, a ministerial view, supported by trade unions, is that NHS Wales will become a single employer, much in the same way as NHS Scotland currently operates. That bargaining agenda continues to evolve and UNISON plays a major role in all aspects of those negotiations as founder members of that body.

A number of challenges are, however, emerging as a consequence of the current economic downturn and the inevitable impact on the budget settlements to the devolved administrations. Dialogue has also started between the Welsh Assembly Government and the NHS trade unions regarding managing the consequences of the downturn, which could have a detrimental impact to the value of £200-£500 million. It is anticipated that the real impact will be at the lower end of that scale and the NHS will not be exempt.

We therefore face challenging times, but such are the consequences and responsibilities of devolution. The minister has assured us that there will be no redundancies, compulsory or otherwise, and that service changes and improvements can still underpin the modernisation agenda by adopting real partnership working to develop local solutions.

The ultimate challenge will no doubt be maintaining the radical agenda that we currently have into the next assembly government period from May 2011. There is a view on the Wales political agenda that a coalition government is attractive to the electorate and it may well be that a coalition government becomes the normal model of politics in Wales in the future. UNISON will continue to work with political partners in order to maintain and defend the gains made over the past 10 years in improving the working lives of NHS staff in all grades and disciplines across Wales.

# Northern Ireland

## Northern Ireland devolved health structures

Unlike the fragmented structures in the other Great Britain jurisdictions, the Northern Ireland health service integrates health and social care in a single structure.

Over the past number of years, the health and social care system has faced radical change as part of a wider government initiative to reform public services in Northern Ireland known as the 'review of public administration' (RPA).

The RPA was heralded as the most significant change in the management of health and social services in Northern Ireland since the creation of the internal market at the beginning of the 1990s.

The initial RPA health model, developed under the previous devolved administration, was supported by UNISON. However, it was radically altered by the Hain direct rule administration and vehemently opposed by us as it sought to transpose a failed English model of the NHS onto Northern Ireland. The first phase of super-trusts was a *fait accompli* at the point of the return of the devolved government. UNISON has sought with some success to alter the second stage model. However, commissioning remains our fundamental objection.

The first phase was completed in April 2007 with the establishment of five new integrated health and social care (HSC) trusts to provide health and social care in Northern Ireland. They replaced 18 trusts. There is also a Northern Ireland ambulance service trust.

The second phase in the reforms was completed in April 2008; it brings the following changes:

- A single health and social care board for Northern Ireland will replace the existing four boards – it will focus on commissioning, resource and performance management and improvement.
- A new Public Health Agency will incorporate and build on the work of the Health Promotion Agency, but will have much wider responsibility for health protection, health improvement and development to address existing health inequalities and public health issues for all the people of Northern Ireland.
- A new business services organisation will provide a range of support functions for the whole of the health and social care system, and the Central

Services Agency will be dissolved and the majority of its services, along with other functions, will be undertaken by the new organisation.

- A single patient and client council will replace the current health and social services councils, with five local offices operating in the same geographical areas as the existing trusts, thus providing a strong voice for patients, clients and carers.

For the first time since trade unionists were removed from decision-making structures by Thatcher, we have secured the return of trade union seats on regional boards. UNISON has secured membership of both the regional health and social care board and the new Public Health Agency.

Other changes include:

- a smaller and more focused department;
- the merger of the Regional Medical Physics Agency with the Belfast Health and Social Care Trust;
- the transfer of the functions of the Mental Health Commission to the Regulation and Quality Improvement Authority.

The Northern Ireland Practice and Educational Council, Northern Ireland Medical and Dental Training Agency, Northern Ireland Guardian Ad Litem Agency, Northern Ireland Social Care Council and Health Estates Agency will remain unchanged. The minister is currently giving further consideration to the position of the Northern Ireland Blood Transfusion Service.

One of the new trusts, Belfast, dominates the picture employing around one in 30 of the workforce in Northern Ireland. With a turnover of approximately £1 billion, it consumes 3-4% of the Northern Ireland Executive's budget.

## Some key UNISON Northern Ireland policy priorities

### Tackling health inequalities

The need to tackle poverty, social exclusion and health inequalities is a key UNISON priority and has been outlined in a number of government policies include 'Lifetime opportunities: Government's anti-poverty and social inclusion strategy for Northern Ireland' and the two main health strategy documents

'Investing for health' and 'A healthier future', published in 2004 (DHSSPS 2002 and 2004).

Whilst UNISON has been critical of the delays in implementation and in the achievement of outcomes, these policies set out a number of goals and targets including to increase life expectancy and healthy life years and reduce inequalities in health between geographic areas and socio-economic and minority groups.

In addition to the relatively high risk of poverty for lone parents, the unemployed, children, those with disabilities and Travellers in Northern Ireland, key challenges include the health impact of poor housing, an unequal education system, fuel poverty, obesity and food poverty. The history of past conflict also leaves a legacy, which must be addressed; it adds to the issues of economic development, poverty and social exclusion.

Some key inequalities include:

- a two and a half-fold difference in the rate of premature mortality between the managerial and professional class and those in routine or manual occupations (Joseph Rowntree Foundation 2006);
- much worse health outcomes in deprived areas – most evident in infant mortality rates, teenage births, admission rates to hospital and cancer incidence (DHSSPS 2007);
- a higher prevalence of long-standing illness among people in lower socio-economic classes, with 30% of professionals/managers suffering from long-standing illness compared with just under half (47%) of unskilled workers (DHSSPS 2004);
- a greater likelihood that people in poorer households will have borne the brunt of the Troubles, either in their areas or in their lives, than those in wealthier households (DHSSPS 2004);
- the relative income poverty (based on below 60% of median income) of 20% of the population (and 25% of children) over the period 2002/2003 to 2004/2005, accounting for 350,000 people (100 children).

### **Challenging the payments by results model and use of external providers**

UNISON has challenged the ongoing push by civil servants to introduce payment by results models, despite political declarations that this will not happen. We are currently opposing the ongoing use

of external providers including English foundation trusts and private ventures to deliver treatment in areas such as ENT, orthopaedics and plastic surgery.

### **Challenging privatisation and PFI**

The use of PFI in areas of high UNISON density is declining following sustained lobbying and campaigning. Examples include the exclusion of all support services from PFI deals at the proposed regional mother and babies hospitals in Belfast; and the exclusion of domestics from the Enniskillen Hospital PFI project, following the decision of the devolved executive, along with the subsequent exclusion of catering, portering, laundry and security staff in the bidding process. Although the PFI framework is still an option in the programme for government, all but one of the main health PFIs are now on hold.

The following are recent key interventions in our campaign for the review of the affordability of health PFI schemes and for the exclusion of staff.

- Overall PFI proposals are being reviewed resulting in all but Phase 1 PFIs being put on hold.
- A robust UNISON bargaining and campaigning process is now in place for Phase 1 projects.
- A submission was made to executive ministers on policy for hard and soft facilities management.
- We are aligning devolved policy for maintenance staff with no compulsory transfer principle in Northern Ireland government accommodation PFI projects.
- We are mainstreaming executive policy recommendations on equality, sustainability and regeneration in negotiations with current and potential PFI clients.
- An intensive local media campaign continues in Fermanagh and Tyrone on the threat of PFI to hospital workers and local food supplies – in September 2008 our protests on the selection of a preferred bidder, heavily reliant on bank loans, received extensive publicity via both the local branch and the regional secretary.
- Following the regional secretary's evidence to the assembly health committee, ongoing briefings have been issued to members of the committee as well as to members of the education and public accounts committees to assist them in their work and investigations into PFI.
- We have made a series of policy interventions and

given briefings to local members of the legislative assembly (MLAs), ministers and the department on PFI.

- A negotiating forum created by UNISON for the Antrim/Mid-Ulster/Whiteabbey PFI scheme held its first meeting in April 2008.
- Substantial delays now exist on the programme for a community health PFI building and UNISON continues to monitor the situation, having publicised our analysis that the NHS LIFT model would require new legislation in Northern Ireland; this has substantially damaged the prospect of this model being used.
- As a follow up to the government's decision to exclude domestics from health PFIs on grounds of cleanliness and cross-infection, we are now involved in departmental and local partnership projects and in the forthcoming departmental review of acute hospital cleanliness.

We were pleased to provide extensive evidence to our colleague Malcolm Wing, former UNISON head of negotiations and service groups, as part of the UNISON UK-wide review of the union's strategy on challenging privatisation and successfully securing in-house returns. Evidence was provided by branch teams, organising staff and public service employers in both health and education who are working with UNISON on partnership models designed to promote public services.

## The Northern Ireland programme for government and budget

The Northern Ireland programme for government, draft budget and investment strategy 2008-11 was released for consultation in November 2008. UNISON responded with three submissions to government, meetings with MLAs and a lobby of civic society.

It is very clear that this was a budget for the economy and not for health. The focus of the programme and budgeting process should have been a dynamic and interdependent process of economic and social advance. Instead the proposals focused on economic progress at the expense of concerted action to tackle economic, health, educational and other social inequalities.

Whilst we acknowledged the limitations on the executive with regard to generating additional revenue and the constraints placed under the

'Barnett formula', it is clear that public spending over the next three years will be financed by tax cuts for the wealthy (through the capping of rateable values and the freezing of the non-domestic element of the rate) and 3% 'efficiency' cuts, amounting to £790 million, in existing programmes and public services.

Responding to the budget proposals in health with a public campaign and major lobby of all political parties we proposed and achieved revised allocations:

- to further the implementation of the Bamford review on mental health;
- to reduce suicide and self-harm;
- to improve cancer survival rates;
- to increase care packages;
- to improve hospital cleanliness;
- to support young people in care.

We are now lobbying for the exemption of the NHS from 'efficiency savings' and a major rally was held at Stormont on 30 March 2009.

The efficiency savings being proposed mean a reduction in frontline services, job losses across health and social care, longer waiting lists and the privatisation of members' jobs resulting in a reduction in wages, terms and conditions and access to training. While we support an efficient and quality health service, we believe that cutting services is not a means of achieving this objective.

Services targeted for cuts include residential homes, trust home care places, acute, elderly and mental health wards, which face closure, and jobs in nursing, admin and clerical support. The result of cuts to these services means additional pressure on an already overstretched workforce and a poorer service to communities in Northern Ireland.

## UNISON building the future – projects that make a difference in health

UNISON Northern Ireland continues to develop innovative partnership models that can create jobs, improve job progression, healthcare outcomes and worker satisfaction and build union strength. These partnership projects continue to contribute to our membership strength and union capacity building in the Royal and Belfast City hospitals.

The West Belfast regeneration partnership project

is a partnership between UNISON, the Belfast Trust and the Greater Shankill and West Belfast community partnerships. It aims to create access to jobs for up to 100 people in long-term unemployment or economically inactive. This involves a pre-employment training programme delivered by local job assist centres. At the same time it is developing career paths in entry level jobs in the new trust. This includes creating new posts as stepping stones to higher grade jobs and a detailed in-service training programme.

The UNISON/Belfast HSS Trust infection control project is the successor to the 'Better ways of working' project, which was piloted at the Royal Children's Hospital in Belfast between 2004 and 2007. The renewed project now extends across both the Royal and Belfast City hospitals and aims to create a best practice, transferable model of partnership working that will improve the practice, skills and awareness of staff with regard to the causes, prevention and control of hospital acquired infection.

The UNISON/Belfast HSS Trust Northern Ireland care homes partnership was launched in January 2007. The partnership builds on the work of the UNISON/SEIU international action research project. Its key aim is to improve the quality of care in Northern Ireland care homes through organisational change based on the principles of 'person-centred care' – an approach which requires that the resident be treated with dignity, respect and equality at all times. The partnership is also focused on improving the working environment for members through improved education, training and other initiatives. The project is seeking to demonstrate that when partnership working is extended to the care home sector, public, voluntary and private providers can benefit from improved quality of care and other organisational outcomes.

## Bargaining in health

In 1993, the government suspended regional negotiations, but they were reinstated following the setting up of a new regional NHS negotiating body.

The disjointed nature of health service reform has resulted in a similarly disjointed approach to bargaining at both Northern Ireland and employer level. There is also strong evidence that the new trusts have been using the human resource

management model to weaken trade union organisation and collective bargaining.

UNISON recently called for a review of the constitution of the health service partnership to remove the confusion over its role and the role of the Northern Ireland negotiating council for health. The partnership constitution has now been rewritten and the negotiating council is reorganising the bargaining agenda.

The negotiating body will now meet on a monthly basis and all parties have committed to a programme of prioritising region-wide policies, which are to be agreed and signed off within a defined timeframe.

There continues to be confusion over the role and remit of local joint negotiating committees (JNCs). In response, UNISON has established monthly meetings of the UNISON leads facilitated by both the head of bargaining and representation and the head of organisation and development.

The democratic role of the regional health service group and its relationship with UNISON leads on JNCs has been clarified and key issues are now being addressed. These include a review of UNISON facility time within the health service. We currently have the equivalent of 30 full-time secondees. Agreement has been reached on accountability mechanisms for posts subject to full-time release overseen by regional organisers to maximise our resources. The regional committee, regional health service group and all lay structures have recently concluded an agreement governing UNISON release.

## Other bargaining and campaigning issues

UNISON is a lead union in the Irish Congress of Trade Unions (ICTU). Partition required that the congress develop a separate function in Northern Ireland in addition to the all Ireland dimension. To co-ordinate on business that involves both governments in Northern Ireland issues, a north-south structure has also been developed. The structure mirrors to a large extent the strands of the Good Friday agreement. A bilateral forum has now been established with direct rule in Northern Ireland. These structures should enable pre-consultation with the secretary of state, Taoiseach, ministers and civil servants. However, much effort is required to ensure that governments respond. The policy and research function of the

ICTU in Northern Ireland largely relies on input from UNISON and others.

UNISON also plays a key role in the north-south health services partnership, formed in 2001, which brings together user and community representatives, union leaders, employer chief executive officers and senior departmental appointees from both jurisdictions. Its key aim is to examine new ways of working at the local level to reduce health inequalities and promote better health outcomes north and south.

The core team and a wider staff team, together with senior activists are engaged in a range of other functions with government departments, non-governmental organisations (NGOs) and political parties including briefing, lobbying, written and oral evidence, parliamentary questions, etc.

Specific campaigns are developed by UNISON, often in conjunction with NGOs and community based organisations. This work is drafted by the core team and supported by lay structures. A range of policy sessions are organised with lay structures throughout each year.

UNISON works with all political parties to develop or influence policy. This process is intensive whether the assembly is in session or direct rule is in operation.

The non-application or adaptation of many Great Britain government policies to Northern Ireland also requires a continual monitoring system in Great Britain and is often contested by the administration of the state in Northern Ireland.

# Activities and next steps

Members of the health service group executive (HSGE) took part in a workshop on devolution at its annual general meeting in July 2009 and the chair reported back to the whole HSGE. Issues considered included bargaining, finance, policy concerns, partnership and the working of the HSGE.

There was consensus that the line should be held in relation to bargaining with all agreeing on the need to uphold UK national bargaining, rather than going down regional or local bargaining routes.

Likewise there was a general consensus on the benefits brought about by partnership working, and on the need for united UK policies on protecting NHS pensions.

The agendas of HSGE meetings need to be devolution-proofed.

In terms of next steps, it was agreed that:

- the HSGE devolution sub-group should continue to meet and that further moves would be taken to engage regional heads of health, such as through dedicated meetings with chairs of regional health committees and chairs of the HSGE (a possible date for a dedicated meeting could be just prior to conference with other ad hoc arrangements);
- on campaigning issues such as pensions and pay, there was a need for joint working (sharing papers, identifying common themes and issues, etc);
- setting up a web page could be explored;
- there was a need to disseminate as appropriate this report.

# Appendix: devolution motions at health conferences

## 2009: Motion 63 – Devolution

Conference welcomes the progress made in effecting motion 59 from conference 2008. The SGE has established an effective sub-group, which has catalogued a series of recommendations to ensure with the compliance with the protocol raised in 2004 in line with Rule D 2.9.5.

The health sector has also fed into the overarching review of democratic processes, which has been examining the role of sectors, devolution, and partnership between lay and full-time staff.

Conference urges the SGE to continue the good progress and seeks further action in implementing (2) (3) and (4) from the 2008 motion 59:

“2) Effective partnership working between full-time and lay colleagues in taking forward all the objectives of the union, including bargaining, social partnership, policy development, organisation and recruitment;

3) Decision making protocols for the SGE to ensure adequate time for consideration of proposals with regions and sector committees; informed debate, thus promoting development of clear recommendations to the wider membership on key issues;

4) Creating and maintaining effective relationships with the UK union, other sectors, regions, and branches.”

## 2008: Motion 59 – Devolution and the functioning of the service group executive

Conference proudly acknowledges that the activists and staff who support our health members at UK, regional and branch levels are second to none in their commitment, knowledge, skill and expertise. Conference recognises the enormous amount of work that has been done for the benefit of our members and UNISON in the face of huge challenges and pressures. Conference is well aware of the particular and intense spotlight that can shine on those who comprise our UK leadership.

Conference acknowledges the responsibility of us all to support and assist those who fulfil these roles. Conference believes that the health service group decision-making processes, around key policy matters and issues of terms and conditions, should

be positive and dynamic and therefore reviewed continuously to reflect experience and changing circumstances.

Conference notes that in 2004, UNISON national delegate conference endorsed a report on the impact of devolution on the union and, in line with rule D 2.9.5, the NEC has published a devolution protocol for bargaining, communication and policy development. The health service group executive (SGE) needs to operate effectively, efficiently and democratically. As an example, whilst agenda for change is a UK agreement, the ‘four nation’ employers are increasingly undertaking their own processes, and, on occasion taking different positions. The 2007 pay award being a classic example. The SGE must be able to respond to the impact of devolution.

The SGE is expected to show strong leadership politically, organisationally and administratively in a complex environment, making sure there is synergy of the constituent parts of the executive. With that in mind conference calls on a review of the way the SGE operates to include the issues below and report back to conference 2009 on recommendations for improving the functioning of the SGE.

A review group should be established, by the office bearers of the SGE, bringing together appropriate expertise and facilitation. Issues for consideration would include:

**1)** the impact of devolution and the wider more pluralist political relationships UNISON now has with administrations in the four countries particularly in the context of the agenda for change agreement;

**2)** effective partnership working between full-time and lay colleagues in taking forward all the objectives of the union, including bargaining, social partnership, policy development, organisation and recruitment;

**3)** decision-making protocols for the SGE to ensure adequate time for consideration of proposals with regions and sector committees; informed debate, thus promoting development of clear recommendations to the wider membership on key issues;

**4)** creating and maintaining effective relationships with the UK union, other sectors, regions, and branches.

