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**Journalists' Briefing Pack June 2009**

# **The biggest story never told...**

## **The big NHS story that nobody is reporting**

Vital NHS services that support millions of vulnerable people in England, consume around 10% of the NHS budget and employ a quarter of the NHS workforce face a massive shake-up that threatens to fragment services, privatise many of them, and replace the planned provision of care with a competitive "market". **The NHS could soon cease to be a provider of these services** in many areas, with contacts handed over instead to profit seeking private companies and untested non-profit "social enterprises", and staff facing the loss of their NHS terms, conditions and pensions.

The services at stake include primary care, care of the elderly, community services for mental health, and learning disabilities, and in some cases overlap with social care and social work: they employ nursing staff, health visitors, occupational therapists and other health professionals as well as non-clinical support staff. They are vital to ensure the efficient operation of hospitals and support for vulnerable people in their own homes.

**These changes to these services are controversial.** They are **experimental**, based on ideological assumptions, and **lack any evidence** to support them. They are being imposed on sceptical front-line staff from the top down, through Strategic Health Authorities and the senior management of Primary Care Trusts. **In many cases they involve more bureaucracy, new tiers of management, and even the appointment of "commercial directors" – all of which divert resources from patient care.**

But the public – and many NHS staff – know little or nothing of what is taking place. There has been no public demand or pressure for any of these changes. Indeed NHS managers have avoided asking the public, or informing them, and they have been assisted in this by the silence in the press.

**NOT A WORD** on the scale and implications of these proposals is appearing in the national or local press. TV and radio news remain silent on an issue which will affect and potentially put at risk primary and community care services for many of their audience.

**The deafening silence on such far-reaching changes is no accident.** Ministers know that when essentially the same proposals were put forward for public debate in 2005, in the ill-fated Department of Health circular “**Commissioning a Patient-Led NHS**” it triggered a huge explosion of anger which effectively cost NHS Chief Executive Sir Nigel Crisp his job, and forced Health Secretary Patricia Hewitt and other health ministers to retreat from some of their more radical ideas, and even apologise to the trade unions.

Now there is **no parliamentary debate**, despite the fact that many of the policies that are now being implemented – without any public consultation – are virtually identical to policies that were strongly criticised by the Commons Health Committee who in December 2005 professed themselves “appalled” by the confusion created by Sir Nigel Crisp’s proposals. No local politicians – councillors or MPs – now appear to be aware of what is being done in their constituencies, or willing to find out.

Ministers want to keep it that way. That’s one reason why this time around there have been **NO** Department of Health press releases to draw attention to the new policies, which have been the subject of intense management activity within the NHS since last summer. That was when the misleading term “**World Class Commissioning**” was adopted, wrapped up in an unreadable literature, littered with pointless and confusing jargon, as a device to divert attention from its central purpose – **the creation of a competitive market that will open up the £11 billion NHS budget for services that up to now have been provided directly by Primary Care Trusts.**

Astonishingly since then not a single DoH Press Release has drawn attention to the World Class Commissioning policy!

## **Transforming Community Services ... into a healthcare “market”**

On January 19 2009 the timetable for a rapid break-up of the existing services was set out by the government in a 110-page DoH document **Transforming Community Services**. It gave Primary Care Trusts until April 2009 to separate their “provider” services from their “commissioning” arm, and establish a contractual basis for the services. PCTs were given another six months (to October 2009) to draw up plans to transform these same services to “stimulate a local market” in health care, “increase patient choice” and ensure “contestability and competition”.

To do this means offering key services out for competitive tender to NHS providers (mainly Foundation Trusts), the private sector, or so-called “third sector”. In many cases creating this “third sector” means pressurising NHS managers to look for ways of separating out and floating off their services as “social enterprises” outside the NHS, regardless of the concerns of their staff.

**NOT ONE** national daily newspaper reported the launch of Transforming Community Services – not least because not a single Department of Health Press Release was issued to publicise its launch or its existence.

**No DoH Press Release since January has headlined on Transforming Community services**, or tried to draw attention to the significance of the changes it is seeking to impose on local NHS services –

not least because there is no evidence that they could secure any significant public support for the proposals.

## **No consultation ... despite talk of “engagement”**

**The lack of any media coverage has ensured that few if any members of the wider public know anything at all about the potential changes taking place in their local services.**

This is despite the fact that almost every policy document has obligatory sections making tokenistic reference to the “engagement” of “stakeholders”, “clinicians” and the wider public. Denied any opportunity to register their views, millions of people are likely to be confronted by a fait accompli as popular local services are broken up and hived off to a variety of unproven providers in an experimental system that has not been tested anywhere in the world.

And to ensure maximum silence, Strategic Health Authorities and local Primary Care Trusts have opted to push through the changes with **no public consultation**, and only the most tokenistic and minimal pretence of even consulting the staff involved.

NHS staff, many of them with long service and extensive training and experience could find themselves losing their jobs as profit seeking private sector companies cherry-pick services offering secure returns for shareholders: or staff could be press-ganged out of the NHS and into “social enterprises” which would offer inferior terms and conditions, and less security for those transferring, and drastically worse terms and conditions to any staff subsequently recruited to their workforce.

## **The Competition Panel that could outlaw cooperation**

To ensure that the private sector is given the maximum opportunity to capture the most financially attractive sectors of PCT provider services, the government is also setting up a powerful new body, the **“Cooperation and Competition Panel”**, with a brief to consider complaints from private providers that they have been unfairly excluded from a local “market”.

The Panel makes little pretence of being unbiased: it is a forum for the private sector and those who believe in markets as a means to deliver health care. It contains nobody with a background in health care management or any commitment to public services. Instead it is composed of one token medic, a group of competition lawyers and an academic health economist, and is **chaired by a former private healthcare boss Lord Carter of Coles**.

Lord Coles’ appointment was announced last September 11 in a Department of Health Press Release, which also reported the enthusiasm for this appointment from the organisation representing major private sector providers, the so-called “NHS Partners Network”. Its vice chairman Geoff Benn is quoted as tactfully underlining Lord Carter’s private sector credentials in private medicine and nursing homes:

“We particularly welcome the fact that he has substantial commercial experience in the sector.”

**The Panel’s powers and policy guidelines have not yet been finalised. Key policy documents were allegedly put out for “consultation” at the end of January, with the consultation running to April 30.** But once again, although the Competition Panel itself put out a press release as it commenced

work on January 30, there have been **NO** press releases this year on the Panel from the Department of Health.

**Not surprisingly, there has therefore been virtually no press coverage of this consultation and no exploration in the media of the issues involved.** Even the explicit, scathing criticism by former Blair government advisor Professor Chris Ham, reported in the *Health Service Journal* (March 5) pointing out that the Panel's guidelines seemed to have been written by a "neoliberal on speed" did not trigger any reporting, discussion or debate in the wider national press.

As Prof Ham points out, the policy proposals are far-reaching. The Panel is seeking to prevent "**price fixing**" which might even mean preventing the Department of health from fixing a standard tariff price. It opposes "**collusion**" between providers, which seems to make it almost impossible for public sector providers to work together and cooperate to ensure a "seamless service" and that all local demand for care is met efficiently. And it sets out stringent restrictions on **mergers** and anything which might seem to result in a local "monopoly" – which could prevent the merger of struggling NHS Trusts or Foundations, and rule out the establishment of Community Foundation Trusts, which in many areas is the only policy option that would keep staff within the NHS.

## **The purpose of this Briefing**

It's late in the day to stop the process that has been started in such a surreptitious fashion: but it is possible to raise public awareness, promote debate on the merits of the proposals, and possibly minimise the scale of the disruption and damage to local services.

That's why UNISON Eastern Region has commissioned this Briefing Pack. Its aim is to offer all health journalists the opportunity to familiarise themselves with these changes, encounter a critique of the policies, and recognise the local and national implications. Enclosed in the following pages are:

- 1) A brief history and critical summary of **Transforming Community Services** at national level (pages 5-8)
- 2) A summary and critique of **World Class Commissioning (pages 9-11)**
- 3) A critical explanation of the purpose and potential powers of the **Cooperation and Competition Panel (pages 12-15)**
- 4) A brief discussion of the proposed choice of organisational forms, including **Community Foundation Trusts and the "social enterprise" model** (pages 16-19)
- 5) A case study: **marketisation policies in NHS East of England.** (pages 20-25)

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# 1. ‘Transforming Community Services’ – a Critical Guide

## History:

In July 2005, just after the general election, then NHS chief executive **Sir Nigel Crisp** attempted to split directly-provided services off from the PCTs, suggesting they should become simply commissioning bodies, with as many as possible of their services hived off – privatised, handed over to “social enterprises”, or run at arms-length until some alternative could be found.

Crisp was looking at a model in which **the NHS would effectively cease to be a provider of services:** instead it would become a fund to **purchase – or “commission”** – services from a range of providers, all outside of the management framework of the NHS, and competing with each other in a new health care “market”.

The “Commissioning” would be done by Primary Care Trusts as local budget-holders, and the proposal was for them to **divest themselves of any other role**, separating themselves from the **services which they had directly provided since they were established in 1999**.

Crisp called his plan **“Commissioning a Patient-Led NHS”** (DoH circular, July 2005), although there was no hint anywhere in his rambling and vague circular on how patients would have any say at all over the reorganisation he was proposing, or what would happen to many of the services which might not attract any interest from the private sector or “social enterprises”.

In fact the Crisp plan involved the merger of **25 Strategic Health Authorities** into just **ten** even more remote and more arrogant super-quangos, and the forcible **merger of over 300 PCTs** into half that number (152), most of them covering much bigger catchment areas, and much less accountable organisations than before, paying only lip-service to public involvement.

This part of the plan was carried through: however Crisp’s rapid-fire proposals to hive off the PCTs’ directly-provided services proved far more controversial, and **ministers were forced by a tide of public anger to intervene and slow the process right down**. But four years later, long after a disgraced Crisp was dispatched with “early retirement” to the House of Lords with a fat pension pot, they are coming back to try again.

## Early warning

In 2007-8 **Lord Darzi’s Next Stage Review** repeatedly stressed the need for every PCT to carry out reviews of their provider services, and in **High Quality Care for All**, published in June 2008, he urged again for them to be split from the PCTs, to allow these to “concentrate on their commissioning role”. Darzi pulled back from insisting on any particular organisational form for the provider services, but he did attempt to clear away a major obstacle to securing staff acquiescence to social enterprises, by opening up the possibility of maintaining NHS pension rights for those NHS staff who transfer, as long as they stay in the same job and work on NHS-funded contracts.

Darzi's review also explicitly connected with the notion of "**World Class Commissioning**", again focused strongly on reducing PCTs to a purchasing rather than a provider role.

Among the 11 "competencies" against which the performance of PCTs were to be judged, a crucial one was Competency 7: "**Effectively stimulate the market** to meet demand and secure required clinical and health and well-being outcomes". To complete the switch from public service to competitive market, PCTs are required to "communicate with the market **as an investor, not a funder**".

This also means helping to "develop provider capacity": so NHS premises, IT services and equipment will also be made available to new organisations entering the market, ensuring that **private bidders can bid for NHS contracts without requiring any significant capital**: nor do they necessarily require any **experience or staff**, as long as they can satisfy the minimal criteria established by PCT commissioners.

## Policy hardens up

The separation of provider and commissioning arms of the PCTs was incorporated into the NHS **Operating Framework 2008-9**. PCTs were given "freedom" to pick from a limited range of options for reorganising their provider services:

- Community Foundation Trusts (of which none as yet exist),
- social enterprises (few of which operate on the scale of PCT provider services);
- integration with other NHS organisations,
- privatisation,
- and "integrated care organisations" with local government.

Additional pressure has come from the ostensibly neutral **Healthcare Commission**: chief executive Anna Walker was reported in the *Health Service Journal* predicting that **specialist services** would be the first segment to be commissioned from the private sector.

The lever for forcing these policies on Primary Care Trusts has been the **Strategic Health Authorities**, which have continued to press for divestment of services and for the opening up of local competitive "markets" in which private sector providers and social enterprises would be given preferential encouragement.

This regional control has left room for some differences in approach: in Hartlepool and Stockton-on-Tees the local Foundation Trust has been allowed to take over the PCT provider arm, and 856 staff, while in other parts of the country SHAs have been much more strongly opposed to this type of solution.

Two SHAs, NHS South West and NHS South Central have looked instead in other directions, and even brought in costly **management consultants** from **accountants AT Kearney** and **private health insurers BUPA** to help increase competition.

## A timetable for enforced change

However all faced the national target of separating “commissioner” and provider services by April 2009. And in January 2009 the DoH document *Transforming Community Services: Enabling New patterns of Provision* set out the next hurdles to be surmounted, requiring PCTs to have drawn up detailed business plans by **October 2009** for transforming local services, explaining how they will increase patient choice, improve service provision and provide “contestability and competition”.

By **April 2010** PCTs will have to have agreed with their SHAs a clear and realistic strategy for the future of the community estate that will ensure that the **estate’s** fitness for purpose is assessed in the light of current and future commissioning intentions, exploring options to ensure that the estate is managed on an efficient and flexible basis to accommodate future changes in need. This means offering NHS premises and assets to fledgling private sector companies and social enterprises.

And **during 2010** PCTs should develop their implementation plan, watched closely by the SHAs which will be responsible for ensuring that PCTs make substantial progress.

## No consultation

Almost none of these changes so far has been subject to any process of public consultation. In Luton, where management proposes the PCT’s services should be hived off in a “social enterprise”, staff were told in a Q&A briefing that:

**“There are no changes planned in the current services ... so for this change formal public consultation is not needed”.**

The lack of consultation is clearly a policy decision rather than a lack of opportunity. NHS East of England, for example, claims to have decided on the enforced separation of PCT commissioning and provider roles back in the autumn of 2007 (even before the launch of the World Class Commissioning programme). Yet East of England’s large-scale public consultation last year on the nebulous strategy document *“Towards the Best, Together”* – of which the SHA is inordinately proud on its website – made **no reference** to the proposals either for a competitive market in health care or for World Class Commissioning.

**The public could easily have been told the plans and asked their views: THEY WEREN’T.**

## What does it mean for staff and patients?

There is no doubt at all that the whole Transforming Community Services programme is designed to **open up a new, competitive market in NHS-funded services**. The previously low-profile and often neglected community and primary care sectors appear to have been chosen partly because of the widespread ignorance of the range of services and their importance.

Since the stormy days of 2005-6 in which Nigel Crisp’s proposals to split provider and commissioning functions triggered a widespread and almost entirely hostile reaction, which forced an embarrassing ministerial retreat, there has been little press attention on these services, and there is little sign of involvement or awareness among MPs, councillors, journalists or the general public.

However the services are also a crucial **interface with the hospital sector**, with primary care referring patients for specialist care, and intermediate care and other services supporting patients discharged from hospital treatment, and those receiving treatment at home. **Primary care services deliver up to 80% of NHS appointments day by day, and PCT direct services employ almost a quarter of the NHS workforce and have budgets of £11bn – 10% of total NHS spending.** The extension of privatisation and a competitive market model into this sector represents a considerable restructuring of the NHS.

**It is also a monstrous gamble:** the model of relying upon a competitive market to deliver health care services has not been implemented anywhere in the world, and it is remarkable that **despite frequent references to “evidence-based” health care, NONE of the SHAs or PCTs can refer to any evidence that this experimental system will deliver the required mix of services to the many vulnerable patients who depend upon them.**

**95% of provider arms** interviewed recently by the NHS Confederation's PCT Network **rejected the social enterprise model**, saying they preferred to remain within the NHS – as do most NHS staff, who have a lot to lose. But the main focus of SHAs and PCTs is on forcing staff and services **OUT of the NHS**, into new forms of organisation. And while in theory there should be the option of remaining as a PCT provider arm, PCT Network director David Stout told the *Health Service Journal* :

**"All the policy pressures are not to stay within the PCT. There isn't any other option than one form or other of foundation trust."**

But while many staff are anxious at potentially losing their hard-won **terms and conditions** within the NHS, many more are concerned that the process of tendering services and offering the tastiest morsels to the private sector **could leave some services stranded, even facing closure.**

PCTs are adamant that they no longer want to provide any services, but their plans are silent on how they will seek to ensure that services are maintained when nobody else bids to run them. **Who will be the provider of default** on services where Community Foundation Trust bids have been turned down, the private sector has discounted any hope of making a profit, and where no social enterprise can be found to step in to the breach?

**And the track record of privatisation by PCTs so far has been far from encouraging.** In Camden, PCT bosses defied repeated angry public protests to award contracts to run GP practices to the American-owned UnitedHealth, whose lower priced bid centred on **lower quality care for patients.** Despite the dogmatic insistence of ministers and senior managers, there is little to suggest that services run to deliver profits for shareholders or build up surpluses in a social enterprise will be in any way better for patients than public services delivered through the NHS.

The long term threat to squeeze down the skill mix, pay and conditions of the workforce in social enterprises suggests that the level of training and quality of care are likely to diminish rather than improve, and the folly of seeking to control complex systems through “regulation” has already been vividly demonstrated by the global banking crisis. **If G20 governments now agree that the free market can't be trusted to run the business of capitalism, it seems irresponsible to establish a similar system to deliver health care to the vulnerable.**

## 2) World Class Commissioning

The Department of Health website<sup>1</sup> now sports an extensive section detailing the origins and progress of World Class Commissioning, dating from the initial proposals back in December 2007.

The literature is largely composed of **clichés, truisms and jargon**. Many of the proposals are unobjectionable, and common ground to anyone concerned with the development of the NHS: typical is this summary in the July 2008 DoH Briefing Pack:

**“World class commissioning describes outstanding performance in the way we commission health and care services. It is a statement of intent, aimed at transforming the way we operate and in so doing ensuring the NHS remains one of the most progressive and high performing health systems in the world.”<sup>2</sup>**

But tucked away as the seventh of the eleven “World Class Commission Competencies” is a requirement that leads to the fragmentation of the NHS – requiring PCTs as local commissioners, overseen by SHAs, to “stimulate the market” in healthcare services.

Like most of the subsequent WCC literature, even this requirement is couched in terms that distract from the controversial core proposal – the **end of NHS provision of many services** for some of the most vulnerable patients, and the creation of a **new, untested, experimental competitive “market”** in health care:

### **“7. Stimulate the market**

**“Commissioners will need a choice of responsive providers in place to meet the health and care needs of the local population. Employing their knowledge of future priorities, needs and community aspirations, commissioners will use their investment choices to influence service design, increase choice, and drive continuous improvement and innovation.**

**“• World class commissioners will have clear strategies for dealing with situations where there is a lack of provider choice, particularly in areas where there is relatively poor health and limited access.”**

*(World Class Commissioning: Vision, DoH December 2007: p4)*

Despite the far-reaching implications of this commitment to sweep away the current system and open up these services to private sector and other bids, WCC literature has consistently **downplayed** this key component. In July 2008, for example, a 4-page DoH *World Class Commissioning Summary*<sup>3</sup> used the word “market” just ONCE, and made no attempt to explain the significance of the controversial Competency 7.

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<sup>1</sup> <http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/index.htm>

<sup>2</sup> [http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/DH\\_083195](http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/DH_083195)

<sup>3</sup> [http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/DH\\_083195](http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/DH_083195)

But running through the entire WCC programme has been an implicit **reliance upon private sector providers**, backed up by an increased level of **private sector management consultancy** to steer PCTs away from the previous NHS system and into the new competitive marketplace.

The DoH WCC web page features a box **urging PCTs to buy in external (private sector) “support”** to assist them in carrying through the programme:

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

In September 2008, the DoH announced<sup>4</sup> that “following a rigorous procurement process”, **SEVEN** organisations, mainly city consultancies, but also including private healthcare providers and insurers, had been selected to drive this process, and “appointed to the PCT board development framework”. The seven organisations are:

- **A.T. Kearney Ltd**
- **ATM, GoodwinHannah**
- **Ernst and Young, Bath Consultancy Group, The Kings Fund, United Health UK**
- **KPMG, University of Manchester Business School, Dr Foster Intelligence, Morgan Cole, Role Plays for Training Ltd**
- **Newchurch Limited, Bupa Commissioning, OD Partnerships Limited**
- **PA Consulting Services Limited, SHM Productions Ltd, 2020 Delivery Ltd, Praesta Partners LLP, Inspired Leaders Network**
- **PricewaterhouseCoopers, The Governance Institute**

The DoH explained that

**“Having a high quality board is a crucial element to PCTs becoming world class commissioners. The ten SHAs identified a specific need for PCTs to improve the performance of their boards, and asked DH to put in place some high quality support that all PCTs could access to help them improve.”**

**No evidence** has been offered to show why these selected organisations can be trusted to deliver “high quality support” to PCTs seeking to commission comprehensive and universal health care services for their local population.

None of the selected seven consultancy organisations is noted for their promotion of cooperation, collaboration or progressive human resource policies: instead all have clearly satisfied the DoH that they are happy to help SHAs and PCTs drive the transformation of these key services from public services publicly provided into a publicly-funded competitive market.

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<sup>4</sup> [http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/DH\\_083194](http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/DH_083194)

It is remarkable that with this extensive focus on the implementation of competency 7, only lip-service has been paid in this process to Competency 3: **“Engage with public and patients”**.

**“In order to make commissioning decisions that reflect the needs, priorities and aspirations of the local population, world class commissioners will engage with the public, and actively seek the views of patients, carers and the wider community. This new relationship with the public is long term, inclusive and enduring, and has been forged through a sustained effort and commitment on the part of commissioners. Decisions are made with a strong mandate from the local population and other partners.”**

The government itself has made even more sweeping commitments to engage with and consult the public, most conspicuously in Lord Darzi’s “five pledges” published on May 9 2008<sup>5</sup>.

Seeking to defuse public scepticism over government health policies, and fears that some services would be downgraded, and hospital and primary care services centralised at the expense of local access, Darzi promised that changes would “always benefit patients”, be “clinically driven” and “locally led” – none of which can be shown to have applied in the implementation of World Class Commissioning. He added two more key pledges.

**“4. YOU WILL BE INVOLVED. The local NHS will involve patients, carers, the public and other key partners. Those affected by proposed changes will have the chance to have their say and offer their contribution. NHS organisations will work openly and collaboratively.**

**5. YOU WILL SEE THE DIFFERENCE FIRST. Existing services will not be withdrawn until new and better services are available to patients so they can see the difference.”**

It is clear that few if any PCTs or SHAs have paid any regard to these two pledges as they force through changes with little if any pretence of public consultation or engagement with front-line staff. Instead they have been committing themselves to sweep away the existing NHS structure... even before they know which if any of the existing services may attract bids from private or social enterprise bidders – or in short how the services will be provided in the medium and long term future. Far from **“seeing the difference first”**, patients and staff are being kept in the dark over the changes, while PCT bosses are simply following orders from above and hoping for the best.

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<http://nds.coi.gov.uk/environment/fullDetail.asp?ReleaseID=366998&NewsAreaID=2&NavigatedFromDepartment=False>

### 3) The Cooperation and Competition Panel; outlawing cooperation

The pace of privatisation across the whole of the NHS is to be driven by the establishment of a new **“Cooperation and Competition Panel”** (C&C Panel) chaired by former **private healthcare and nursing home boss Lord Carter of Coles**, whose appointment was eagerly welcomed by the private sector.

The Panel was set up last autumn with the explicit purpose of allowing private sector providers to raise complaints that they have been unfairly treated, and that a local area has not been sufficiently opened up to competition between would-be providers – whether this be in community services, primary care, mental health or acute hospitals. **No equivalent right to appeal exists for NHS Trusts, Foundation Trusts, health workers or local communities or patient groups convinced that their services would be better delivered by a public sector organisation.**

In other words the Panel has the task of shifting the goalposts and bending the rules wherever necessary to ensure that the private sector gets what it wants.

Policy documents make clear that the Panel sees its role as responding to private sector complaints against potential **mergers of NHS providers**, and against what they see as unfair procurement policies, **“collusion”**, or **“price fixing”**.

**As such, despite its misleading title, the Panel is transparently biased against cooperation, collaboration or planning between different sections of the NHS.**

Interestingly it **does not regard the 1 million-plus staff who deliver NHS services as part of the long list of local, national, and institutional “stakeholders”** it seeks to work with (Consultation document 3.14). The longer list of stakeholder organisations included in the consultation includes the BMA and the RCN, but **excludes UNISON**, representing **400,000 health workers**, and any other TUC-affiliated unions.

The draft policy guidance for this obscure body was in theory put out to three months **public consultation on January 30<sup>6</sup>**, although it has barely been reported since then even in the health service press. It has been subject to virtually **no debate**, and few health workers, MPs or members of the public will have had any idea what was being proposed. The consultation **ended on April 30**.

One person who did flag up the importance of this Panel was Professor Chris Ham, a former advisor to Tony Blair’s government, who branded the guidelines as **“written by a neo-liberal economist on speed”**, and criticised its **“one-eyed”** focus which undermines integration of services and regards almost any collaboration between providers as **“collusion”** (*Health Service Journal* March 5).

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<sup>6</sup> <http://www.ccp-panel.org.uk/reports-and-guidance/consultations.html>

The Panel's total opposition to any form of "price fixing" might even question the Department of Health's policy of establishing a **national tariff for treatment costs**, warns Prof Ham.

Although the word "cooperation" is included in its title, there is no sign of any commitment to cooperate: the C&C Panel is single-mindedly focused on driving through a competitive system. Its policy documents **endlessly reiterate claims for the alleged benefits of competition**, many of which have also been echoed in the policy documents of Primary Care Trusts and SHAs, despite the total absence of any evidence to support them:

**"In general terms, competition can be expected to have numerous beneficial effects: costs are driven down, and innovation and productivity increase, so increasing the quality and, more generally, the diversity of choice available as service providers respond to the preferences of their patients."**

None of these alleged benefits is supported by even a shred of evidence from health care systems anywhere in the world. That's why not one of the policy documents produced by the Panel, PCTs or SHAs offers even a single concrete example of the alleged benefits of competition being delivered. But the Panel goes on to make even more extravagant and absurd claims for the merits of competition against planning:

**"As set out in the Framework for Managing Choice and Competition, choice and competition in the NHS can be expected to:**

- improve quality and safety in service provision;**
- improve health and wellbeing;**
- improve standards and reduce inequalities in access and outcomes;**
- lead to better informed patients;**
- generate greater confidence in the NHS; and**
- provide better value for money."**

This list is pure fantasy: indeed not even the most fundamentalist of free-market ideologists would dare to claim that markets "improve health" or "reduce inequalities" – that's not what markets are supposed to do.

**Markets by their very nature cannot eliminate inequality**, especially in health care, where the focus of market-based services on surpluses or profits means that – as with private medicine – they tend to focus the greatest resources on the least serious, least complex health problems, which are least risky to treat, and most likely to deliver a surplus. **Services which cannot deliver a surplus cannot survive in a market system, regardless of the level of social need for them.**

That's why **the most unequal health services in the world are those most heavily based on a competitive market system** – most obviously the USA, where one in six of the population is excluded from formal health insurance cover, but where "average" health spending per head is by far the highest in the world.

The same "competitive" system in the USA results in the most **massive bureaucracy and administrative costs, accounting for up to 30% of health spending in the private sector**, while the publicly-administered Medicare system spends around 8% of its turnover on administration. Nor is there a benefit in terms of quality of care – whether this be improved life expectancy or even a reduced number of medical errors and accidents.

Having spelled out its completely biased, free-market approach, the Panel's guidelines go on to claim that:

**“The benefits of competition for patients and taxpayers will only be realised, however, where there is effective competition between service providers for patients or contracts to provide services to patients (i.e. service contestability).**

**“Where the process of competition is dampened, or otherwise hindered, by a merger, the benefits to patients and taxpayers from choice, competition and service contestability may be weakened or lost.”**

Of course all this, too, is a deception, empty words. **The private sector does not want genuine competition, because there is no way private medicine is viable in a free market.** The inequalities of capitalism mean that the people most likely to need health care tend to be the very young, the very old and the very poor – who are least likely to be able to pay a market price for their care. **That's why even in the private sector-led USA almost 60% of health spending comes through government in one way or another.**

The only way New Labour has been able to build up the previously marginal private healthcare sector of 1997 into a slightly less marginal one in 2009 has been through **state sponsorship and blatant favouritism**: preferential allocation of ring-fenced contracts to private providers; **paying above NHS rates** for Independent Sector Treatment Centres (ISTCs), some of which deliver only a fraction of the work commissioned; paying out **sweeteners**, start-up **subsidies**, and **guaranteed long-term contracts**.

Even now **private contracts** with the NHS are **exempt from the “Payment by Results” system** that applies to all NHS and Foundation Trusts, while public sector providers **are excluded** from even bidding for ISTC contracts.

Genuine competition would kill off the private sector, which delivers **marginal levels of minor treatment at higher cost**, while leaving all of the more complex and demanding treatment, all emergencies and chronic care, and almost all mental health care, to the NHS.

**Private providers don't want competition: nor do they want to take over the whole of the NHS. They want to split it up and slice off (cherry-pick) the bits they find profitable ... and leave the rest to the NHS – and the Competition Panel is being set up to help them do it.**

The NHS is viewed by the Panel as a business like any other, with no recognition that certain services have to be maintained and made available to meet local health needs.

Any attempt to stabilise NHS Trusts and their services through **mergers** is seen simply as an obstacle to private sector involvement, and therefore **“anti-competitive”**: so any planned mergers of NHS organisations with a combined turnover of more than £15m a year in primary care, £35m in community services or £70m in acute and mental health care (i.e. virtually any NHS providers) could be referred by the Panel to the Office of Fair Trading, or even the Competition Commission, and potentially blocked.

This seems likely to pose serious problems where PCT provider arms seek to link up and form Community Foundation Trusts. **To gain the scale of operation required to convince Monitor to grant Foundation Trust status seems very likely to trigger the intervention of the C&C Panel.** With

the one remaining NHS route closed off, provider services would be forced to resort to becoming “social enterprises” or see services bundled up and privatised.

In similar fashion, any attempt between two or more NHS providers to **cooperate** and divide responsibility for services between them – or to agree NOT to provide the same services or to compete with each other for the same pool of patients – could also be branded by the C&C Panel as **“collusion”**.

And the Panel even seeks powers to intervene in cases where – even without any collusion – an NHS provider is seen as having too large a share of a local market without sufficient competitive pressure.

Far from expressing any concern for the continuity of services in Trusts and providers destabilised by the new competitive market, the Panel sees the instability as a virtue. It is supposed to make NHS Trusts behave more like profit-seeking businesses:

**“Few NHS-funded healthcare service providers have a profit maximisation objective. But, service providers generally need to earn enough revenue to cover their costs. Losing patients to other service providers will affect their ability to cover their costs. This increases their incentive to provide patients with high quality services and thus ensure that they are amongst the service providers of choice for current and future patients.”**

**(C&C Panel Consultation document, page 16<sup>7</sup>)**

The C&C Panel goes on to discuss measures to restrict “predatory pricing” – but only when it is complaints against NHS providers, not when it is companies like UnitedHealth pursuing “loss leaders to secure contracts in primary care and other services.

With a Panel as blatantly biased as this towards one blinkered view of a competitive market system, it is unlikely that any issues relating to the continuity of patient services or the recruitment, training, development and retention of a qualified workforce will be taken seriously into account.

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<sup>7</sup> <http://www.ccpnl.org.uk/content/CONSULTATION-Mergers.pdf>

## 4. A critique of the organisational forms on offer

All of the suggested possible arrangements for the continued provision of PCT services carry doubts and problems attached.

**“ARMS-LENGTH PROVIDER ORGANISATIONS”** are generally seen as **interim measures** to hold services together before the varying mix of provider services are carved up into smaller contracts to allow competition and alternative providers.

Creating these bodies involves **additional management costs** – as does every further fragmentation of services. The only advantage from NHS staff point of view is that at least for a transitional period they **remain NHS employees** and covered by full NHS terms and conditions.

**INTEGRATION WITH OTHER NHS ORGANISATIONS** also appears to offer the possibility of maintaining continuity of employment and NHS terms and conditions. In theory Provider arms could consider “vertical integration” through merger or joint management with the local acute services Trust, or “horizontal integration” through merger with one or more other provider arms in neighbouring areas.

However options for the merger of existing NHS Trusts with other organisations may now fall foul of the **Cooperation and Competition Panel**, which argues that:

**“Where the process of competition is dampened, or otherwise hindered, by a merger, the benefits to patients and taxpayers from choice, competition and service contestability may be weakened or lost.”**

Any attempt to stabilise NHS Trusts and their services through mergers may as a result be seen as an obstacle to private sector involvement, and therefore “anti-competitive”. As a result the Competition Panel proposes that any planned mergers of NHS organisations with a *combined* turnover of more than £15m a year in primary care, £35m in community services or £70m in acute and mental health care (**i.e. virtually any NHS providers**) could be referred by the Panel to the Office of Fair Trading, or even the Competition Commission – and potentially blocked.

The PCT Network estimates **half of provider** arms are looking to merge with neighbouring PCTs' community services, and half of the merged organisations might want to become **community foundation trusts**. But this is likely to incur the wrath of the “Cooperation and Competition Panel” and **NHS chief executive David Nicholson**, who made clear last year that he did not want to see community foundation trusts “reinventing a monopoly”.

**INTEGRATED CARE ORGANISATIONS:** another possible link-up is between NHS providers and local government social care services – maybe through pooled funds or transfers between local authorities and the NHS, or new organisations such as care trusts, a few of which have already been established.

From a staff point of view, if the new body is NHS-run there is a guarantee of NHS terms and conditions, including pension, and Agenda for Change. If local authorities take over services, then TUPE would apply meaning that new starters may receive either NHS or LA terms and conditions, including pension.

Although there may be questions over the viability of these bodies, and possible disagreements over funding, this part of the NHS would remain in the public sector.

**COMMUNITY FOUNDATION TRUSTS** offer PCT provider staff the only real hope of remaining NHS employees. But it may be a faint hope. **So far not one Community Foundation Trust yet exists**, and at present applications to join “pilot” CFT programmes are limited in number.

Of course the unions have raised many criticisms of the Foundation Trust model. The **criteria** imposed by the **independent regulator, Monitor**, for hospital Trusts to qualify as Foundations have been exposed by the disastrous performance of **Mid Staffordshire Hospitals** and **Birmingham Children’s Hospital**, both of which passed the regulator’s tests, but delivered dangerously poor services. Monitor’s initial targets can now be clearly seen as focused purely on would-be Foundations’ **financial performance**, and how they function as a free-standing business, and not at all on the **quality of patient care**.

It is widely argued that Community Foundation Trusts will find the financial bar set proportionately even higher, even though many PCT provider arms are relatively small organisations compared with the large acute hospital Trusts. This could force provider services to seek mergers or resort to other even more problematic solutions.

Ministerial claims that Community Foundation Trusts (or CFTs) are **‘accountable’** or **‘responsive’ to local people** are also discredited by mounting evidence that many existing FTs are now **even more secretive** than regular NHS Trust Boards (which themselves had to be instructed in 1997 by health minister Alan Milburn to hold meetings in public and to publish their board papers). **More than 75% of FTs now hold their Board meetings behind closed doors**, with the press, public and even local council scrutiny committees excluded.

**SOCIAL ENTERPRISE:** The other options open to provider arms, are the various permutations of the social enterprise model: social enterprises are not-for profit businesses in the sense of not distributing profits to shareholders – but they all also need to generate a surplus each year, and therefore run as a business in what is supposed to be an increasingly competitive market.

Different structural models of Social Enterprise range from companies based on shares to worker co-operatives, and they enjoy **preferential treatment**, with **Lord Darzi** and others making concessions to facilitate the transfer of NHS staff with **retained NHS pension rights** – but only as long as they work the same job, delivering NHS-funded care.

However SEs are largely untried and untested in the delivery of large-scale health care services. Government sources suggest that there are something over 55,000 social enterprises in the UK, turning over a staggering £27 billion each year. More than 60% 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 Social Enterprises are small organisations with budgets of below £1 million a year**, and more than a third are tiny, with **budgets of less than £50,000. More than half employ fewer than 25 people** and in two thirds of social enterprises volunteers outnumber paid staff. According to the DoH in 2007, just 2% of third sector organisations had budgets in excess of £5m, meaning that even the smallest NHS Trust turnover would be off the scale of the firms featured in the Department of Health report.

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

Any new SEs would need to keep their heads above water in the choppy waters of a competitive health care market: any financial problems would immediately have to be transmitted into a reduction in the terms and conditions of their staff, the main item on the budget.

Another immediate drawback of all of these various models is that **the staff concerned cease to be NHS employees**, and new recruits would never become NHS employees. This will put all of their terms and conditions at long-term risk once the short-term protections and guarantees for NHS staff transferring have been lost. Management at Luton Community Services, for example, while trying to convince staff of the case for a Social Enterprise have recently admitted that:

***“The new organisation will agree a period of time in which the current terms and conditions of employment will continue, after this ‘grace period’ which has to be agreed some terms and conditions will change. This will be discussed with all staff and their professional representatives but realistically the new organisation will not be able to compete in the commercial world adhering to all of the current terms and conditions [emphasis added].***

***“New social enterprises will have to develop pension schemes that are the equivalent to the NHS pension, we’ll be working with staff side and other SE’s to look at the options available and take legal advice to ensure we can continue to provide pensions that attract staff to LCS. We cannot at this point say what form they will take.”***

PCTs are obliged to consider requests from “staff” under the **‘Right to request’** a social enterprise: but the formula is **deliberately vague on how many staff at what level are required to make the request in order for it to go ahead**. This leaves the possibility of a tiny group of managers effectively hi-jacking the remainder of a provider arm workforce into a Social Enterprise that few if any of the other staff actually want or support. With trade unions largely excluded from any involvement, there is of course **NO trade union “right to request” that managers drop unpopular proposals** for a Social Enterprise, or any right for staff to **appeal against** a scheme or **demand a ballot** on whether a scheme should go ahead.

In Surrey 84% for example of staff voted in 2006 AGAINST the formation of the much-touted Central Surrey Health company, which was launched anyway. It now employs around 650 nurses, therapists and support staff formerly employed by the local East Elmbridge and Mid Surrey PCT. Two former senior PCT staff who had spent 18 months working to establish the company took over as management, completely ignoring the views of their staff and their main unions.

The first SE set up under the “right to request” provision has just launched with 500 staff transferred from Kingston PCT. Staff transferred in this way under TUPE have no automatic link to pay increases under Agenda for Change, although SE management may make various short or medium term promises to adhere to NHS pay scales. NHS pension rights may be retained only by ex-NHS staff undertaking NHS-funded work and only as long as they stay in the same job – obstructing any future development or promotion prospects.

New starters in the short or medium term would have to be offered “no less favourable terms” and conditions but would not be eligible for NHS pension rights. Social Enterprises will remain vulnerable to takeover or to future business failure as the NHS faces future financial pressures. They may also be vulnerable to hostile judgments by the Co-operation & Competition Panel.

NHS-funded services handed over to Social Enterprises would not be publicly provided or accountable to Oversight and Scrutiny Committees; and services would be fragmented and “regulated” rather than planned and monitored.

**PRIVATE SECTOR provision.** Where PCTs decide to bring in a private for-profit provider, individual services or bundles of services may be transferred to private or voluntary sector organisations.

NHS staff transferred would maintain their terms and conditions at least for an interim period under the TUPE conditions transfer, but would lose NHS pension and have no automatic link to Agenda for Change. Any TUPE protection could effectively soon be removed by employers claiming an “Economic, Technical or Organisational” (ETO) reason. Many staff who have been transferred from public to private sector employees have lost Trade Union recognition, and this in turn can be a prelude to losing other terms and conditions. New starters in such companies would begin with “no less favourable” terms and conditions, but these would also be vulnerable to an ETO claim.

One very big disadvantage for patients and PCTs is that ‘cherry picking’ by the private sector will ensure that they home in only on selected, profitable, services, leaving non-profitable services for other providers, potentially leaving a number of services without an external provider. And these NHS-funded services would be fragmented and not be publicly provided. Nor would the providers be in any way accountable to local people or to local Scrutiny Committees.

## **Staff concerns: who really cares?**

All providers bidding for PCT services are in theory supposed expected to demonstrate:

- **An HR Strategy**
- **HR policies and workforce planning**
- **Provision of access to Continuous Professional/Personal Development**
- **Staff engagement – through a staff survey, TU recognition, partnership working, consistent with NHS Constitution principles**

However the minimal levels of communication and consultation so far demonstrated by SHAs and PCTs in the process of World Class Commissioning and Transforming Community Services suggests that this series of commitments are about as valuable as Lord Darzi’s “five pledges”.

# 5. Case study: NHS East of England

According to the summary at the NHS East of England March Board meeting, provider arms in the six counties and two unitary authorities of Eastern England are fairly close to the national pattern, with almost half of the PCTs (6/14) seeking to remain within the NHS, while the remainder look to wholly or partly non-NHS solutions.

- Six provider arms – Cambridge, West Hertfordshire, East and North Hertfordshire, Peterborough, Norfolk, and SW Essex – have expressed a preference for future services to be remodelled as **Community Foundation Trusts**.
- Two (Mid Essex and West Essex) have opted for an **Integrated Care Organisation**, although West Essex also wants to transform its services into a Social Enterprise, and is also preparing to put cleaning and catering services out to tender.
- PCT provider bosses in North East Essex and Luton have also opted for **Social Enterprise**.
- South East Essex has opted for a complex hybrid “**joint holding company**” preparatory to an Integrated Care Organisation.
- And three PCTs – Great Yarmouth and Waveney, Bedfordshire and Suffolk – have opted for the **wholesale privatisation of care**, under the euphemism “managed dispersal”.

PCT Boards have to submit development plans to the SHA by May 5, including a firm declaration of their preferred model, and a transition plan.

Thousands of NHS staff therefore remain uncertain of their future prospects as decisions are made with no serious engagement with the unions and many questions raised by local and regional union reps left unanswered.

## How the PCTs seem to see the future

**Mid Essex PCT**, according to its Board paper in March 2009, is looking to a Community Foundation Trust that would work to offer integrated care in partnership with social services. However it notes that there are clouds on the horizon:

“in order to pursue a successful CFT application, CECS would almost certainly need to partner with other community service providers in order to achieve the required financial quantum”.

This raises questions over the availability of suitable partners and the potential intervention of the “Cooperation and Competition Panel”.

**Luton Community Services**, intent upon establishing a Social Enterprise, has made it quite clear that it is opposed to any public consultation on what is seen as a purely managerial change, although it is one which involves all of their staff being transferred out of the NHS, and management have yet to demonstrate that this scheme has any wider support among staff.

**NE Essex PCT**, also now apparently committed to a Social Enterprise model, insisted, somewhat ludicrously, in its 2007-8 Annual Report that **“we now need to ensure that public involvement runs through our organisation like the writing on a stick of rock.”** There is as yet little indication of this commitment taking shape in practice. The PCT Commissioner is set to expand, with proposals to establish a **Director of Business Delivery** and a **“Commercial Services Directorate”**, including a **Director of Commercial Services**, and assistant directors of marketing and procurement. The **additional cost of this expanding bureaucracy**, none of which enhances patient care, has yet to be explained to the local public.

### **“Managed Dispersal”**

Communication between PCT bosses and staff seems to be especially poor in the three PCTs which are planning to hive off their services to private sector providers under the ridiculously-titled “managed dispersal” system. Effectively the existing NHS services will be smashed into smaller pieces and offered up for private companies.

In **GREAT YARMOUTH AND WAVENEY** there has been no public consultation on any plans – and no consultation with staff either. Union reps report that they have been unable to get a succession of questions answered by PCT bosses: “The staff side keep asking questions with no answers coming back”.

No doubt this is because managers have been preoccupied with the running of a “Project Board” consisting of the Chief Executive Mike Stonard<sup>8</sup> in the chair, and containing “executive directors and senior support staff”: this set-up apparently “drives the work of a team of nine people who are delivering individual elements of the revised Plan”. In addition “specialist consultancy support” was “acquired in late December, although PCT bosses are too coy to name the company involved.

Obviously all this important and expensive management activity means there is no time to explain anything to the workforce, or to local people. PCT bosses told a Joint Staff Forum in January that

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

From this, having rejected the possibility of a Community Foundation Trust bid in 2008, and arguing that a social enterprise would be too difficult because of NHS pensions, it appears that Great Yarmouth PCT bosses have just slid through indifference and inertia into planning to privatise their provider services.

In **SUFFOLK**, where PCT bosses have recently had to deny attempting to gag angry staff at Felixstowe Community Hospital who had been sent letters telling them not to speak to journalists, and the PCT has also been criticised for its evident inability to build partnerships and relationships with patients,

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<sup>8</sup> Mr Stonard has since stepped down as Chief Executive, to be to be replaced by North East Essex PCT chief executive Paul Zollinger Read, who will cover both posts. While staff and local campaigners were extremely frustrated at the persistent failure of the PCT to answer any questions under Mr Stonard, it is hard to see how the hand-over to a half-time chief executive will bring any real improvement.

clinicians or the media – or listen to responses from stakeholders – the PCT has decided to opt for a 5-year rolling programme of tendering for the various provider services.

This “managed dispersal” approach has been combined with the proposal that Suffolk Community Services adopt a social enterprise model, despite the prospect that it could be faced with a successive loss of a number of key services under the tendering programme. So one way or the other Suffolk’s PCT provider workforce seem certain to find themselves outside the NHS, regardless of their views or wishes.

**NHS BEDFORDSHIRE** have opted to break up services into a set of “clusters” for competitive tendering, having decided that a county-wide Community Foundation Trust, even together with Luton’s community services would not be big enough to secure Monitor’s approval.

It will be little comfort to NHS staff condemned to forcible transfer to private providers as yet unknown that the PCT has “developed its management structure, ensuring it has the skills and requirements to become a world class commissioning organisation”. Among the PCT’s many improvements outlined in its barely-readable Operational Plan 2009-10, we find that:

**“A central intelligence unit has been developed [!] to support commissioning decisions ... NHS Bedfordshire is further developing its ‘radar capability’ to identify and respond early to key risks to the quality of patient care ... further developing market intelligence will be key.” (p6)**

While the PCT plunges into a new world of jargon and the unknown territory of wholesale privatisation, and provider staff face the loss of NHS employment rights, pension rights, terms and conditions, the consolation is that the PCT is developing new capacity and a new focus:

**“During 2009/10 a line of sight link will be created to understand the inter-relationship between demand patterns within the various acute groupings and we will measure the shift of activity from acute to primary care or other defined care networks.” (p13)**

The PCT will pull out of providing any services, but instead try to keep track of a bewildering matrix of 367 separate contracts with acute hospitals, mental health providers, community services, primary care and continuing health care. It assures us with the evidence-free assertion that

**“a market approach will ensure value for money and the highest standard of services by increasing competition and contestability.” (p29)**

First services up for privatisation seem set to be Bedford Prison, Dermatology and Arlesey Medical Centre. Once again local people and NHS staff are the last to know the far-reaching changes being imposed through what is allegedly to be ‘World Class Commissioning’.

## **NHS East of England: A display of arrogance**

A recent expensively-produced 16-page supplement in the *Health Service Journal* (February 26) contained a number of “motherhood and apple pie” articles massaging the egos of EoE directors: it also says a couple of sensible things (keeping acute hospitals plus A&E services, and rejecting a polyclinic model for primary care in the largely rural EoE).

But the sting was in the tail, with the page 12 article headlined “**Open for Business**”.

This spells out the extent to which the SHA – and the PCTs following its orders – are focused single-mindedly on “stimulating the market” and creating openings for private sector providers and “social enterprises” – despite the lack of any evidence of public support, and despite the opposition of the trade unions.

Director of Strategy Steve Dunn parrots phrases from the standard documents reeled out by the new Cooperation and Competition Panel, which are allegedly out for “consultation”.

- In fact there is **no public awareness, discussion or debate over these proposals**, which have **not been covered in any** of the national press or in any detail in the HSJ or nursing press, and on which the SHA itself has deliberately avoided any consultation with the general public or with NHS staff.
- This is probably linked to the fact that there is **no public support for privatisation and fragmentation** of NHS services.
- There has **never been a public petition or campaign demanding any of these changes**, and there is no evidence that any section of the public has been convinced to support any of them.

Steve Dunn argues that free choice, payment by results, practice based commissioning and world class commissioning “are all designed to increase competition and contestability”.

- Maybe they are: but he does not show how this would improve services:
- nor does he show how the new competitive market they are trying to create can possibly ensure that accessible, comprehensive services remain available to the local communities across East of England.
- Nor does he show that any significant section of the public agrees with him.
- We can tell him now the unions do not agree with this approach.

Dunn goes on to refer repeatedly to developing a dialogue with “**a diverse set of providers – including NHS providers, the independent sector, GPs and third sector organisations**”.

It's clear which ones they are most interested in.

- The whole focus is **openly biased and skewed towards developing and expanding the private sector and social enterprises**, at the expense of existing NHS providers and services.
- both of these will have very serious consequences in **fragmenting the NHS**.
- The viability of some NHS Trusts and services could be fatally undermined by these proposals: the SHA nowhere discusses how it will ensure that vital services are protected
- Both have the potential to leave **gaps in care** which will no longer be filled by PCT provider services, but which neither profit-seeking private providers nor SEs may wish to take on.
- Nowhere does Mr Dunn talk of discussing the implications of these proposals and policies with the SHA's **large workforce**, or **the trade unions that represent them**. Instead he is keen to “**improve dialogue with the independent sector**”
- There are apparently quarterly meetings with **independent sector leaders**
- **Commercial directors** are being appointed (at what cost? The SHA is advertising for a Head of Healthcare Market Management at a salary of up to £77,000) to ensure PCTs favour the independent sector even more than the existing directors.

- and a **competition panel** has been set up at SHA level, which has made clear that it is eager to “**make it easier for the third sector**”
- but **the article does not even mention NHS staff**: the SHA
  - **won’t talk** to the EoE NHS workforce
  - keeps the unions in the dark on key issues,
  - **fails to respond** to questions and requests for information,
  - and largely ignores the legitimate concerns of **the tens of thousands of NHS staff working in PCT provider services**, who have not signed up for these policies and quite reasonably fear for their jobs, their pensions, their long-term pay and conditions – and the future continuity and quality of the services which they are presently delivering to local people

This is the context in which Dunn raises the controversial plan to “franchise” out **Hinchingbrooke Hospital** to a private sector or other operator. The SHA has

- given **no proper reply** to the detailed response to earlier proposals, and further critical points and questions raised by the trade unions,
- failed to set out or publish a satisfactory **business case** to show why franchising would offer any security of services to patients in the Hinchingbrooke catchment area
- failed to identify any **potential bidders**,
- or demonstrate how they would ensure that these bidders would have the **expertise** to run a complex general hospital – especially given the costly failure of previous franchising experiments, including Good Hope Hospital in Solihull.
- failed to explain how in an NHS policed by the Cooperation and Competition Panel the original notion of **paying above NHS tariff price** for services from Hinchingbrooke would be permitted by the Panel – or affordable for Cambridgeshire PCT.

The plans for “World Class Commissioning” appear to be taking shape **without any public engagement, debate or support**. The literature that has been published is deliberately couched in meaningless technobabble, indecipherable to ordinary people who speak English.

PCTs are clearly under pressure from the SHA (and the SHA from the government) to break up local services and lure in private and social enterprise providers, regardless of local conditions, local opinion, and the local workforce.

Some PCTs (**Bedfordshire, Suffolk**) are apparently declaring behind closed doors their intention to **divest themselves of all services and outsource the lot** – but, like all of the PCTs in EoE they have

- published **no plans**, costed or otherwise
- invited **no comments**,
- **discussed nothing** with existing staff who they would expect to transfer to new employers
- **identified no organisations** that might bid for contracts
- offered no means to ensure the present mix of services remains operational and available to patients at the same or improved quality.

The HSJ supplement may have given a massively expensive spurious ego boost to the managers involved, **but it has also underlined the hollowness of their claims that the SHA is seeking to work in “partnership” with the unions and with local communities, which are barely even mentioned.**

5 April 2009