

July 2009

UNISON

Eastern Region

Sorry - can't afford nurses any more: we are commercial directors



A health worker's guide to 'World Class Commissioning'

An explanation of the whole complex of policies flowing from what has become known as "World Class Commissioning" could be a very long and complicated document.

So UNISON Eastern Region has decided to make it simpler, lighter, and easier to read, by dividing the whole issue into bite-sized chunks, rather like ministers have been dividing up the NHS and offering tasty morsels to the private sector.

We think it would be a mistake to take some of these ideas and ridiculous jargon terms too seriously, since few of them reflect any serious thought or content, none of them is based on any evidence – and most are used by senior NHS managers in the way a drunk uses a lamp-post: more for support than illumination.

So we will take some of the bizarre language of World Class Commissioning, explain its real meaning, and show how it fits together into a drive for privatisation and fragmentation of the NHS – policies UNISON has consistently opposed.

More detail on any of these issues can be found in UNISON Eastern Region's special newspaper *Eastern Eye* and from other sources.

"World Class Commissioning"

The new name for the discredited policy of "Commissioning a Patient-Led NHS" that was unveiled back in 2005 by then NHS chief executive Sir Nigel Crisp (later known as Lord Cheesy Wotsit).

The policy then meant splitting up Primary Care Trusts, and hiving off their directly-provided services. It was met by a storm of protest and was so unpopular that it lost Crisp his job, and key proposals were delayed by ministers. Now the same

proposals are being pushed through as "World Class Commissioning".

They do not tell us which part of the world they are copying, but "Commissioning" is the key word, meaning the separation of purchaser from provider – splitting the NHS into a "market".

"Competencies"

"Competence" may seem a strange word to associate with many Primary Care Trust bosses, but in this context a "competency" effectively means one of the standards by which PCTs are assessed by Strategic Health Authorities.

There are eleven "competencies" in World Class Commissioning, most of them largely harmless (even though worded in the most confusing and jargon-ridden language). But the most damaging one is Number 7 – "stimulate a local market" in health care.

"Stimulate a local market"

This has nothing to do with subsidising stall-holders: the requirement is to ensure that private sector providers, whether for-profit or allegedly non-profit, are encouraged to bid

for contracts to run services previously delivered directly by the PCT.

"Any willing provider"

In order to maximise the possible competition for local contracts, PCTs are required to draw up a list of services that will be opened up to literally any company or organisation prepared to do the job – "any willing provider" – and compile a list of private sector and other providers which claim to be willing to deliver services at the NHS tariff, and which pass a few minimal criteria for quality.

Step forward Delbooy and Rodney.

Obviously the views of patients and of NHS staff are ignored in this process.

"Transforming Community Services"

This is the general process of driving through these changes in PCTs in England. Few people know that an extensive 120-page document setting out a process for privatisation of PCT services was published in January on the Department of Health website.

Ministers have made no attempt to publicise it or discuss the policy with health workers or the wider public.

It is worth noting that in Scotland, where the NHS market has been scrapped and services reintegrated, and

in Wales, where the same process is under way, these policies do not apply.

There, devolved governments, listening to the concerns of their electorate, have stuck much more closely to the traditional principles and values of the NHS. We, on the other hand, have government from Westminster ...





FESC

Not a swearword from the cast of Father Ted (above), but yet another, more elaborate way of bringing in the private sector to tell PCT bosses how to spend their public sector "commissioning funds".

The DoH World Class Commissioning web page features a box urging PCTs to buy in external (private sector) "support" from an approved list of 8 city consultancies and private health providers to assist them in carrying through the programme:

"The support and development framework will give commissioners access to the tools they need to drive improvements, either by sharing services and good practice, developing internal resources, or buying in external expertise, for example through the Framework for Securing External Support for Commissioners (FESC)."

"External expertise"

Private management consultants. Price is no object: consultancy fees are generally in the region of £1,000 per consultant per day, plus expenses.

The big question is why highly-paid PCT directors and community service management teams are so lacking in expertise they need to be spending such large sums on external advice from companies with little or no actual knowledge of the NHS, health care, health workers or public services.

One of the private companies wheeled in to assist the NHS spend its money on "world class commissioning" is management consultancy Ernst and Young: but it is now clear that would not know quality care if it

injected them in the leg.

Their latest offering is a briefing document recommending that more patients must be persuaded to "switch" between GPs, creating a 'competitive tension' between them.

They advised 'NHS Primary Care Contracting' (another superfluous and costly body) that "a high level of patient 'churn' is essential to ensuring healthy competition".

One PCT boss went further and explicitly suggested that patients should be encouraged to swap GPs just as many have been persuaded to switch from one electricity or broadband supplier to another. Switching rates of up to 60 percent are described as "optimal".

How can this type of consultancy really be value for money?

"Contestability"

A weazle-word used by politicians and NHS bureaucrats who know that "competition" is a dirty word to many who value the NHS.

It means that there should always be an alternative provider available – in theory to put pressure on the NHS to improve, but in practice the only consequence is to undermine the public sector, force costs up, and force quality down.

"Third Sector"

Reminiscent of Tony Blair's "third way," in theory "third sector" organisations stand between for-profit private sector providers and the charitable, voluntary sector.

It includes not-for-profit businesses which retain surpluses rather than distributing them to shareholders as profits.

According to the DoH in 2007, just 2% of third sector organisations had budgets in excess of £5m, meaning that even the smallest PCT community services turnover would be off the scale in comparison with the firms examined by the DoH..

"Social Enterprise"

Unrelated to the famous starship or Captain Kirk, social enterprises are the businesses that inhabit the "third sector" – a galaxy not so far far away from regular business.

Social Enterprises however are all **outside** the NHS. Some time after they have transferred NHS staff on their existing terms and conditions, some may even attempt to invoke "economic, technical or organisational" reasons for changing their contracts – so union representation is vital.

There are over 55,000 social enterprises in the UK, turning over a staggering £27 billion each year. Two thirds of them provide health and/or social care in England, with an average turnover of £343,000.

Public schools, the Royal Opera House ... and even BUPA, Britain's largest private medical insurer, apparently all fit the model of "social enterprises".

But 84% of Social Enterprises are small organisations with budgets of below £1 million a year, and more than a third are tiny, with budgets of less than £50,000. More than half employ fewer than 25 people and in two thirds of social enterprises volunteers outnumber paid staff.

Handing large-scale business to these untested organisations is a massive gamble – by a government that has been on a losing streak for at least the last 18 months.

"Right to request"

PCTs are obliged to consider requests from "staff" under the 'Right to request' a social enterprise: but the formula is deliberately vague on how many staff at what level are required to make the request in order for it to go ahead.

This leaves the possibility of a tiny group of managers effectively hi-jacking the remainder of a provider arm workforce into a Social Enterprise that few if any of the other staff actually want or support.

With trade unions largely excluded from any involvement in decision-making, there is of course NO trade union "right to request" that managers drop unpopular proposals for a Social Enterprise, or any right for staff to appeal against a scheme or demand a ballot on whether a scheme should go ahead.

In Surrey for example 84% of staff voted in 2006 AGAINST the formation of the much-touted Central Surrey Health company as a "social enterprise" – it was launched anyway.



“Engagement”

No promise of matrimony here, but a false promise by NHS bosses to consult with and listen to staff. There is little evidence of this anywhere in Eastern region.

“Clinicians”

This is the phrase to describe GPs, consultants or nurse managers who we are told support the proposed changes floated by PCTs and community services management.

Seldom are these people ever identified, and no evidence is ever provided that these alleged clinicians actually support the proposals on the table.

Any clinical staff who do NOT support the proposals are, of course, ignored under the provisions of “engagement” above or “consultation” below.

“Consultation”

The process whereby PCTs and community service managers claim to invite and respond to the views of the local public and NHS staff.

However there are virtually no examples of consultations in the NHS ever resulting in a change of policy – or even answering any of the hard questions asked by a sceptical public.

Many PCTs and NHS Trusts have now substituted the more expensive but less troublesome process of consulting *with lawyers* to discover obscure reasons why a formal consultation is not necessary.

Some have gone further, and opted out of consulting even their own staff: this was the view adopted by Great Yarmouth and Waveney PCT bosses:

“the best practice is to consult with staff, but we will only use the 90 day consultation if redundancy is involved, which it is not.”

“Stakeholders”

These are people assumed to agree with the controversial proposals put forward by SHAs, PCTs or community service managers. This term of course excludes front line staff and any informed elements of the public. These are to be ignored under the provisions of “engagement” and “consultation” above.

“Independent Sector”

This is the private sector – generally the for-profit private sector, since non-profits are normally described as “social enterprises”.

“Innovation”

New ways of bringing in the private sector.

“Commercial director”

Someone paid a very large salary by the public sector to find new ways of bringing in the private sector to deliver services at greater cost, with more bureaucracy, in a more complex and fragmented system. The NHS managed very well for 60 years without any commercial directors. Now they are everywhere!



“NHS Partners Network”

The grasping private for-profit providers invited by Tony Blair in to the “NHS family”. They are very happy with World Class Commissioning and especially pleased with the establishment of the “Cooperation and Competition Panel” (see below).

They have encouraged ministers to go even further, but would be equally happy to see David Cameron’s Tory boys and girls take up the task.

“Cooperation and Competition Panel”

This “arm’s length” organisation has been set up as an appeals panel for aggrieved private sector bosses looking for a way in to local NHS services.

The Panel was set up last autumn with the explicit purpose of encouraging private sector providers to raise complaints that they have been unfairly treated, and that a local area has not been sufficiently opened up to competition between would-be providers – whether this be in community services, primary care, mental health or acute hospitals.

No equivalent right to appeal exists for NHS Trusts, Foundation Trusts, health workers local communities or patient groups convinced that their services would be better delivered by a public sector organisation.

The Panel is chaired by former private healthcare and nursing home boss Lord Carter of Coles, whose appointment was eagerly welcomed by the private sector. Its members are all from the private sector or professions, none of them with any record of commitment to public services.

Interestingly the Panel does not regard the million-plus staff who deliver NHS services as part of the long list of local, national, and institutional “stakeholders” (see above) it seeks to work with.

“Stakeholder organisations” exclude UNISON, representing 400,000 health workers, and any other TUC-affiliated unions

“Price fixing”

This is a term used by the Competition Panel to oppose two or more NHS Trusts agreeing a minimum sustainable price for a service.

It appears that the Panel could even decide that the Department of Health’s Payment by Results (see below) tariff of fixed costs for NHS Trusts could constitute “price fixing”, allowing a price war over health care.

“Predatory pricing”

This term suggests a Jurassic Park clash of monsters in a red-toothed battle for supremacy: actually it is the Competition Panel’s way of preventing local NHS trusts

charging too low a price for treatment, to squeeze out potential private sector organisations which are hampered by the need to make profits.

“Collusion”

Two or more NHS organisations working together to improve services and ensure access to care. This might be seen by some (such as UNISON) as the way the NHS should work: for the Competition panel it is an obstacle to competition between providers and the development of a market in health care - and so must be stamped out.

“Monopoly”

Where a single NHS provider organisation meets the health needs of its local population. This is seen as a bad thing by the Competition panel which wants rival organisations to contest and compete for every contract, regardless of the waste of management time, resources and money, and regardless of the problems this creates for planning services.

“Payment by Results”

This misleading phrase has nothing to do with results, or with clinical outcomes: it is the fixed scale of national charges for treatment which must be paid by Primary Care Trusts for any work done by NHS Trusts.

Trusts now only get paid on this tariff for the patients they treat: any patients diverted to other providers take the funding

with them in Margaret Thatcher’s old phrase “the money follows the patient”.

So where a private sector provider takes over a service, the money would follow the patient out of the NHS. Payment by Results is at the very core of the new market in health care – but it only applies to NHS hospitals.

Private providers get paid more, they have fixed, long –term contracts on a “play or pay” basis that guarantees their income even when they treat far fewer than the contracted number of patients. So the cuts are focused in the public sector and the profits are scooped up by the private providers.

“Foundation Trusts”

These organisations are not-for-profit corporations in which staff remain NHS employees, but management are no longer part of the NHS management or accountability structure.

Foundation Trusts answer not to the Secretary of State for Health, but to an “independent regulator” known as Monitor (see below). Monitor assesses applicant Trusts not on the basis of the quality of health care or the provision of comprehensive and accessible services (neither of these is part of the regulator’s brief) but as businesses.

Ministerial claims that Foundation Trusts would be ‘accountable’ or ‘responsive’ to local people have been discredited by mounting evidence that many existing FTs

are now even more secretive than regular NHS Trust Boards (which themselves had to be INSTRUCTED in 1997 by health minister Alan Milburn to hold meetings in public and to publish their board papers).

More than 75% of FTs now hold their Board meetings behind closed doors, with the press, public and even local council scrutiny committees excluded.

“Community Foundation Trusts”

These elusive creatures appear to offer PCT provider staff the only real hope of remaining NHS employees and not being privatised to a for-profit or “social enterprise”. But it may be a faint hope. So far not one Community Foundation Trust yet exists, and at present applications to join “pilot” CFT programmes are limited in number.

“Monitor”

A large a frightening lizard – and also the name for the regulator charged with keeping track of Foundation Trusts.

Monitor is itself heavily privatised, and notorious for its heavy reliance on management consultants, including many from McKinsey’s to international management consultancy based in the USA, where health care is more expensive, less efficient, more bureaucratic, more dangerous and more exclusive than in any other wealthy country.

It’s good to know they are bringing their “external expertise” (see above) to help out the low-cost, universal and much more efficient NHS.

Monitor’s lack of any real quality criteria were exposed recently by the Mid Staffordshire hospitals scandal, where the Trust whose abysmal standards were killing patients had been rubber-stamped for Foundation status with no questions asked just before the revelations hit the headlines.

“Towards the best, together”

This is the deceptive title of the nebulous strategy document put forward for a large-scale public consultation last year by NHS East of England.

The SHA proudly displays this on its website – even though the document made no reference to the proposals either for a competitive market in health care or for World Class Commissioning.

The public could easily have been told of these controversial plans and asked their views: SHA bosses decided not to ask.

Now the SHA keeps fobbing off the unions with promises of discussions and a refusal to consult on the proposals it has been effectively imposing on PCTs.

Far from moving towards the best, or wanting to go together, they have so far been charging towards the private sector, ignoring the workforce and the local communities whose services are at risk.



Join UNISON’s campaign to defend our public health service

If you want to work with UNISON to try to stop this vandalism that is threatening vital services for some of the most vulnerable NHS patients, there are things you can do:

- If you are a health worker, and not yet a member of a trade union, make sure you join UNISON, the biggest health union – and link up with our local branches and Eastern Region. To join, ring UNISON Direct on 0845 355 0845.
- If you are already a UNISON member, make sure you distribute copies of this information sheet to colleagues at work and to friends and neighbours. Make sure your branch gives regular updates, and seeks to work with local campaigners to defend NHS services and challenge privatisation and social enterprises. You can get more copies of this information sheet from UNISON’s Regional Office on 01245 608904/01245 608932.
- Why not become a UNISON rep or shop steward? Call 01245 608904/01245 608932.
- If you are a member of a community organisation, contact us for extra copies of this information sheet to help spread the word on what is happening, and make sure your organisation discusses the threat to health services and writes to local councillors and MPs urging them to take action.
- MPs can lobby Health Secretary Andy Burnham and other health ministers, and can put down Parliamentary questions to draw this issue into debates in the House of Commons. Councillors can press for local Scrutiny Committees to call in PCT bosses and challenge their plans and their refusal to consult with local people on such fundamental changes to the NHS. But they are not likely to do so unless they feel the pressure of an angry public behind them.

We still have some time to stop these dangerous experiments being carried out: UNISON wants our services kept intact and kept firmly in the public sector – for the good of our members, our patients and the wider public interest.

Join UNISON: ring UNISON Direct 0845 355 0845