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THE PATCHWORK PRIVATISATION OF OUR HEALTH SERVICE:

A Special Report

Unite in the Health Service

THE PATCHWORK PRIVATISATION OF THE NHS

Published by Unite

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INTRODUCTION

There have been a series of NHS policies unveiled by the Government in the past few years; the purpose of these policies has been to break-up the NHS from a national, integrated organisation into a series of multiple providers badged as the NHS, all competing against each other. The private and third sector are able to compete against the NHS to win contracts to provide health services.

Unite believe this is a fundamental shift in the core principles and values of the NHS - a change from a comprehensive publicly owned and accountable direct provider of healthcare into one where a myriad of private sector contractors vie to provide parcels of healthcare funded from taxation.

This guide and campaign tool-kit is not exhaustive but gives an overview of the patchwork privatisation happening to the NHS. It aims to give Unite reps and members and local communities an understanding of what is taking place and help them to develop an effective campaign strategy to keep NHS services public.

OVERVIEW OF WHAT IS HAPPENING TO THE NHS

WHAT IS PRIVATISATION?

'Privatisation' does not have a precise definition. The classic model has involved whole enterprises being moved into private ownership through the mass sale of shares, although this is only one type of privatisation. Some supporters of privatisation have defined it so broadly as to mean "the act of reducing the role of government, or increasing the role of the private sector, in an activity, or in the ownership of assets." *(1)*

Academic definitions accept that the deregulation of state monopolies, the outsourcing of state responsibilities and ending services that were once offered by the state can all constitute privatisation. *(2)* This is the form of privatisation we see in the NHS today. The government denies that it is privatising the NHS as the health service remains free at the point of need, funded from taxation, but this claim does not stand up to these academic definitions of privatisation.

Further, in its 'reform' programme the government has used these methods of privatisation on such a scale and in so coordinated a way as to make it a unique phenomenon. Individually, policies such as encouraging the private sector to takeover GP surgeries can be presented by the government as an attempt to solve a specific problem. However, when all the different forms of NHS privatisation are knitted together a grand design can be seen; the accumulative impact of which threatens the future of our NHS.

In short, we are seeing something new: the 'patchwork privatisation' of a major public concern.

WHAT'S SO BAD ABOUT PRIVATISATION?

There are many reasons why NHS privatisation is deeply worrying.

COST

Privatised healthcare tends to cost more. It requires a large bureaucracy to operate, with huge transaction costs that come with contracts, billing and litigation. We can also see the poor value derived from Independent Sector Treatment Centres (ISTCs) and the high extra costs associated with PFI builds. On a wider scale, America, where private healthcare is most developed, spends over 16% of its GDP on health, yet more than 45 million Americans lack any health insurance. Britain spends half that, yet the NHS covers everybody.

ACCOUNTABILITY

Accountability suffers when private involvement increases. 'Commercial confidentiality' makes it impossible to scrutinise public spending because the information is not available.

FRAGMENTATION AND PROFITEERING THREATEN THE QUALITY AND QUANTITY OF SERVICES

The most important consequence of privatisation is the fragmentation of the health service. It has been an explicit goal of government health ministers like Alan Milburn to break up the "state monopoly," opening gateways for the entry of the private sector. *(3)* This has gone hand in hand with a process of commercialisation – putting public bodies on a commercial footing (such as with foundation hospitals) and redesigning the system along market lines. Having organisations and services competing against each other undermines collaborative working practices and good communication across services. The creation of a lucrative health care market can also impact upon the continuity of care people receive, there is always the threat that the private sector or other providers who take on a service that does not secure the expected financial returns may cut their losses and withdraw from the provision of that service.

The profit motive also encourages 'cherry–picking', where the private sector takes on the lucrative work, leaving the rest to an NHS under increasing financial pressure. Cherry-picking also results in the loss of training opportunities for junior doctors as ever-larger shares of routine surgery are diverted away from the NHS. Centres for research and medical innovation, are also threatened. This can ultimately lead to services being cut. Already some services are being dropped and fees are creeping in. For example, the Queen Charlotte's and Chelsea Hospital in London ran a

scheme offering pregnant women a one–to–one midwife service (the recommended NHS standard) for a £4,000 fee *(4)* .

This is an attack on the very foundations of the NHS as a comprehensive, integrated health service. The great strengths of the NHS have always been cooperation and service, not competition and profit.

THE ANATOMY OF NHS PRIVATISATION

Below we look at some of the 'reform' policies introduced by the government in recent years that make up some of the 'patchwork'.

CREATE A MARKET

Running the NHS on market lines means all aspects of healthcare have to be bought and sold – even within the health service. This does not constitute privatisation in itself, but provides the foundation that makes the patchwork privatisation of the NHS possible.

THE PURCHASER-PROVIDER SPLIT AND COMMISSIONING

This is fundamental to creating the NHS market. The purchaser-provider split divides the function of providing healthcare (such as hospitals and, for some services, the Primary Care Trust) from a Trust's function of purchasing health services on behalf of patients and service users. Trusts can commission (contract) others to run services – the private sector and the third sector can compete against current public provision to win these contracts. As well as different providers having to compete with each other to win contracts, competition has also been embedded by allowing patients and (theoretically) users to choose between different providers as to where they are treated.

The drive has been to push NHS Trusts and Primary Care Trusts (PCTs) into being commissioning bodies, rather than directly providing care themselves. The latest impetus to this agenda is the recent publication of Transforming Community Services which sets out how Trusts have to re-organise services so that there is a formal purchaser-provider split and decide if they are going to commission outside organisations to provide community services.

The purchaser-provider split and the market system have cost the taxpayer millions in contracts, billing, legal fees and the like. Transaction and administration costs, which before the purchaser/provider split accounted for 6% of the NHS budget leapt to 12% in the mid-1990's.
The new market system could push them close to wasteful American levels, where they account for over a quarter of healthcare spending . *(5)*
Professor Allyson Pollock has written that "As in the US, billions of pounds, probably approaching 20% of annual NHS funds - estimated to be £20 billion in England in a year - are being squandered on what are called the transaction costs of the market" *(6)* .

'PAYMENT BY RESULTS' (PBR)

As part of developing this market and competition, the 'Payment by Results' (PbR) funding system has been established where services and procedures are paid for by the commissioning body after they have been delivered or performed. Service providers therefore have to compete – and win – patients and service users to secure income. This financial system underpins the NHS market.

Service providers are paid by NHS Trusts (the purchasers, or commissioners of care), rather than being given a budget guaranteeing funding in advance. (These rules are not applied to the private sector for ISTCs, which are given guaranteed funding – see below). This creates a powerful incentive to treat the patients with less complex conditions who can be pushed through the system quicker, so a larger volume can be treated. On the flip side, there is an incentive to squeeze out people who are more time consuming, such as those in need of chronic care. If a hospital loses patients to another hospital or to a private facility, it loses income. This puts hospitals in competition with each other to attract patients, meaning they will have to spend taxpayers' money on advertising. Under the 'choice' agenda, every patient who opts (or is sent) on the NHS for care in a private hospital or treatment centre takes the funds with them out of the NHS. This all has a destabilising impact on NHS hospitals and services by taking away their ability to plan, as they no longer have any idea how much income they will have. The prices for treatments under 'payment by results' are set according to a fixed tariff, a rigid system that does not take into account that certain NHS trusts have historically higher costs than others, meaning some are plunged into deficit while others make big gains without doing any extra work.

‘Payment by results’ also creates tension within the NHS as hospitals do as much work as possible to earn income, while Primary Care Trusts try to cut their costs as much as possible. ‘Payment by results’ is designed to force NHS bodies to act like competitive businesses. This fragmentation destroys much of the flexibility that the NHS used to have, making it difficult to move money around to where it is most needed. This rigidity is a prime cause of the periodic deficit crises that lead to cuts and closures.

In April 2006 ‘payment by results’ was rolled out to cover over 80% of hospital work – a move that went faster and further than in any comparable country. It effectively made the English NHS a giant experiment in an untested system of funding healthcare. The government has consulted on rolling Payment by Results out further, to cover primary care.

CHOOSE AND BOOK

This is the electronic system that lets patients choose where to have their operation. The ‘menu’ of choices has to include at least one private or non–NHS facility. This acts as a golden stairway for the private sector to raise its business within the health service. Tony Blair said that by 2008, 40% of the work carried out by private hospitals will be paid for by the NHS. *(7)* This has precipitated the arrival of huge foreign healthcare corporations like United Health, the merger of South African giant Netcare with BMI (Britain’s biggest private hospital group) and a surge in the share prices of companies like Care UK *(8)* . Meanwhile, many PCTs have established ‘referral management centres’ to vet doctors’ referrals and, in some cases, divert patients to private sector facilities, completely undermining the notion of patient choice *(9)* .

THE IMPACT ON PRIMARY CARE

Primary care is the front–line of the NHS, and has found itself on the front–line of the privatisation battle. Primary care comprises most non–hospital services, such as GPs and district nurses and is responsible for 90% of NHS activity. Whereas the previous section was about the market system that makes privatisation possible, this is where privatisation–proper begins.

PRIVATISING GP SERVICES

In 2006 huge multinational corporations started to takeover GP surgeries.

This marked the beginning of a massive change in general practice that will have profound implications. The 'alternative provider of medical services' (APMS) contract is the vehicle being used to bring in the private sector. *(10)* This is a new form of contract, which according to the government is intended to be "light touch" – i.e. not have much public oversight *(11)* . It requires a dramatic shift towards a commercial business model in general practice, as contracts must be bid for in competitive tenders. The government has already awarded the contract for a 7,000–patient practice in Barking and Dagenham to private company Care UK, and other contracts are waiting to be signed. Under political pressure, PCTs have begun to put practices out to tender – a survey showed that one in three plan to strike a deal with the private sector for GP services. *(12)*

Originally, the government justified the policy by saying there were not enough doctors in the deprived areas that need them most. But private companies are moving in across the board. The government claims this does not represent a big shift, as traditional GPs are independent contractors making profits. This is misleading – traditional GPs take as their salary whatever is left of the money needed to run their practice, after covering the running costs of the surgery and staff wages. They consider themselves – and are considered legally – part of the NHS.
One of the central fears attached to privatised GP services is that continuity of care will suffer. Company doctors will be less wedded to a particular area and the doctor–patient relationship will be harmed.

"My fear now is that GPs will struggle to win contracts because these big firms want to get involved. That will be a shame. Firms have to make profits for their shareholders and that leads to care being compromised, whereas GPs have been trained and worked for the NHS all their lives, the ethos is different." GP Elizabeth Barrett, who was instrumental in the successful campaign to halt the handover of a practice in Derbyshire to the giant American healthcare corporation UnitedHealth.

OUTSOURCING PCT CARE

As well as commissioning care for patients, for example, from hospitals, PCTs also provide a wide range of direct services like district nursing and health visiting. NHS reforms, as set out in 'Commissioning a Patient-led

NHS' (2005) and 'Our Health, Our Care, Our Say' (2006), aim to create a health service where Trusts to divest themselves of directly providing health care. Instead, using their purchasing function, Trusts commission (contract) others to provide health care services. Private companies and third sector organisations will be able to bid to run and provide services contesting against current public sector provision.

PRIVATISING THE COMMISSIONING FUNCTION OF PRIMARY CARE TRUSTS (PCTS)

This takes privatisation one step further into the heart of the NHS, giving the private sector a role in the decisions on what care patients can receive. In late June 2006 the Department of Health advertised for large companies to tender for the management functions of PCTs as part of the 'Framework for External Support for Commissioning' (FESC).The Department of Health drew up a list of approved companies that PCTs can contract to carry out part, or all, of the PCTs commissioning of health services. This would place large, multi-national private companies in the driving seat of strategic primary care decisions.

"We are moving to a position where we'll have companies not only providing health care but also deciding which healthcare patients will be able to receive – in other words, deciding to some extent how the NHS budget should be spent". Dr Sally Ruane, of the Health Policy Research Unit at De Montford University.

PRACTICE BASED COMMISSIONING

Practice based commissioning transfers the buying power for purchasing many treatments from PCTs to groups of GPs. Instead of the money being held by a public body with responsibility for the whole local population, it is handed to practices accountable only for their registered patients. Increasingly these may be run by corporations like the American giant UnitedHealth, which could easily dominate the market in any region and gain huge power over what kind of care patients receive and who provides it. The result would be the same as with outsourcing PCT commissioning above, arrived at in a more piecemeal fashion.

"I work in the NHS as a health visitor. The government might prefer it if I worked for some private company or voluntary

organisation, but I believe in the NHS. It's there to provide the care patients need, not to buy it in like a glorified insurance firm" Norma Dudley, health visitor

UNBUNDLING OF PRIMARY CARE SERVICES

Primary care services are being broken up into saleable commodities in a process known as unbundling. The compulsory duties of all GPs have been whittled down to a core, which primary care trusts can then top up with extra services from other providers. Currently, commercial providers have won 20% share of the market revenue in out-of-hours contracts *(13)* . There are already serious concerns about out–of–hours GP care – inadequate services have put extra pressure on A&E departments, as people have found themselves with nowhere else to go. There has been a high number of complaints about the quality of services in some areas. *(14)*

"Out-of-hours GP cover in Cornwall was controversially taken over by private company Serco in April 2006. Since then, many people have had problems seeing a doctor in the evenings and at weekends. Serco has missed almost all its targets, including for emergencies and urgent home visits. Most worryingly, only 55% of emergencies received a visit within one hour in the peak holiday month of August" *(15)*

THE IMPACT ON SECONDARY CARE

Secondary care is the treatment patients receive after referral, usually in a hospital or treatment centre. It is the highest–profile part of the NHS where private involvement has been very controversial.

INDEPENDENT SECTOR TREATMENT CENTRES (ISTCS)

ISTCs are private sector clinics usually specialising in straightforward treatments, such as cataract operations or hip replacements. The NHS signs contracts with private companies to carry out the work at a fixed overall price, which is paid whether the operations are actually performed or not. This means that, unlike NHS hospitals that are subject to 'payment by results', ISTCs get special treatment, with contracts that guarantee full funding regardless of how many patients opt to use their services. There have been two 'waves' of ISTCs, the first at cost of £1.7 billion and the second is worth £3.75 billion *(16)* .

The government claimed ISTCs were needed to provide extra capacity quickly to reduce waiting times, stimulate innovation and enhance patient choice. However, Parliament's Health Select Committee found ISTCs have made only a very modest contribution to cutting waiting lists; the reduced waiting times are overwhelmingly the achievements of the NHS *(17)* .

The Department of Health documents explaining the second wave of ISTCs make it clear the point is no longer to expand capacity, instead using the term 'contestability', i.e. increased competition. ISTCs mean that the NHS loses funding for the routine work that has been taken away, but must still provide the expensive care, such as emergency admissions and chronic cases, which the private sector is not interested in 'competing' for. This is causing the finances of some hospitals to become destabilised. *(18)*

The government will not release its method for calculating value for money because of 'commercial confidentiality', but does admit that on average ISTCs have been paid 11.2% more than the NHS for each operation. This higher price is paid despite the fact that ISTCs only take on uncomplicated cases and do not have to train junior staff – another area where they are having a damaging effect. With these factors added in, private companies are being paid around 30% more than the NHS *(19)*. ISTCs have also been criticised by the Healthcare Commission for the quality of the data collected, meaning that a systematic assessment of care could not occur *(20)* .

Cataract operations at a private treatment centre in Oxfordshire have cost up to 600% over the odds. The ISTC was forced on the local NHS by the Department of Health, but performed only 93 of the 572 contracted procedures in half a year. Meanwhile eye operations at an ISTC in Portsmouth have cost seven times more than they would on the NHS in its first 6 months. *(21)*

PRIVATELY RUN NHS HOSPITALS'

Lymington New Forest Hospital in Hampshire became the NHS first hospital to be fully privately run. A £36 million PFI (Private Finance Initiative) hospital was purpose built and immediately transferred to be run by the Partnership Health Group, a subsidiary of Care UK in December 2006. The huge expense of building the hospital has been met by the taxpayer to enable a private company to make profits.

PRIVATE AMBULANCE SERVICES

In many areas non-emergency ambulance services are being put out to tender. Where the contracts are won by the private sector, there have been problems. For example, the South East Coast Ambulance Service NHS Trust is having to deal with patients who private company GSL have been paid to carry, with some patients have been left waiting for up to nine hours. *(22)*

DIAGNOSTICS

ICATS AND CATS

Integrated Clinical Assessment and Treatment Services (ICATS), or Capture, Assess, Treat and Support Services (CATS) are centres that sit between primary and secondary care, carrying out diagnostic tests and performing some operations. They also have the power to refer patients on to hospitals and treatment centres. They are not always privately run, but where they are (as in Cumbria and Lancashire) they represent a dangerous development because of the possibility of conflicts of interest. For example, in August 2006 South African company Netcare was awarded the contract for an ICATS in Manchester. Netcare also runs an ISTC in the area, the Greater Manchester Surgical Centre. Netcare's ICATS could now refer patients to Netcare's ISTC, or, on the other hand, direct unprofitable patients with complicated conditions away from the Surgical Centre. *(23)* As well as these conflicts of interest, ICATS and CATS will take outpatient and day-case work away from NHS hospitals, possibly rendering the latter non-viable and harming the training of junior doctors.

"The Manchester ICATS is of considerable concern because of the obvious conflicts of interest. It was a scheme that came from above – from the Department of Health – and was pushed through despite unease in the local NHS" Debbie Abrahams, former chair of Rochdale Primary Care Trust who resigned in protest at the market reforms

PRIVATISATION OF PATHOLOGY SERVICES

In August 2006 the government announced an expansion of private sector involvement in pathology and diagnostic tests. Five private companies were chosen to supply more than 1.5million diagnostic procedures, including x-rays, ultrasound scans, and blood and other tissue tests, under contracts worth £1bn over 5 years. This came after a review by Lord Carter warned of the dangers of fragmenting pathology through privatisation – a position reinforced by the Royal College of Pathologists. *(24)*

FACILITIES

PFI

Under the private finance initiative (PFI) an NHS trust signs a contract with a consortium of companies, which builds and maintains a hospital. The NHS trust then rents the hospital from the private consortium, typically over a 30–year period. There is overwhelming evidence that this is a hugely expensive way of building hospitals. PFI deals come with so called 'soft–services' like cleaning and maintenance, which the NHS trust has to pay the private consortium for, often at hugely inflated prices. One PFI consortium charged a trust £333 to change a light switch. *(25)*

There are now over 700 PFI schemes and it estimated that private companies will profit by £23 billion over the next 30 years (the average length of contract) from NHS PFI buildings. An accountants report for the Audit Commission of Queen Elizabeth Hospital in Woolwich found that half the Trust's deficit of £20million in 2005-6 was due to the annual PFI charge it has to pay, £9million a year more than it would have to pay if the hospital had been traditionally funded *(26)*. This is a significant amount of money leaving the NHS, and as PFI annual charges have to come from operating budgets there is an immediate impact upon the services Trusts can afford to run. Hellowell and Pollock *(27)* found that by 2013/14, when all of schemes in the current programme are in operation, PFI payments will be £2.3 billion a year. In total, the amount of money to be repaid by NHS trusts will almost double, from around £50 billion in 2005/06, to more than £90 billion by 2013/14. The cost of PFI contracts for most trusts is greater than the capital (i.e. the value of the actual building the NHS gets). Hellowell and Pollock linked this is debts that Trusts began to carry stating that "Crucially this under-funding has led to the emergence of financial deficits, and, under government pressure to balance the books, plans for further cuts to services."

The purported purpose of PFI is to transfer the risk attached to building a hospital to the private sector. Once a hospital is built the risk is so small that astronomical profits can be made from refinancing deals – as in the case of the Norfolk and Norwich Hospital, where the Octagon consortium made gains of £95m, and tripled its original expected internal rate of return from 19% to 60%, but left the hospital with extra potential liabilities of up to £257m should it need to terminate the contract early. *(28)* The signing of PFI contracts locks NHS services into a 30 year fixed way of delivering services, at a time

when the government is arguing for flexibility. Many PFI schemes – especially the more expensive ones – have been for large scale acute hospitals, which are likely to be less and less in demand as resources and the focus of healthcare delivery is shifted to more community based care. Yet the PFI annual charge will continue having to be paid.

"For an NHS trust to have a PFI hospital is like having a massive 30 year old mortgage, except the terms are worse than you'd get from any high-street bank and even when its all paid off, you still might not own the house" Karen Reay, National Officer for Health, Unite

LIFT

The local improvement finance trust (LIFT) scheme is often referred to as the primary care version of PFI, but there are differences. The rate of profit flowing out of the NHS to private shareholders is just as high despite the much lower risk of building a GP surgery compared to building a hospital. LIFT projects are costing up to 8 times more than traditional ways of building. In Newham in east London, two LIFT premises that cater to just 9% of the local population are taking up 28% of the PCT's accommodation budget. *(29)* As with PFI, the cost can only be met by starving other areas of funding, ultimately leading to deficits and cuts in services. Furthermore the LIFT model institutionalises conflicts of interest, as it requires an NHS trust to have a stake in a profit–making company, while at the same time buying services from it and evaluating its value for money. *(30)*

SUPPLIES

PRIVATISATION OF NHS LOGISTICS

NHS Logistics bought and distributed health equipment to hospitals. It was an award–winning non–profit organisation, reinvesting its surpluses in the NHS. The government decided to outsource it and a large part of the NHS Purchasing and Supply Agency to the German delivery firm, DHL, and its sub–contractor, Novation, in the biggest single privatisation in the NHS yet. Novation were awarded the crucial role of procurement with control over £4 billion of NHS money. There were serious outstanding allegations against Novation in the US with the Department of Justice investigating the company over bribery and defrauding American public health schemes. *(31)* There is also a wealth of evidence to suggest that Novation's activities inflate the price of medical supplies in the US. *(32)*

"Putting Novation in charge of NHS supplies is like appointing Jack the Ripper to run your neighbourhood watch. Or to use a more recent analogy, hiring Enron to operate your power grid". Phil Zwig of the US medical supplies company Retractable Technologies, which received a $155 million settlement from Novation and other companies over allegations of foul play.

PRIVATISATION OF OXYGEN SUPPLIES

The service supplying oxygen to patients with breathing difficulties was privatised in February 2006. Previously it had been run by local pharmacies working with GPs, and oxygen was delivered within a strict NHS target time of hours. But after the service was handed over to four multinational companies – Air Products, Allied Oxycare/Medigas, Linde and BOC – there was chaos, with patients arriving at pharmacies blue in the face after being unable to obtain oxygen for three days. One woman, Alice Broderick, died while waiting for an emergency delivery of oxygen that took nine hours to arrive. As late as August 2006, GPs were still reporting problems with the service and were having to issue prescriptions in the traditional manner. *(33)*

THE COMMISSIONING PROCESS AND THE 'ALTERNATIVE PROVIDERS'

As outlined above the drive is for the NHS to be broken into competing business units. The implementation of this agenda requires the formal separation of Trusts purchaser and provider arms. In December 2008 the government published 'Transforming Community Services' (TCS) *(34)*. This is guidance issued to Trusts about the possible options of future service delivery and how this formal separation can be implemented. In this section Unite have outlined in broad terms what these options are for Trusts. Where an option means staff will be transferred out of the NHS the implications for staff are outlined in a later section.

Below is a summary of main options given to Trusts in the TCS guidance; Unite feel it is important that workplace reps understand the process they may be confronted with in their Trust, some of the jargon that will be used and decide what option they can argue for. **There is a drive nationally to privatise services –this is included in the options presented to Trusts in the TCS document. But it is important to remember, remind Trusts, and campaign around the fact that there is also the option of keeping services as part of the NHS; Trusts do not have to privatise services!**

TRANSFORMING COMMUNITY SERVICES – POSSIBLE NEW MODELS FOR SERVICE DELIVERY

NHS ORGANISATIONS

There are options that mean PCTs retain services in the NHS although they will have to make arrangements to meet the criteria that the purchasing and providing functions are formally separate.

DIRECT PROVISION *(35)*

PCTs may retain providing services by establishing "separate governance arrangements so that the provider service is treated like any other provider"*(36)* .

What does this mean? Though this re-organisation, like others, organises NHS services along competitive market lines services are retained in the NHS. This also means that staff would remain employed by the NHS and therefore covered by NHS terms and conditions and have access to the NHS pension scheme. This also

applies to new staff members.

COMMUNITY FOUNDATION TRUSTS *(37)*

Hospitals have been able to become Foundation Trusts since 2002. Foundation Trusts have particular governance arrangements laid down in legislation and have a degree of autonomy from the Secretary of State. The pool of NHS organisations able to apply to become Foundation Trusts has gradually widened since 2002. The TCS guidance states that "For a PCT provider arm an NHS trusts is created to take on the provider arm and apply for FT status" *(38)*.

What does this mean? Again, the establishing of a Community Foundation Trust organises NHS services along competitive market lines. Services remain in the NHS though meaning staff remain employed by the NHS and therefore covered by NHS terms and conditions and have access to the NHS pension scheme. This also applies to new staff members. Foundation Trusts do have narrow freedoms within the Agenda for Change agreement however. Foundation Trusts also have some freedoms over the use and disposal of NHS assets and the ability to raise private finance and enter into agreements with the private sector.

☨ For more information on Foundation Trusts, and what to do if your Trust begins going down this route, read the 'Unite briefing and campaign guide to Foundation Trusts', available on the Unite website.

VERTICAL INTEGRATION

'Vertical integration' of services where different with organisations "typically, carrying, out different stages of a patient or user pathway" *(39)*. This could be achieved through an outright merger of an NHS acute trust with a PCT provider arm, or there may be a looser contractual relationship between acute and community services through multi-disciplinary team working and joint management *(40)*.

What does this mean? This is a route where individual Trusts' plans would need to be carefully scrutinised for the implications. If all stages of a 'pathway' remain in the NHS then staff would retain NHS terms and conditions, membership of the NHS pension scheme, as would new joiners, if staff had to transfer as part of any integration.

HORIZONTAL INTEGRATION

'Horizontal integration' involves a number of PCTs integrating their provider functions and may be the first step on the route to creating a community

foundation trust.

What does this mean? Services would remain in the NHS and therefore staff would remain employed by the NHS.

OUTSOURCED ORGANISATIONS

In the first section of this booklet it was outlined how market competition and privatisation is a costly way of running a health service, and how co-operation and the sharing of best practice is undermined. Below, the main ways the 'Transforming Community Services' document gives to Trusts to privatise their services is outlined.

SOCIAL ENTERPRISE *(41)*

'Social enterprise' can itself be a fairly wide term and there is no rigid or fixed description. There are several different legal organisational forms that a social enterprise can take (some of these are highlighted in the TCS guidance to Trusts. Broadly though, social enterprises are profit making businesses thought to have a 'social' aim. A great deal of support has been given to the setting up of social enterprises from central government in order to implement the 'commissioning' agenda across the public sector.

For health this agenda has meant that individual NHS staff (or groups of staff) have a 'right to request' they be allowed to establish a 'social enterprise' to deliver a particular service, or range of services under contract from the PCT. If the business plan is approved by the PCT the business will be established and awarded an initial 3 year contract.

What does this mean? The social enterprise would be an external business operating under contract; therefore staff working for these organisations will no longer be part of the NHS. The full implications for staff of this is outlined below. While greater staff, user and patient involvement in decision making is often touted as a positive feature of social enterprises this is simply not a guaranteed inherent feature of social enterprises as sometimes portrayed. There will be some that may have greater involvement, others will have worse; the frustrations at how the organisation is run may simply be transferred over to the new organisation along with services and staff. Even though some social enterprises may be established with the best intentions of wishing to develop better services for patients, service users and staff, in the future these organisations may be

vulnerable to being bought by others, including large, multinational firms. There is also no guarantee that after the initial 3 year contract the social enterprise will win further contracts from the PCT.

☨ For more information on Social Enterprises read the 'Unite guide to Social Enterprises' available on the website.

PRIVATE SECTOR/COMMERCIAL ENTERPRISES

The door is open for a PCT to put a particular service, or bundle of services out to tender and to contract directly with a private company for future service provision rather than re-organise its own services.

What does this mean? There would be serious implications for staff as they would no longer be employed by the NHS. The implications of this are outlined later. There are also serious concerns about the impact of private sector involvement on the quality of services in the drive to reduce costs.

CONTRACTUAL, PARTNERSHIP AND JOINT WORKING ARRANGEMENTS

VERTICAL INTEGRATION

What 'vertical integration' of services involves is outlined above (under 'NHS organisations) but it should be borne in mind that the door is open to part of the pathway being outsourced. If part of a 'pathway' was being outsourced – either to a private company, the third sector or the Local Authority - and staff were being transferred to that employer then they would be transferred out of the NHS.

INTEGRATED CARE SERVICES *(42)*

This may involve, for example, community services and local authorities creating joint health and social care services. This may be through joint management arrangements or formally through the creation of a "care trust" model.

What this mean? Transferred staff will retain NHS terms and conditions and retain full membership of the NHS pension scheme. New starters will offered either NHS or local authority terms and conditions and may be entitled to join either the NHS or Local Government pension scheme (dependent on individual circumstances).

WHAT ARE THE IMPLICATIONS FOR STAFF IF THEY ARE OUTSOURCED?

The previous section outlined in broad terms the different ways that NHS Trusts' have the option of re-organising themselves. These involve a number of options that would result in staff being transferred out of NHS employment. There are serious implications for the quality of services, accountability and cost of breaking up NHS services into a series of competing small business units which have been outlined at the beginning of this booklet. There could also be a profound impact upon terms and conditions, pension, and even trade union recognition. This section looks at these employment and industrial impacts of outsourcing on staff and their trade unions.

Ultimately, the quality of a service such as healthcare depends upon the experiences and encounters patients and service users have with staff. The need to win service contracts from NHS Trusts to secure future funding and win new contracts in the years to come may lead to an erosion in the number of staff, their terms and conditions and the resources available to those staff.

Current NHS staff

- Staff that are transferred from NHS employment would be 'TUPE transferred': they would retain their Agenda for Change terms and conditions at the time of transfer. This includes access to the NHS pension scheme. These terms and conditions could be changed at some time in the future.
- Staff would no longer be covered by the national negotiating arrangements in the NHS, meaning they would not be entitled to any future pay uplifts or agreed changes to the Agenda for Change Terms and Conditions of Service.
- If staff moved from this employer to another outsourced community service they would lose their entitlement to access the NHS pension scheme and would be treated as 'new staff' rather than former NHS staff.

† For more information on 'TUPE' visit the 'Resources' section of the Unite website and download our legal guide TUPE - Transfer of Undertakings (Protection of Employment) Regulations 2006.

New staff

- New staff would not be entitled to Agenda for Change terms and conditions or access to the NHS pension scheme.
- The Code of Practice on Workforce Matters is statutory guidance that applies across the public sector. The Code states that new starters will be entitled to overall no less favourable terms and conditions to transferred employees. However, there are question marks over whether or not people will implement the code. This raises the prospect of the creation of an unfair, two-tier workforce where employees carrying out similar roles receive different pay, terms and conditions.

Trade unions

- To negotiate pay, terms and conditions on behalf of staff, trade unions need to be recognised by employers. Currently there are national negotiations between the trade unions, the Department of Health and devolved administrations and the NHS employers nationally. This national strength places the trade unions in the best possible position to argue for improvements in pay, terms and conditions for staff and for action on issues such as workload, violence at work, equality and tackling discrimination.
- There is nothing to compel the myriad of different providers which would be providing health services if Trusts outsource services in their reorganisation to recognise trade unions. Recognition would need to be sort separately with each employer which can often be a lengthy process. With the fragmentation of health services between a number of providers across the country it may become impossible to sustain a national agreement. While some employees may be able to secure higher wages Unite believes the splintering of trade union strength will leave many worse off.

STOPPING THE PRIVATISATION

Local campaigns defending services will strengthen the work of the union nationally lobbying and campaigning against the governments drive to marketise and privatise the NHS. Throughout the campaign your Regional Office will support and advise you and the central Unite health sector team will also be able to support you.

This section is designed to help Unite reps to build a broad, mass campaign against privatisation of local services by involving the local community. The weight of this campaign can then be used to effectively intervene in key parts of the process Trusts will be going through to re-organise their services. Bringing the weight of a mass campaign to bear on the Trust will put you in a much stronger position to keep local services as part of the NHS. Even if you initially feel despondent about your chances of success it is still important to campaign and involve the public. Having this on your side will put you in a much stronger bargaining position to protect your members terms and conditions if the outsourcing goes ahead but you may also surprise yourself with what is possible.

Throughout the process of re-organising services the criteria used for decision making by the Trust will have a large impact on the possible outcomes. The below guide should help you in identifying what should be part of this decision making process. Actions for Unite reps should take place as far as possible in alliance with other trade unions to ensure that staff build a united front. You will need to adopt an approach that can oppose the application and secure the best outcome for staff and the local community. The 'Questions' and 'Actions' for workplace reps given below are not exhaustive, but they should help to steer you through what is a complex process.

† Reps should read the Unite Guide to Campaigning in the NHS – the below section just quickly highlights some of the things reps can do as part of their campaign, but the Campaigning in the NHS booklet goes into much greater detail.

As a first step Unite workplace representatives should ensure they have:

✓ A copy of 'Transforming Community Services' guidance to Trusts; its useful to know what guidance the Trust is following. The TCS document is available on the Department of Health website,www.dh.gov.uk.

✓ Contacted the Unite Regional Office and ensure you have an up-to-date membership list, informed your Regional Officer that you want to organise a campaign to influence how your Trust is going to re-organise its services and ask for their support in this.

✓ Contact details of:

- The Primary Care Trust board members,
- The name and contact details of the lead person overseeing the re-organisation of services in your Trust,
- The local media – press, radio and any locally focussed blogs,
- Local elected councillors, and if they are on your local Overview and Scrutiny Committee. These are committees which are linked to local councils, and are made up of local councillors. They are supposed to consider the development of the local health service, policy implementation and the effects it may have on NHS partners, public health matters and reducing health inequalities. You should also find out if any of your local councillors are part of the Unite councillor network – your Regional Officer can do this.
- Your Trusts' 'Local Information Network' (LINk) which is supposed to involve patients, service users and local people,
- Your local MP,
- Your regional Social Partnership Forum staff side members.

✓ Registered on the 'My Unite' section of the Unite website and are familiar with the website. You will be able to access and download materials and share information, ideas and experiences in the Health Sector on-line discussion forum.

✓ A copy of the Unite Guide to Campaigning in the NHS – this is an invaluable guide to winning campaigns in your workplace.

✓ Up-to-date information on the composition of the workforce – this should include a breakdown by service and gender, race, ethnicity, religious, disability and sexual orientation. If your Trust is not collecting this information ensure they do so: it will be important for Equality Impact Assessments further down the road.

REVIEWING COMMUNITY SERVICES

The first step the Trust will take is reviewing its services. This review should identify what the local population will need from a service and how best to meet those needs.

Questions for Reps...

...If your Trust is going to review community services....

▲ Will the review be carried out by the Trust or will it be carried out by external consultants?

▲ What are the assumptions and assertions contained in the remit of the review about the performance of the current 'in-house' services? Assumptions and assertions which are not evidenced and which may steer or bias the review to conclude that the current 'in-house' service is not capable of meeting future needs must be challenged at this stage.

▲ Will the review be an 'efficiency review' of current services, an appraisal of the different future service delivery options, or a wider review of local public health needs? Will there be an Equality Impact Assessment?

▲ How are workforce issues, such as the training needs of staff, vacancy figures and workload going to be considered in the review? Will the review encompass how the current 'in-house' services can be improved through improved training, filling vacancies etc?

▲ How are trade unions and local public going to be involved in the review and what systems of effective communication are going to be put in place to ensure partnership working?

▲ What is the timeline for the review, and is it achievable for the review to be conducted properly?

...If your Trust has conducted the review already you will need to ask the questions listed above.

ACTIONS FOR UNITE WORKPLACE REPRESENTATIVES…

✓ Work with other trade unions in your Trust to organise a meeting of staff to explain what the review is, how it will take place and the threats of service re-organisation ahead. There are materials on the Unite website, and the support of your Regional Officer, that can help you to explain to members of staff what lies ahead.

✓ Recruit staff who are not yet members of a union and ensure that there is effective communication with all members so they are kept up-to-date and understand what is happening. A high density of members who are well organised will place the union and its members in a stronger position.

✓ Make early contact with the LINk group, the Overview and Scrutiny Committee, your local MP and other groups in the local community who could feed in their views to the Trusts' review. Discuss each others concerns and talk about whether they are willing to echo your concerns when they feed into the Trusts' review of services. This should include workforce issues, but particularly how these impact on service delivery. For example, ensure people are aware of 'frozen posts' or reductions in training. They may also not be aware that the review is the beginning of a re-organisation process that may lead to services being privatised, and you will need to explain the threat this poses to service quality. Other local groups you should consider contacting are trade union members in the local Labour party, your MP, local trades councils and other community hubs, such as community centres and places of worship.

☨ *Check the 'Unite Guide to Campaigning in the NHS' for more details and help on these actions.*

CONSIDERING THE OPTIONS FOR SERVICE DELIVERY

Your PCT will need to make a decision about how it is going to organise services in the future; the most important point is to establish that there should be no move away from NHS provision without a rigorous, detailed, evidence based reason. This may be difficult given the wider context of changes to the NHS – again, the Regional Officer and Unite nationally can support you. The consideration the PCT will give to the different options of organising services will flow from the review of community services.

Unite reps should ensure they…

✓ Have a copy of the review of community services, any associated 'efficiency reviews' and Equality Impact Assessments. If the Trust has still not conducted an Equality Impact Assessment ensure they do, and that it is regularly reviewed and amended as appropriate

Questions for Unite reps…

▲ What options for service delivery is the Trust considering, and for which services? It needs to be established what the scale of the threat is – the Trust may be decided to take a different approach to different services. Or, is the Trust going to bundle all community services together?

▲ How is the decision making process of the PCT going to work? Are they going to decide on a favoured option for future service delivery and then invite tenders if they decide to involve the private or third sector organisations or are they going to invite tenders on all options before they decide which to opt for?

▲ When the Trust is reviewing the different options for service delivery will they be including analysis of the transactional costs associated with contracting with organisations outside the NHS? For example, the monitoring of the contract to ensure services are being properly provided and associated legal costs

▲ Will the Trust be considering the associated risks with outsourcing as part of their decision making process? For example, what would happen if the PCT assesses that the services that were contracted for are not being delivered? What would happen to staff and services if the new provider collapsed?

▲ If the Trust decide to go to a tendering process, will 'in-house' bids be considered?

There will be a process of service re-organisation after the decision is made about what option of service delivery to implement. You will need to ask key questions and establish principles about how that re-organisation is going to take place ahead of the final decision on which service delivery option to implement.

▲ How are staff and their trade unions going to be involved in the decision making process? Will there be proper facilities time for trade union representatives during the decision making process and the re-organisation of services?

▲ How will the PCT ensure that the proposed changes will be 'patient led'; support integration between health and social care services; support the development of community based services; and improve public access to local services?

▲ How will services be maintained during the reorganisation so that patient care is not compromised and staff kept motivated?

This is an important stage – while the PCT are still deciding what to do - to bring a mass campaign to bear on the Trust with public support for keeping services within the NHS. Any campaign needs to involve a broad section of society and articulate the adverse impact on service delivery and quality to counter any attempts to paint staff as simply defending their own interests and being against any change.

ACTIONS FOR UNITE REPS….

✓ Draw up a campaign strategy with the help of your Regional Officer to build activity in the run-up to, and during, the decision making process against the out-sourcing of NHS services. You should develop an understanding of what is driving your Trusts' decision making process so you can decide on what the most effective way of pitching your campaign message is.

✓ Arrange for members to discuss and then draw up a plan about how services can be improved without privatisation. This plan may favour one of the options for retaining services in the NHS outlined above. It may also cover issues such as improved training and Career and Professional Development for staff and the need for increased resources in targeted areas. You will be able to get generic 'Health B4 Profit materials including stickers and leaflets that you can be helped to adapt for your own local campaign

Any campaign strategy has to involve building a broad alliance of local people, elected representatives and local organisations as suggested above. Activities you should consider – and the list is not exhaustive – are;

✓ Develop campaign materials, for example, posters, leaflets and a simple factsheet about what the threat of privatisation to local services and why you and others think services should remain in the NHS. Health B4 Profit' materials including stickers and leaflets that you can be helped to adapt for your own local campaign.

✓ Draft a model letter to circulate around your supporters and encourage them to send letters to the local MPs, local Councillors and the board of the PCT.

✓ Take a group of staff to meet ocal MPs and explain what is happening and your concerns over privatisation. Ask them for their support for your campaign, to contact the PCT board and ask them what other actions they would be willing to take to support you.

✓ As well as contacting local councillors, the Trusts' LINk, trade union members and in the local Labour party, your MP, local trades councils and other community hubs, such as community centres and places of worship, hold a stall at a busy public place at the weekend to explain to members of the public the threats of privatisation and hand out campaign materials and model letters.

✓ Arrange a public meeting and rally; be realistic about how many people will attend and book an appropriate venue. Make sure that the event is built effectively through posters in prominent places, leaflets given out and the details sent around on email with people encouraged to circulate widely.

✓ Involving the local media– contact press, radio and any local blogs, see if they are interested in covering your campaign. If you have a public meeting coming up they may let you have a comment piece before the event, or be interested in covering the event itself. Explanations of how the Trust is considering options over how services will be delivered in the future – this includes the possibility of private sector companies taking over services – need to be brief and simple. You should simply explain what you and the staff feel the dangers of pursuing these options would be and the impact on the local community. It is helpful if local patients and service users, local Councillors, MPs and others could give quotes to the media about why they are opposed to privatisation. Let members and supporters know when articles are appearing in local media; encourage people to write letters to the press and leave comments underneath articles and blogs online.

For more information on these actions and others read the 'Unite Guide to Campaigning in the NHS'! Again, your Regional Officer and Unite nationally can support you.

IF SERVICES ARE GOING TO BE TENDERED FOR

It is crucial that certain things are included in the Trusts' criteria for evaluating bids. The Trust should evaluate prospective providers to ensure their bids at least include;

✓ A clear and unambiguous commitment to partnership working with the recognised trade unions.

✓ The full implementation of the Code of Practice on Workforce Matters – statutory guidance issued by the Government to the public sector giving underlying principles on god employment practice when contracting with the private sector.

✓ It should give details of how education and training will be delivered and funded.

✓ There should be concrete plans to address staff shortages.

✓ It should set out policies and actions to tackle institutionalised discrimination to ensure a diverse workforce at all levels of the organisation and carry out public sector equality duties.

✓ A commitment to consult with other local employers (including other NHS Trusts) before implementing changes that may impact on the local labour market.

✓ There should be a commitment to 'best practice performance' standards.

Additional questions that the Trust should ask as part of its assessment of bids are *(43)*;

▲ What impact will this transfer have on the place of work or pattern of work for affected staff?

▲ Will the new provider commit to Agenda for Change and the Knowledge and Skills Framework?

▲ Will the new provider honour future improvements to NHS pay and conditions of employment and other collective agreements for staff?

- ▲ Will the new provider play its part in taking students on placements, providing work for newly qualifying professionals and play a full role in local workforce planning?

- ▲ How will the provider access HR expertise?

- ▲ Will the provider offer full professional liability insurance?

- ▲ Will the provider have a scheme similar to the NHS Injury Benefits Scheme?

- ▲ Does the provider have a strategy for maintaining a safe working environment that encompasses health and safety structures and risk assessments?

■ CONCLUSION

Unite have launched the campaign to stop the break-up and the patchwork privatisation of the NHS because staff are fed up with the mantra that says private companies and the competitive market are an efficient way of running public services and the NHS.

This guide has hopefully given you a helpful starter in building that campaign at a local level to challenge the policies that lead to vast amounts of public money being siphoned off into private companies rather than spent on patient care. Remember, your Regional Office and the union nationally are available to help and support you and have produced materials that can be used.

NOTES

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