Hiving off Peterborough's health care

A UNISON response to Peterborough Primary Care Trust's consultation document The Next Steps

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Introduction
Yet another reorganisation

Peterborough PCT has a total budget of £250m a year, and has responsibility for commissioning health and adult social care services for its local population. 87% of this allocation is spent purchasing services from a range of local NHS, voluntary and private sector providers (which include nursing homes): but at present 13% of the budget, currently £32.5m per year is spent by the PCT itself in directly providing a range of community health and adult social care services.

Given the current government obsession with introducing "competition" (or to use the fashionable buzz word of the day, "contestability") to the NHS, the PCT has already instituted an internal reorganisation which has effectively constituted the directly-provided services as a self-contained "arms-length" operation, with a separate system of accountability, and standing outside of the PCT's wider commissioning process.

The new proposals set out in ***The Next Steps*** would effectively hive off these services to a free-standing organisation outside of the PCT altogether: this might take the form of a Foundation Trust (although it is not clear whether the financial regime established by Peterborough PCT would satisfy the tough requirements of the Foundation Trust regulator, Monitor) or a "social enterprise".

The PCT has made clear that it prefers the "social enterprise" option, although it may seek to split the services up and hive off some primary care to the "independent" sector.

In issuing the consultation document, Peterborough PCT is asking local people to give a blank cheque to carry through plans for a major reorganisation of these directly-provided services – but a reorganisation which the PCT itself argues will make no immediate difference to the services delivered to patients:

> "We are not proposing changes to services, rather to look at organisational arrangements …" (page 2)
> "We are not proposing any direct changes to services …" (page 5)
> "The changes proposed are about how services are commissioned, not how they are delivered." (Staff Appendix: Frequently asked Questions and Answers, page 21)

If this is the case, it is hard to see any benefit to patients, whose main interest is inevitably centred on the quality and quantity of services they are able to access when required – or any strong argument for implementing the changes which the PCT is proposing.

The case for change becomes even weaker when the PCT tells us at such great length how many excellent and innovative services have been successfully introduced within the existing organisational framework, without the need for reorganisation.

> "We have already made significant progress in Peterborough with directly provided services. In 2004, we brought together health and social care services for adults, through a partnership agreement with Peterborough City Council. These services are now provided jointly by integrated health and adult social care teams, alongside our General Practitioners.
> "We have also developed a number of local services such as community matrons, a falls response service and a musculoskeletal assessment and treatment service. These are important steps, but we still need to do more to deliver what people want." (page 6)

UNISON welcomes these improvements in services, ALL of which have been achieved within the framework of the PCT.

We note that retaining these services within the PCT has helped to keep down administrative costs and focus attention on the delivery of care rather than the endless reorganisation of structures, which in themselves contribute little or nothing to patient care or the quality of services.

And we note that any reorganisation along the lines proposed in *The Next Steps*, establishing a new, free-standing Foundation Trust or Social Enterprise, would inevitably divert more of the available NHS resources AWAY from front-line services and patient care and into management and unnecessary bureaucracy.

We see no evidence that this diversion of resources will do anything other than undermine existing services, pile additional pressure on to front-line staff, and potentially call into question some of the services currently available to local people. In other words, despite the PCT's assurances, UNISON is concerned that the long-term implications of the changes the PCT is proposing would throw the future of some services – and the staff working in them – into question.

Local services under threat

UNISON is happy to support the suggested direction of travel for most of the services currently provided by the PCT: but The Next Steps does not make any convincing case as to why these positive changes and developments cannot be carried through better and with much less disruption WITHIN the current management structure of an "arms-length" service.

We are however very unhappy to see that one of the more progressive policies in relation to primary care services – the salaried service in Botolph Bridge, Dogsthorpe and Burghley Road – is also under threat under the Next Steps proposals, with a plan to force the GPs delivering these services into the "independent sector".

The establishment of primary care services based on salaried GPs has been a long-time aspiration of progressive GPs, the Socialist Medical Association and the trade union movement. And UNISON is alarmed to note the extent to which today's NHS now appears to discriminate against the GPs who opt to work directly for the NHS as employees rather than cling on to their pre-1948 status as "independent contractors". On page 12, The Next Steps argues that

> "Another issue is that, because the three surgeries are directly managed, they have not attracted additional funding that is routinely paid to the other independent sector general practices, leading to an inequitable service for patients.
> "We want the patients at these surgeries to receive a more equitable service, with funding in line with the other independent sector general practices in Peterborough.
> "We want recruitment and retention to improve and we want better premises for the patients of the Dogsthorpe Medical Centre and Burghley Road Surgery."

It is outrageous that the PCT, as the commissioner and provider of these services is effectively blackmailing the GPs with the threat that funding will be withheld for new premises unless they agree to switch to the independent sector.

The PCT gives no explanation or evidence as to how patients' interests could possibly be served by insisting that GPs must be self-employed rather than NHS employees.

A similar question potentially arises with the Salaried Dental Service – although the PCT proposals for this are far from clear. The Next Steps (page 12) admits that the salaried service was only introduced to fill in gaps left by the lack of General Dental Practitioners. Since this will remain the case it is hard to see how any reorganisation of the service would leave services intact.

Dental care has been a case study of the unrelieved failure of policy for successive governments since the 1980s, and local people in Peterborough should be concerned to ensure that a service that has been shown to deliver care to those unable to access it elsewhere should remain intact and secure.

"Unplanned care services"

Here Peterborough PCT adds yet another phrase to the lexicon of terms that have been used to describe scaled-down services to take to most minor cases from A&E. Since the 1990s we have seen "Minor Injury Units", Minor Accident Treatment Services, the Darzi Report's proposal for 'Urgent Care Centres' – and now this PCT formula, which promises the least by avoiding the words "injury", "accident" or "urgent".

These services all have one factor in common: they are all relatively expensive to provide, and relatively under-used if they are in premises separate from the main A&E services. UNISON is happy to support the development of primary care services located in or close to A&E departments, effectively acting as a "triage" system which can allow the front-line A&E staff to concentrate on the most serious cases needing their attention.

But we are less convinced of the value to patients or the local NHS of free-standing centres which may result in greater delays in accessing treatment for patients who mistake their more serious condition for a minor ailment.

So while we are happy to agree to the provision of enhanced and out of hour primary care services at the Rivergate Primary Care Centre, we do not regard this as an equivalent or an alternative to proper resourcing of the new A&E when it opens on the Edith Cavell Hospital site in 2010.

Nor do we see this as any justification for the proposed reorganisation of PCT services to establish a Social Enterprise.

Spurious criteria

Page 14 of The Next Steps (**How we will assess providers of community health and adult social care services**) rings with smug and deceptive phrases which have little or nothing to do with the proposals for reorganisation that the PCT is putting forward.

The opening sections of the document have made it clear that the current organisational framework has already allowed the PCT to develop a range of flexible and innovative services.

It is also very clear that neither the case for change itself, nor any of the specific proposals outlined in The Next Steps, arises from the wishes, requests or demands of local people or service users: all of them arise first and foremost from the PCT's perception of government policy, and the government's blinkered obsession with establishing a "market" system for the provision of health care.

So there is little conviction behind the PCT's claim that any of its various suggested options offer "engagement and ownership" either to local people or to NHS staff – who are nowhere mentioned, nor are their concerns (about the continuity of services and the security of their jobs, terms and conditions) anywhere addressed in the consultation document.

A succession of buzz-words ("more flexibility, independence, control and choice for individuals"; "greater focus on innovation"; "extended partnership working") prove to be redundant, empty of content and irrelevant to the actual subject of the consultation.

Virtually none of the 18 bullet points on page 14 has any genuine meaning in the context of the actual proposals and the current situation of Peterborough PCT, which centre on the formation of a Foundation Trust or a Social Enterprise.

How did we get into this situation?

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: they have also gradually take on responsibility for a greater share of the total NHS budget.

However in the summer of 2005, shortly after the last general election, health ministers made clear its ambition to strip the Primary Care Trusts of the majority of their directly-provided services, reducing them to a purely "commissioning" role.

The government has been pumping 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.

A circular to this effect, the highly controversial letter from then Chief Executive of the NHS Sir Nigel Crisp – misleadingly entitled "Commissioning a Patient Led NHS" – offered a confused and confusing blueprint for wholesale privatisation and reorganisation of the health service. In fact the policy has always been driven from the top down and imposed upon the NHS: it has never had anything whatever to do with the wishes or demands of patients, locally or nationally.

Critics, including UNISON, immediately pointed out that the proposed policy would inevitably result in the NHS being reduced to little more than a centralised fund to pay for treatment commissioned from a new range of providers.

The providers in the new, competitive 'market' for health care would include Foundation Trusts and a range of new 'not for profit' providers, including social enterprises: but there would also be private sector hospitals, treatment centres and other clinical providers that would deliver services for profit, even though they would be financed through the NHS.

Treatment would be purchased within an increasingly competitive (and therefore fragmented) market system in which:

- ☐ the commissioners (purchasers) would be enlarged and even less democratic or accountable Primary Care Trusts – some of which were 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 the established mechanism of 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 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.

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 any of these insurance companies – most notably the US insurers, which (as Michael Moore's recent film Sicko exposes so effectively) 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.

Since then we have had the recent (October 2007) government announcement that 14 large-scale private corporations, including four massive US health insurers plus McKinsey's, the management consultants who have been popping up as highly-paid 'advisors' all over the NHS, have been "approved" to bid for contracts advising PCTs on commissioning services – and effectively offered the power to shape PCT decisions on what services should be commissioned and from which providers.

The 2006 White Paper *Our Health, Our Say …* also 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 one of 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", which includes "social enterprises".

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*, IFF Research Ltd for Department of Health February 2007)

"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

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 is being promoted to NHS managers 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[1]. Cooperatives are

[1] Shares are issued to stakeholders including staff but carry no entitlement to dividends and no resale value. An especially pointless version of this is proposed in the "Frequently Asked Questions and Answers" issued to NHS staff by the PCT which suggests (page 20) that **"Every member of staff becomes a shareholder and the maximum personal liability of any employee of the organisation would be £1. Staff would be asked to pay £1 when the organisation is set up and would get it back if they leave".** Exactly what purpose is served by this bureaucratic rigmarole is not clear: social enterprises are run like businesses, with a management structure and hierarchy, and "shareholders" will be as impotent and irrelevant in this sector as they are in major corporations, which always ignore all but the very largest shareholders.

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.

As a result Peterborough is one of very few PCTs seeking to go further and faster than most others down the line of hiving off their services and adopting new, completely untested and more expensive models of organisation.

What of the claimed advantages of a new model?

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

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

In Surrey for example 84% of staff voted last year ***against*** the formation of the much-touted Central Surrey Health company. It 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.

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 to adopt an arrogant or bullying approach and have members intimidated even 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 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 could 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 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.

Of course the new Boards of Governors have no real say on Foundation Trust policy, any more than the worker "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 it is the case that 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 other Trusts and the local PCTs when they face deficits. Indeed 57 Foundation Trusts, including Peterborough Hospitals, are currently sitting on combined unspent surpluses that amount to £1 billion, which they are under no obligation to share or spend – while other NHS Trusts and PCTs like Peterborough are forced into making cuts to balance their books.

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.

We know from the most recent Peterborough PCT papers that it is engaged in driving through a £7.27m package of cuts ("savings plan") this year, which involves slicing funds from learning disability services but also cutting back on commissioned activity. If the directly-provided services were a Foundation Trust or a Social Enterprise, they would face the same potential cutback and the same constraints on expanding and improving

their services – except their overhead costs would be higher, and the pressure on patient care would be correspondingly greater.

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 at present.

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.

"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, emphasis added)

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.

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.

UNISON is quite willing to accept that Peterborough PCT may not at this stage be proposing restructuring as a means to impose job cuts: but we are fearful that any attempt to function as a business and generate increased surpluses could well force managers down that road.

The new company would still be entirely dependent on funding from the PCT. 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 the PCT: indeed their long-term redundancy rights may well be better protected as part of the NHS than through a brand new company.

One year ago …

"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 was launched on Sunday and 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.

One such idea is to provide a single call centre for GP referrals and take the pressure off doctors who currently have to juggle filling in complex forms while ensuring the right care is given to their patients.

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)

What about the NHS staff affected?

Benefits for staff?

It is shocking to find that the Next Steps consultation document does not attempt to address the issues from the standpoint of the staff employed by the PCT. Instead a separate document has been issued as a Staff Appendix, which gives some extremely misleading information and very little reassurance to staff.

Asked what benefits the proposed changes might offer staff currently employed by Peterborough PCT, the Staff Appendix Frequently Asked Questions and Answers (FAQA) has little of substance to put forward:

> "The incentive is to continue and improve on the high level of service you provide to the service users currently. …
> The incentives important to us are:

1. Retained and protected terms and conditions
2. Opportunity to improve terms and conditions
3. Increased access to training and development
4. Greater staff ownership and involvement in decision making
5. Ability to retain surpluses to improve services and terms and conditions
6. Increased opportunities to be flexible and innovative" (page 21)

UNISON would argue that the first "benefit" is simply an interim, temporary promise of no detriment, while the second and third are pure speculation without any supporting evidence.

Number 4 is pure fantasy, given that the changes are being imposed from above regardless of the views and wishes of staff, and will impose a system equally if not more unresponsive to staff views.

Number 5 begs the question of what happens if the social enterprise or Foundation starts to lose money rather than scooping up surpluses – and number 6 lacks any evidence to support it and could be regarded as a benefit for managers rather than staff

Pensions

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

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 UNISON has 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, with 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.

Viability

The issue of staff pay and conditions also raises the issue of the financial viability of the proposed Foundation or Social Enterprise. Again the FAQA document is forced to be cagey about future prospects: answering a question on quality (page 22) it tells staff that:

> "Finances are also important and the new organisation will have to be financially sound. It will have to negotiate sufficient funding from the commissioners to maintain the quality of the services."

It goes on to claim that making a surplus would not be a priority – despite many of the claimed advantages of the Social Enterprise model and Foundation status centering on the right to retain surpluses:

> "A key priority will be achieving financial balance to ensure we can continue to provide high quality care and support services. This will be the case whatever the model.
> "It will be good to make a surplus as Foundation Trusts and Social Enterprises are able to keep any surplus to develop and improve services, but it is not the main priority." (page 23)

Responding to the question "Will services be fragmented", the document tries to avoid the obvious and simple response "yes" by telling staff:

> "The Commissioners are responsible for introducing more competition in service delivery to drive up quality and choice for the people who use them. To do this, they are looking at the future direction of specific areas of the provider services. It is possible that some parts of the organisation would be best delivered by different organisations." (page 23)

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

Interestingly the PCT's FAQA paper avoids giving any guarantee of job security, offering instead a profoundly evasive statement (page 21)

> "In a changing environment, job security cannot be guaranteed. However, this change is not about reducing services or staffing levels, it is about how services are commissioned by the PCT, therefore we do not anticipate jobs being any more at risk because of this than they are at any other time."

Jobs will become less rather than more secure as the process of market-style reforms transforms the NHS from a planned public service into a competitive market place. It is clear that competition will increase as more players seek to compete for a share of the £70 billion-plus NHS 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.

Privatisation - Living in denial

Asked: "Is this privatisation? Is it back door privatisation?", once again the FAQA chooses the route of evasion rather than confront a difficult reality. **The privatisation is not through the back door, but through the front.** The document tells staff:

> "No, services will still be provided as part of the public service for NHS and social care, free to the patient at the point of delivery, whatever the chosen model is."

UNISON believes that this is wilful deception: the question was not whether or not patients would be charged for services delivered by the new organisation, but what is the character of a Social Enterprise, compared with the existing publicly owned and publicly-run service?

The only honest answer is that a Social Enterprise, or 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!

UNISON does not believe that this is a policy that many, if any, NHS staff would willingly embark upon. PCT managers obviously recognise that, which is why it is being imposed in such dishonest fashion.

Conclusion

The PCT proposals are not driven by patients, by popular pressure or by evidence that the new models deliver improved services: they are driven from the top down by government policy, itself ideologically driven in defiance of the evidence that competition in health care does nothing to improve quality and service to drive up costs. The proposals amount to a more bureaucratic and expensive managerial structure, which will divert resources from patient care.

UNISON urges the PCT to reject all of the alternative options and to retain services as an "arm's length" subdivision of the PCT until and unless ministers intervene directly with an instruction to change.

This arrangement has been proven to deliver good quality, innovative, cost-effective services to local people, and retains the jobs within the NHS where terms and conditions are governed by national agreements and Agenda for Change.

Since this system is not broken, there is no point in wasting managerial time and money trying to fix it. Instead the PCT should be discussing with the unions how best to enhance staff training opportunities to ensure they can develop and improve services.

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JRL