FRAGMENTING THE NHS

Dangers to staff, services and patients from ‘social enterprises’

A special report commissioned by
UNISON Oxfordshire Health Branch

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Introduction: new NHS market

The government is pumping tens of millions of pounds into schemes to encourage NHS Trusts and services currently provided by Primary Care Trusts to reorganise as "social enterprises" or "third sector organisations" – running as not-for-profit companies. The government vision from next year is that an ever-larger section of the NHS service providers should be broken up into Foundation Trusts and so-called Community Interest Companies.

The NHS itself would effectively be reduced to a fund for the purchase of services from a variety of providers including Foundation Trusts, private sector hospitals, treatment centres and other clinical services (delivering services for profit, financed through the NHS), together with a range of new "not for profit" providers including social enterprises (1) in a new, competitive "market" for health care.

In UNISON's view this would threaten the eventual collapse of the NHS as a system allocating resources and delivering services on the basis of social and clinical need rather than on financial and market criteria, because the expansion of private sector provision (which is more expensive than existing NHS services) would concentrate in the acute hospitals sector, draining additional funds from less commercially attractive (and already under-resourced) services such as mental health, learning disability, and care of older people.

1 This long term strategy was most explicitly described in the controversial 2005 Department of Health circular "Commissioning a Patient Led NHS" drafted by NHS Chief Executive Sir Nigel Crisp, and by subsequent documents implementing aspects of these policies, notably the reorganisation and merger of PCTs and of Strategic Health Authorities into even larger and less accountable organisations.

UNISON regards the whole strategy for reorganisation as a nightmare vision that would put many vital services for vulnerable people at risk, undermine the quality and accessibility of many more services, and pose a very serious threat to the jobs, pay and conditions of NHS staff, many of whom would find themselves employed by companies outside of the NHS and run on commercial lines, with even less local accountability than there is at present.

In other words the very market system that the Boards of some Trusts and PCTs seek to embrace is likely to undermine rather than strengthen the viability of any Foundation Trust or social enterprise which might be established in the period ahead.

It is not a formula for stability and security among Trust staff, but of permanent uncertainty as powerful private sector players press their demands for an even larger share of the NHS budget, pushing less high profile services even further to the margins.

There would be little if any democratic control to protect existing services against proposed disinvestment by commissioners or by the new business-style providers looking to maximise surpluses and eliminate losses.

How did we get into this situation?

Two years ago the government made clear its ambition to divest the Primary Care Trusts (2) of the majority of their directly-provided services, reducing them to a purely commissioning role. This would inevitably result in the NHS being reduced to little more than a centralised fund to pay for treatment commissioned from this new range of providers. This treatment would be purchased within an increasingly competitive market system in which:

- the commissioners (purchasers) would be the newly-enlarged and even less democratic or accountable Primary Care Trusts – some of which are already looking to hive off their commissioning role to private sector corporations.
- the service providers would no longer be in any way locally accountable – through relatively local Trusts and PCTs: instead they would be answerable only at national level, through "regulators" which report not to the Department of Health but to Parliament or even – in the case of social enterprises – to the Department of Trade and Industry .
- In fact even this level of accountability is largely an illusion: while Monitor, the office of the regulator of Foundation Trusts, is in theory answerable to Parliament, we have already seen health ministers refusing to answer MPs' questions on the conduct

2 Primary Care Trusts were set up in 2002 to combine the delivery of public health, primary care (GP services) many community health services and often mental health care with the commissioning (purchasing) of hospital services for their resident population. PCTs have subsequently been reorganised twice, most recently last year when many were combined to form county-wide bodies.

and services of Foundation Trusts in their constituencies – which no longer report their figures and performance to the NHS, but work exclusively with Monitor, the regulator.

Putting all these factors together it is clear that far-reaching and highly controversial changes are being proposed to alter the fabric of a National Health Service formed almost 59 years ago to replace the chaos and failure of a "mixed market" of private, charitable, voluntary sector and municipal provision. A new "mixed market" is being created by New Labour's "modernising" reforms, and UNISON is convinced that it will have the same unhappy results as it did prior to 1948.

Justifying the need for change

NHS bodies promoting these latest changes argue that there is no choice but to reconfigure Trusts and PCT services as a completely different type of organisation – either as a so-called "social enterprise" completely outside the NHS (while retaining the use of the NHS logo), or as a Foundation Trust – again outside of the main structures of the NHS accountable only to an "independent regulator", Monitor.

We will examine these proposals in more detail below: but there are reasons to believe that this stark choice is misleading, and the NHS managers are exaggerating the scale and significance of the pressure for organisational change. In fact it is clear they are implementing their own agenda – regardless of the concerns of staff, service users and the local community.

The most categoric statement of government policy requiring Trusts and Primary Care Trusts to reorganise came in the highly controversial July 2005 letter – entitled "Commissioning a Patient Led NHS" – from the then Chief Executive of the NHS, Sir Nigel Crisp, which offered a confused and confusing blueprint for wholesale privatisation and reorganisation of our health service.

Crisp envisaged an NHS in which the public sector provision of health services through PCTs and NHS Trusts would be reduced to a bare bones minimum, with the main focus shifting to "commissioning" care, with the NHS regarded as a vast insurance fund to pay for treatment, making maximum use of contracting out to a variety of private sector providers, Foundation Trusts and so-called "social enterprises".

There were widespread protests from both trade unions and Labour back-benchers over Crisp's scheme, which turned out to have been hatched up by a few back-room mandarins and health ministers without any wider discussion. After months of protests and pressure some of the more outlandish proposals were toned down, postponed or dropped: Patricia Hewitt even came to a UNISON seminar and apologised for having got it wrong.

But her apology was worthless: nothing had really changed. So, having learned nothing and forgotten nothing, ministers last year again triggered a summer of controversy … this time by advertising to invite private insurance companies to take over control of a large slice of the £64 billion NHS commissioning budget. The *Financial Times* health correspondent Nick Timmins concluded that:

> "The move is likely to attract interest from the big US insurers such as United Health and Kaiser Permanente, Discovery of South Africa, BUPA, PPP and Norwich Union in the UK, and possibly German and Dutch insurance funds."

At first sight the very notion was a sick and silly joke: putting these companies in charge of the NHS budget would be like putting Hannibal Lecter in charge of liver transplants. To make matters worse, there is of course not the slightest shred of evidence that these insurance companies – which specialise in screening out and excluding potential subscribers with pre-existing illnesses, chronic conditions, and of course the low-paid and unemployed who cannot afford their premiums – have any relevant or useful expertise that could inform the commissioning of a comprehensive health care service for a whole resident population of a PCT in England.

It seemed possible that the whole story was an exercise to test out the public response … until it was revealed that an advert had been placed that week in the Official Journal of the EU, inviting companies to bid for framework contracts to deliver commissioning and management services to PCTs. The terms of this invitation made it quite clear that virtually all aspects of the PCTs' role were to be offered out to private bidders:

> "This will include, but not be limited to, responsibility for population health improvement, the purchasing of hospital and community care, supporting local GPs develop practice-based commissioning [sic], the management and development of community health services for the PCT resident population, and other services."

Handing over to the insurance companies

This plan to allow the private sector to get its hands firmly on the vast NHS commissioning budget followed on the formula first put forward by Thames Valley Strategic Health Authority for Oxfordshire in 2005, which proposed to merge five Oxfordshire PCTs into a single body – and to hand over responsibility for commissioning (and thus control of the resulting £600m budget) to a private company (widely rumoured to be United Health).

The Oxfordshire plan generated such a unanimous tide of local protest, linking all parties in condemnatory votes on the County Council, inflaming the anger of GPs, winding up trade unionists and galvanising MPs in opposition, that ministers were eventually obliged to step in and call a halt to the experiment.

The SHA was told by health minister Lord Warner to drop – or at least postpone – its plans, and it seemed that the issue of privatised commissioning had been put on the back burner. And again in 2006 the initiative was once more brought to a premature halt: an

advert was withdrawn as a result of unexplained "drafting errors", and a letter from Hewitt was hastily published, attempting once again to assure an even more confused and sceptical public that there was no plan to privatise the NHS.

The 2006 White Paper *Our Health, Our Say …* became a significant new element driving Primary Care Trusts towards further and faster privatisation and "outsourcing" of services, reviving the Crisp plan to reduce PCTs' role to commissioning services. Last summer a Department of Health implementation document Making it Happen again stressed the need for "better partnership working with third and independent sectors".

But *Our Health, Our Say …* is a White Paper, not legislation: and it also seeks to create the impression that service users, staff and other stakeholders should be involved in decisions rather than simply being confronted by a fait accompli in the form of a new organisational structure dreamt up and imposed by a local Trust board or PCT.

So what is a "social enterprise"?

Figures vary from one account to the next, but it appears from government sources that there are something over 55,000 social enterprises in the UK, turning over a staggering £27 billion a year – an average of around £490,000 each. More than half of them, 35,000 organisations, currently provide health and/or social care in England, with an average turnover of £343,000, and another 1,600 plan to do so in the next 3-5 years.

The average figures are deceptive, however, since 84% of them 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.

37% of those providing any form of health care concentrated on advice, with another 10% offering counselling and 15% offering alternative therapies. Just 2% of third sector organisations have budgets in excess of £5m, meaning that even the smallest NHS Trust turnover would be off the scale of the most recent Department of Health report.

(Third Sector Market Mapping, Department of Health February 2007)

Social enterprises fall into a so-called "third" sector which is a woolly category or organisations ranging from voluntary sector organisations and charities (with their uneven record on accountability, employment practices, trade union recognition and quality of services) through to "social enterprises" and 'not-for-profit' companies which run to all intents and purposes like a normal private business. Public schools, the Royal Opera House … and even BUPA, Britain's largest private medical insurer, apparently all fit the model of "social enterprises".

Ministers have insisted that Foundation Trusts – as not-for-profit public corporations – are a form of "mutual" provision and a variant of a social enterprise, but the other main form of social enterprise which NHS managers are being encouraged to adopt is that of the Community Interest Company (CIC) based on legislation pushed through in 2004. A CIC has many of the commercial freedoms attached to public limited companies, but does not distribute profits. Different varieties of CIC include companies limited by guarantee and companies limited by shares (3).

Cooperatives are another potential option, as is the launch of a charitable company, but this requires dual registration both with Companies House and with the Charity Commission, and is quite restrictive. Of all of these options, only Foundation Trusts would allow staff to retain their employment within the NHS.

In July 2006 a policy paper from the "Third Sector Commissioning Taskforce" was published by the Department of Health, entitled 'No excuses. Embrace partnership now'. It emphasised the government's relentless drive towards this and other forms of privatisation:

> "delivering health and social care services is no longer the preserve of the public sector, and … third sector as well as private providers have a valuable role to play in shifting the balance of provision closer to where people live, and the type of responsive services people want."

Indeed: local PCT bosses are now being urged to develop "partnerships" which not only privatise the living, but also aim hive off the dying to various outsourced forms of care, with a brief to:

> "explore current and potential community resources, including workforce, community hospitals, third sector, independent and social enterprise provision; and create End of Life networks"

But while it is clearly true that the Department and ministers have kept up the pressure on Trusts and PCTs to implement market-style reforms and contract out more care, it is also clearly the case that popular campaigns have been able to hold back this process, inflict reverses on some key policies, and protect many local services against cutbacks.

What of the claimed advantages of a new model?

1) NHS managers supporting social enterprise and Foundation Trusts argue that the organisational models they propose would result in staff having more say on terms and conditions. However there are three obvious reasons why UNISON is unconvinced that this would be the case:

a) All of the evidence of the formation of Foundation Trusts and the transformation of NHS services into so-called "social enterprises" is that these are initiatives devised,

3 Shares are issued to stakeholders including staff but carry no entitlement to dividends and no resale value.

planned and carried through by management regardless – and generally in defiance – of the wishes and views of staff.

In Surrey 84% for example of staff voted last year against the formation of the much-touted Central Surrey Health company, which was launched anyway. It now employs around 650 nurses, therapists and support staff formerly employed by the local East Elmbridge and Mid Surrey PCT. Two former senior PCT staff who had spent 18 months working to establish the company took over as management, completely ignoring the views of their staff and their main unions, UNISON and Amicus.

If staff can be so blatantly ignored and taken for granted in establishing these new organisations, which are to be structured and run as private businesses, why should we believe staff would be any more influential once the new business is up and running, and accountable only to Monitor or a regulator operating through the Department of Trade and Industry?

b) Terms and conditions for NHS staff are covered by national agreements, most recently and comprehensively renegotiated in five years of talks on Agenda for Change. This agreement covers many issues of pay scales, hours, holidays and premium payments. So the only way staff could be given "more say" over pay and conditions would be if the Trust were to tear up the Agenda for Change agreement and establish local pay agreements, as happened in the mid 1990s under the Conservative government's NHS Trusts.

Where BUPA is king

"In healthcare the UK experience of social enterprises is too limited to draw any firm conclusions. The most successful social enterprise in the sector is BUPA which has achieved market leadership in health insurance and private hospitals."

Kingsley Manning, Newchurch Briefing Paper June 2006

Foundation Trusts have always argued that one of the "freedoms" they seek is the freedom to vary NHS pay scales – but UNISON is painfully aware from past experience of local pay bargaining in the NHS that such variations can move downwards as well as up. And once the national agreement is gone, there is no basis left to uphold the basic minimum NHS pay scales.

To make matters worse, the huge waste of managerial resources in seeking to negotiate and maintain local pay bargaining is likely to be a short-term on-cost that the social enterprise or Foundation may try to avoid – by imposing pay structures and settlements unilaterally, or even by derecognising the unions. The track record of voluntary sector and charitable organisations as employers is pretty poor, and while they will be keen to carry through their restructuring with minimal opposition from union members their willingness to recognise trade unions in the medium and longer term should not be assumed.

Once a social enterprise has floated off from the rest of the NHS, the power and negotiating strength of UNISON to represent members will depend entirely on the level or organisation and self-confidence of the stewards and members in that particular company. Only those certain that they have local level leadership and membership strong enough to take on such a trial of strength should even consider the gamble that is involved: management will be closely scrutinising the union's responses to some of their potentially damaging proposals to gauge how far they can press for future concessions on pay, hours and working conditions.

In cases where managers feel able adopt an arrogant or bullying approach and have members intimidated before a switch to social enterprise status, we can expect their attitude to be even worse afterwards.

c) In any Trust which transforms itself into a community interest company (CIC) staff would strictly speaking no longer be employed by the NHS. Existing staff would initially transfer on their same terms and conditions under TUPE regulations, but this offers no long-term protection: the new company could simply give notice and rewrite staff contracts. Agenda for Change, and any future nationally agreed uplifts in pay, would therefore no longer apply – indeed the fragmentation of the NHS into a myriad of small and self-contained organisations my make a national pay system impossible to sustain. And while it has taken years to force private contractors working with NHS Trusts to raise their pay rates and conditions to match those of Agenda for Change, there is no similar obligation on "social enterprises", which will be free to run a 2-tier workforce.

2) Those defending the restructuring to create social enterprises and Foundation Trusts argue that staff and service users would be able to "become more involved": but if they really want to be more inclusive, there is nothing to stop Trusts and PCTs opening up spaces on the Board or co-opting people on to working committees right now. The new Boards of Governors have no real say on Foundation Trust policy, any more than the shareholders in the Central Surrey Health company who have been dragged into the new structure against their will.

In other words all of the complex and costly trappings of democracy and accountability would in reality leave the core of the Trust management structure entirely unscathed. But there would be the huge additional secretarial task of administering a list of members, keeping it up to date, sending out communications, and running spurious "elections" to an impotent "Board". The net impact on local accountability would be zero, but the bureaucratic costs could be considerable, for no tangible benefit.

3) Advocates of social enterprises and Foundation Trusts claim that a new organisational model could give them more control over their finances – but this is only partly true.

Of course on the one level withdrawing from the NHS management structure and "local health economy" ***would*** relieve a Trust of its obligations to make cash cuts and efficiency savings to bail out deficits in other Trusts and local PCTs. But it would be wrong to conclude from this that Foundation or social enterprise status is any kind of magic 'get out of jail free' card guaranteeing financial stability.

The reality is that the Foundation/CIC and its services – in whatever form – would remain, as now, totally dependent upon contract income from the local PCT and social services (and possibly also from GPs if they are forced into greater levels of "practice-based commissioning"). So if there are financial pressures in the local area/county, it is highly likely that these will be transmitted to the Trust in the form of restricted or reduced contract income – either requiring fewer services, or requiring the Trust to do more for less.

4) Supporters of the idea claim that a social enterprise would be able to borrow more freely and access more in the way of community loans and grants than Trusts do now.

Sadly this is not the first time that NHS managers have been lured into accepting changes on the false promise of access to credit and development capital – which in almost every instance proves to be an illusion.

Back in the early 1990s, the Conservative government, floating its internal-market reforms in the NHS, advocated the formation of NHS Trusts as "public corporations" that would be allowed freedoms including varying local pay rates and … borrowing additional money. But even before the first Trusts had launched this glimpse of freedom had been withdrawn, and Trusts found out they faced the same cash limits as before.

More recently the New Labour government in launching Foundation Trusts as part of a full-scale competitive market in health care also hinted that they would enjoy enhanced powers to borrow from the private sector as well as privileged access to public development capital. Once again this proved a cruel deception, with few Foundations running a sufficiently large surplus to allow them to borrow significant extra sums from anywhere.

UNISON is not convinced that Gordon Brown as Chancellor or Prime Minister will allow an unregulated borrowing spree by fledgling social enterprises. Managers who seriously believe this to be the case should check out the evidence so far, and demand some written guarantees before gambling on an uncertain future.

Living in denial

Those arguing for the switch from NHS Trust to social enterprise have heatedly denied that this means:

- privatising services
- undermining employment security or making job cuts
- making decisions without involving everybody

The final claim is clearly false: there has been no consultation anywhere which genuinely allows anyone other than the Trust Board to decide on the options and make the final decision.
But the fundamental deception centres on the claim that establishing social enterprises does not constitute privatisation. Because whether they admit it or not, a Community Interest Company IS a form of privatisation. It would take services out of any framework of NHS planning, and each CIC management would be obliged to run their new company just like any other private company.

And while they would not be allowed to distribute any profits to shareholders, there would be nothing to prevent a CIC from generously distributing some of its surplus as bonuses or enhanced salaries for top managers, and paying their directors much more. Community Interest Companies will be subject only to "light touch" regulation, not through the Department of Health but … the Department of Trade and Industry, and registered at Companies House! Is that where health workers see their future?

NHS Trusts may try to argue that they are not at this stage proposing restructuring as a means to impose job cuts: but UNISON is fearful that any attempt to function as a business and generate increased surpluses could well force even well-meaning managers down that road. We know that some are already looking to pay any new recruits lower wages and offer them inferior terms to improve the new company's competitive position.

"Not for profit" can be misleading

"A Community Interest Company is first and foremost a limited company carrying on a social activity and must be viable as such. A CIC carrying on a business will need to generate surpluses to support its activities, maintain its assets, make its contribution to the community and in some cases make a limited return to shareholders. … The phrase "not for profit" is frequently used in this area. This can be misleading and should only be used in the context of the company not having as its primary purpose the generation of profits for private investors. If a CIC fails to make profits from its activities (or in some way generate sufficient income to cover its running costs) it will eventually fail altogether."

(The Regulator of Community Interest Companies, September 2006)

The new companies would still be entirely dependent on funding from PCTs and in some cases social services – many of which are themselves facing increased pressures. If cuts in jobs and services are required as a result of this, it will be of little consolation to staff to find the letterhead notifying them of redundancy carries the name of a company rather than an NHS Trust: indeed their long-term redundancy rights may well be better protected as part of the NHS than through a brand new company.

How would the change benefit services?

We have shown why some of the claimed advantages of reorganisation are pipedreams, which effectively mislead people into expecting much more from the changes than can be achieved. The expectation of extra borrowing is largely an illusion, and Foundation Trusts are "accountable" only to Monitor, while Community Interest Companies are only accountable to the Department of Trade and Industry!

Among the claimed "advantages" of social enterprises and Foundation Trusts are that they would:

- no longer be tied to NHS targets and obligations – although it is obvious that if the organisation departs too far from these targets it will not secure the contracts and funding it needs from PCTs.

- be free to choose how and where to spend its money – except again that if it invests in services which are not priorities of the NHS and social care, it will face mounting difficulties.

- face an "asset lock" preventing it from selling or giving away its assets to private companies. This is not quite true, since the only prohibition is on selling assets below their market value to any organisation which is not also a social enterprise. The regulator can grant permission for the company to dispose of assets as long as the receipts flow back to the company and are not distributed to shareholders or directors.

- be able to use the NHS logo and continue to work within the 'NHS family': this is an advantage precisely because of the values of public service associated with the NHS – values which are not associated with companies of any sort, whether for-profit or non-profit. We believe that the NHS should remain as more than a kite-mark or "brand" – and should continue as a provider of public services

- be very accessible to users, staff and the public, who would "be involved as full and authoritative members in running the organisation": however we know this is not actually the case. Indeed one of the largest social enterprise projects so far in health, Central Surrey Health, was formed despite the express opposition of 84% of UNISON members responding to a ballot, but "as yet members of the public have not become co-owners".

84% of staff said no: but managers pressed ahead

"ABOUT 650 nurses, therapists and support staff have quit the NHS and officially taken over the running of nursing and therapy services in Mole Valley as part of a radical shake-up of the NHS.
Central Surrey Health … is a non-profit making limited company owned and managed by the nurses and therapists themselves and is the first of its kind to be introduced in this country.
The new service, costing in the region of £20 million for a three-year contract, is backed by the East Elmbridge & Mid Surrey Primary Care Trust (PCT) board of executives and the Government.
Healthcare staff will, in effect, sell their services back to the local PCT and hand back control to core nursing and care staff.
Two former PCT senior employees will jointly run the service: Jo Pritchard, a former director of nursing and primary care; and Tricia McGregor, the PCT's former director of therapies. Both have spent the last 18 months developing business plans and ideas to get the project off the ground.
…
Each member of nursing staff received a single 1p share in the new company and will retain their existing NHS benefits, pensions and contractual terms and conditions. If they leave the company, shareholders will forfeit any dividend.
Jo Pritchard said: "Central Surrey Health will offer top-class nursing and therapy services to the people of central Surrey. It will do this by combining a strong commitment to NHS core values and principles with the benefits of a social enterprise model and real staff involvement."
Although it was launched on Sunday, more than 84% of staff in a recent survey were opposed to the changes with some staff feeling a sense of bereavement at leaving the NHS.
Unions, including AMICUS, claimed little consultation was carried out among staff before the proposals were consulted on and a decision made."

(*Surrey Advertiser* **6 October 2006)**

How would social enterprises affect the rights of NHS and other staff?

PENSIONS

Existing NHS employees face a number of potential problems if their Trust or PCT opts to restructure all or part of itself as a Community Interest Company. It would mean they would cease to be employees of the NHS, and there are serious doubts whether or not it will prove possible to organise continued access to the NHS Pension Scheme, which is one of the most attractive public sector schemes and a considerable and valuable asset to all staff.

It has been claimed that only "some forms" of social enterprise would result in staff losing their NHS pension scheme membership – despite the fact that this is widely recognised as one of the biggest problems faced by "third sector" organisations (see the Health Service Journal 15 February 2007:14-15).

Just one – highly publicised – social enterprise, Central Surrey Health, has managed to negotiate a special arrangement through which its 650 staff can remain in the NHS Pension Scheme, but this is so far the exception that proves the rule. And so far no scheme has been announced to enable new recruits to a social enterprise outside the NHS to join the NHS scheme: it is most unlikely that this will be agreed.

In other words, the safeguard of retaining NHS pension rights covers only those members of staff who would be the first transferred to the new company: any later recruits would inevitably face reduced pension rights – especially if they had not previously worked in the NHS. Social enterprises would begin to develop their own two-tier workforce, like many other organisations operating as contractors to the NHS.

On the issue of pay and conditions we must remember that in a potentially competitive market more and more of these companies will wind up competing head to head with voluntary sector and other organisations which do not offer their staff NHS pay scales, sick pay, and other terms and conditions, but pay much less – and are able as a result to offer services at lower cost to PCTs and social services.

At a time when more and more private companies are trying to ditch their final salary pension schemes we can expect a rising number of social enterprises to be forced into undermining the pay and conditions of their staff as the competition hots up. This means that any concession that may be made now on pensions to pacify anxious staff would necessarily be temporary rather than permanent.

PAY SCALES/HOLIDAYS

If transferred to an NHS Foundation Trust, staff would initially be guaranteed continuity of terms and conditions, which have been lengthily renegotiated through the Agenda for Change agreement, which applies throughout the NHS. But Foundations have been promised freedom to vary pay scales – and therefore to depart from Agenda for Change – and there is no guarantee that in all cases management will seek to enhance pay rates and conditions.

Staff transferring to a new Community Interest Company (CIC) would also have an initial period in which their NHS pay and conditions would be protected under the transfer of undertakings (TUPE) arrangements – but these would not apply to any new staff recruited to the company, and there are ways in which employers can simply give notice and impose a new contract. One of the "freedoms" of CICs is also their scope to adopt "more flexible reward packages" which as we have argued can mean variation downwards as well as up.

Whatever the new organisational structure, a break from Agenda for Change even if it meant short-term increases would leave staff in future wholly dependent upon their own strength of organisation and leadership to maintain their pay and conditions, which would no longer flow automatically from a national agreement. It is quite possible that management in such a situation will seek to reduce their commitment of time and resources to negotiating pay and conditions by effectively imposing pay settlements and effectively de-recognising the trade unions.

SICK PAY

One of the other noted benefits of direct employment through the NHS is the allowances and entitlements for sick pay – which became one of the key issues of grievance for ancillary staff who lost these entitlements when they were transferred to private cleaning and other contractors as a result of competitive tendering.

Only the NHS contract carries the sick pay provisions, and the NHS scheme is able to share risk across a relatively large pool of staff in one of the world's largest employers: by contrast a CIC much smaller numbers of staff and standing outside the NHS as a self-contained business, would not be able to sustain anything like such generous sickness benefits.

Mental Health Officer status

For any members of staff who currently enjoy Mental Health Officer status, offering enhanced retirement rights, there is another major problem arising from any transfer of employment out of the NHS. The reckonable time of service required to achieve and maintain MHO status is specified to be "NHS employment" – and even those who take a

break from front-line service to teach in universities and medical schools risk losing their status as a result.

Job security

Trusts proposing social enterprises may be keen right now to create the impression that all jobs would be guaranteed in the switch to a CIC: but it is clear that competition will increase as more players enter the NHS market-place looking for a share of the £64 billion commissioning budget. As private management consultants Newchurch point out, there can be no certainty that new CICs will enjoy any special privileged status as a former part of the "NHS family", while

> "It is also very unlikely that the conventional for-profit private sector will sit idly by and allow any procurement process to be tilted in favour of social enterprises. If EU procurement procedures are taken as a guideline then no special provision can be made for the social enterprise." (Newchurch Briefing Paper, June 2006)

Newchurch also highlight one significant disadvantage affecting social enterprises compared with for-profit rivals: they have only limited access to capital and no ability to raise equity through shares. On top of this many existing non-profit services have experienced severe instability as a result of PCTs and social services offering only short-term contracts, and seeking to squeeze down budgets:

> "Future revenues cannot be guaranteed, nor can terms and conditions of employment be set in stone. Job security will depend upon business success, on winning and retaining services in the face of diverse and increasingly effective competition."

Few people have sought out NHS jobs expecting to confront this type of pressure. Ministers, the Department of Health, Trusts and PCTs are being less than honest in underplaying the scale of the risks in the plans they are so energetically promoting.

CASE STUDY

Ridgeway Partnership Trust

The plans put forward by Ridgeway Partnership Trust (RPT) (formerly Oxfordshire Learning Disability Trust) can be seen as a classic example of the new thinking among NHS managers under pressure to comply with new models … models and policies which have never been put to the electorate or properly explained to the NHS workforce.

In a "consultation" process due to complete in March 2007, RPT has spelled out a limited exercise seeking the views of a cross section of stakeholders on a range of potential options for a new organisational form, making clear its preference for the establishment of a Community Interest Company (CIC). In seeking to promote support for the far-reaching changes it is proposing, the Trust Board has given one-sided and misleading information on Foundations and on social enterprises.

The limitations of the consultation have been spelled out from the outset: the RPT Board has made it crystal clear that no matter what the pretence of an open and inclusive consultation process, any decisions will only be taken by the Trust Board itself – and that it does not regard the structural reorganisation of the Trust as an issue requiring a formal consultation.

Nor is the Board in any way deterred or influenced by the evidence that several of its potential models have already been proved highly controversial and unpopular with NHS staff and the wider public.

Of course there is relatively little hard evidence to go on: UNISON is alarmed that the Trust is contemplating the adoption of new organisational structures which have only been tested – if at all – by acute hospital Trusts and mental health Trusts on the one hand (Foundation Trust status) and by a handful of very different and tiny organisations on the fringes of health and social care.

RPT Trust is one of only two specialist Learning Disability trusts in the NHS. It is also substantially bigger than any of the existing social enterprises in health, most of which are extremely new, and only deliver advice or counselling services. Just 2% of third sector organisations have budgets in excess of £5m, and Ridgeway Partnership Trust with its £19m of assets, 334 staff and rising turnover of almost £32m in 2005-6 would be off the top of the scale of the most recent Department of Health report.

(Third Sector Market Mapping, Department of Health February 2007)

We are concerned to see that the Trust Board is so determined to ignore what evidence

does exist showing the attitudes of NHS staff in previous cases. In our view this raises serious questions over the value and significance of the present consultation process – and the Trust's repeated protestations that it wants to work in "partnership" with other stakeholders.

The Trust Board has insisted from the start that the new form to be adopted is a matter which it alone will decide. The public and stakeholders of all descriptions are to be excluded from the real decision-making process. So after the Trust has gone through the motions of inviting, receiving (and very likely disregarding) the views of various local stakekolders – it will deliver its deliberations as a *fait accompli* at the beginning of April.

Since they have already made clear that the status quo is not an option, we must assume that the Trust Board is preparing to impose a very substantial change upon staff and service users, whether they like it or not.

Despite the mounting evidence that large numbers of NHS Trusts will fail to meet the criteria to launch as Foundation Trusts by next year, RPT clings to the notion that no NHS Trusts will be allowed to survive after that date, and that as a result RPT still has no choice but "to move into a different form by 2008 or we could be merged with or acquired by another organisation". **UNISON is not convinced. We think the Trust board has got it wrong. In our view their efforts to force through such drastic changes against a rigid timetable flow from old plans that have since been revised and then discarded by ministers.**

We do not accept that such far-reaching changes could be carried through without having a negative impact on the range and quality of the services we provide – and potentially on the jobs, wages and conditions of RPT staff. We note with concern that the Shape Our Future document explicitly argues that all social enterprises "use a strong business ethos to compete to provide services/goods".

The Trust Board warns that if its plans are rejected then RPT might be acquired or merged with another free-standing Foundation or social enterprise (perhaps they are thinking of the Mental Health Foundation Trust?) or a for-profit private sector organisation. Voluntary sector bodies such as Mencap would not have the resources to contemplate a take-over. We are not convinced that any organisations with both the resources and the interest to take over RPT can be identified – although we do note that RPT itself has been eager to take over other services in neighbouring counties. The Board has not provided any convincing evidence to show why staff should reject the possibility of a merger with another NHS organisation committed to public service values, but be expected to support plans to take over services from other NHS Trusts, and reinforce the "independence" and autonomy of their own directors in a new company launched at their expense.

RPT Trust Board's "Shape our Future" document appears to endorse government pressure for provider organisations to become "more independent and "savvy" in their operations as businesses". Stakeholders are being asked to go along with the transformation of the Trust into a much more hard-nosed, competitive and business-style organisation which might itself contemplate further expansion at the expense of other rival service providers.

UNISON is also concerned that there would be nothing to prevent a Ridgeway Partnership CIC from generously distributing some of the surplus as bonuses or enhanced salaries for top managers, and paying their directors much more. The company would be subject only to "light touch" regulation, not through the Department of Health but … the Department of Trade and Industry, and registered at Companies House! This is not where health workers at RPT see their future.

RPT Trust Board insists at present that it is not proposing restructuring simply as a means to impose job cuts: but UNISON has already seen the Board discussions on opening up a gap between the pay and conditions of new recruits and those transferring from the NHS, to improve their competitive edge in the new NHS market. If they will contemplate these steps in advance of laubching the new company, it is easy to believe that as they attempt to reorganise a Trust to function as a business and generate increased surpluses managers could well be forced into imposing redundancies and service cuts as part of the package. The same commercial and business pressure will also threaten to undercut any short-term promises that may be made to staff over the protection of terms and conditions and pension rights.

With all these large question marks over the future viability of the organisation and stability of jobs, pay and conditions for our members, UNISON notes there is little in the way of clear-cut advantages on offer to make such a massive gamble worthwhile. The Trust Board plans have failed to demonstrate any significant improvements in services or accountability from the reorganisation that could not be achieved by the RPT under the current organisational framework.

The Trust could now, if it chose, co-opt additional Board members from stakeholders and the wider public: it could even establish a system to elect them. It could open up its decision-making to much wider involvement and scrutiny. It could involve staff more actively in this process – even co-opt staff reps to work with the Board. None of this requires the establishment of a new company. Why don't they just press ahead and do it, saving precious time, money and management resources instead of forcing through a high-risk and unpopular restructuring that could put key services at risk?

Drafted for UNISON Oxfordshire Health
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February 2007

Appendix

UNISON's policy (agreed 2006 Health Conference)

Marketisation of Health and Staff Co-ops

"Conference opposes the break-up of the NHS and introduction of a health market involving private businesses, foundation trusts, charities and community interest companies (co-ops). Conference recognises that staff co-ops may appear attractive to certain groups of workers who believe that they can win market share against huge, well-resourced health companies.

However, healthcare is not a cottage industry. Workers co-ops typically raise capital by asking their members to buy into the co-op and members often pay in thousands of pounds. If the co-op fails to win contracts the workers lose their job and also their savings.

While producer co-ops may survive temporarily in niche markets by using the methods of big business: that is cutting costs by worsening pay and conditions, by deskilling and by providing poorer services, the fate of their members is likely to be disastrous.

Conference opposes the government's proposal to set up a Social Enterprise Unit within the Dept of Health. Conference believes this is a wasteful misuse of funding which should be used within the NHS. The Unit will use NHS funds to help establish small businesses (whether commercial or not-for-profit) to take over NHS services, and could encourage staff to leave NHS employment to work for such 'enterprises'.

Conference opposes the use of community interest companies in our sector and calls on all regional health committees and health branches to oppose their set up and warn members of the likely consequences of participation. Our position remains the defence of the NHS and total opposition to the marketisation of health."