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RADIOGRAPHERS



**TRANSFORMING COMMUNITY SERVICES  
NHS NORTH WEST JOINT TRADE UNIONS  
HALF DAY CONFERENCE**

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**UNISON REGIONAL CENTRE, ARENA POINT,  
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**A BRIEF GUIDE TO THE IMPLICATIONS OF THE  
DIFFERENT MODELS OF SERVICE PROVISION UNDER TCS  
INCLUDING THE PROS AND CONS OF EACH OPTION**

**PLUS SOME USEFUL INFORMATION LINKS**

# Transforming Community Services

## Possible Implications of Different Models of Service Provision

The following is an outline of some of the possible pros, cons and/or other considerations of the different models being proposed. The list is not exhaustive.

### 1. Vertical and Horizontal Integration

#### Pros

- Remain in the NHS – public and staff goodwill and confidence
- Retain T&C and Pensions for new and existing staff
- TU recognition and easier TU organisation
- Reduced duplication of services
- Economies of scale so more opportunities to work in varied clinical areas and access to CPD plus cover for absence
- Whole care pathway solution
- VAT advantage (independent orgs pay corporation tax on income from NHS funded patients and will not be able to reclaim to the same extent as NHS orgs. Could affect the price non NHS orgs can provide services. TCS suggests large orgs could find economies in other ways. No mention of smaller orgs TCS p41)
- Horizontal integration is a well established and flexible model

#### Cons

- Bringing together different organisational cultures
- Mgt/staff cuts as services reviewed post merger
- Increased travel for individuals
- Different working patterns and arrangements to be reconciled: e.g. bank holiday arrangements, or on call
- Vertical integration creates a potential tension with govt pressure to move services from secondary to primary care
- Move to multi site working (e.g. hospital based staff move to health centres/home visits)
- TCS makes it clear that VI/HI that reduces number of providers and therefore patient choice will need to be carefully considered by PCTs
- Potential monopoly provider reduces patient choice

### 2. Community Foundation Trust

#### Possible Pros

- Remain in the NHS –public and staff goodwill and confidence
- Retain T&C and Pensions for new and existing staff
- Freedoms to move away from AfC, but these are constrained and set out in AfC agreement
- Regulation by Monitor ensures financial vigour

- Regulation by Monitor restricts freedoms (this could be seen as a pro or con)
- Staff entitled to membership of the Foundation trust. Members should be regularly consulted about the future, can vote and stand in elections. Can become staff governors
- FT have a statutory duty of partnership and staff involvement
- Reduced duplication of services
- Larger organisation may improve access to CPD plus cover for absence
- Easier TU organisation
- Degree of protection for some services- can only be changed with permission of the regulator
- VAT advantage

### Other considerations

- Ownership passes from the government to independent corporations. Community should be in control but seldom works in practical terms
- Freedoms to move away from AfC, but these are constrained and set out in AfC agreement
- Mgt/staff cuts as services reviewed to meet CFT financial requirements
- FTs set up to run as commercial business units.
- Able to make capital investments, sell assets, retain surpluses, borrow money and risk insolvency
- Can generate income from treating private patients and some are more enthusiastic about this than others
- Greater freedom to enter into agreements with private sector partners
- Private sector could establish themselves as an FT
- DoH guidance stresses staff involvement but says very little about trade unions
- Potential monopoly provider reduces patient choice

### 3. Arms Length Provider Organisation

This is often viewed as the safe option where no change will occur. However it is essential to be aware of the potential implications of this model:

#### Considerations

- Major advantage of still being in the NHS and all therefore all staff will preserve NHS T&C & pensions.
- It may also preserve existing teams and working arrangements.

However:

TCS is supposed to be 'neutral' in respect of different delivery models ("*There is no prescribed ideal form*" p 21 TCS) but it is also clear that the Govt do not want the status quo to prevail in terms of provider arrangements. PCTs will be under intense pressure to divest as the following points demonstrate:

- TCS **requires** commissioners to 'stimulate the market' i.e. encourage new providers to come forward to promote patient choice and competition to drive up standards

- Even ALPO will have to go through the process of being accredited to become 'an any willing PCT accredited provider' (AWPP) of services. (All organisations that want to bid to provide NHS services will have to go through this process)
- Commissioners will assess ALPO against the same criteria as any other potential provider of a service so if they are not competitive they may not win contracts. It is therefore unlikely that ALPO will remain unchanged if they are to compete for contracts successfully
- Ministers and certainly civil servants have made it clear that this is not their preferred outcome. A senior civil servant was more explicit making it clear that ALPOs were a staging post to the more 'innovative' models
- TCS says that other potential providers including staff requesting SE should be given whatever support is appropriate, in order that they can be business ready to enter the market
- TCS requires SHA to review regularly with PCTs a decision to choose to retain directly provided services (p13)
- PCTs will be required to demonstrate how service provision will "enable patient choice and ensure fair competition between providers" p17 There will be a Cooperation and Competition panel
- The NHS performance regime has been extended to include PCT direct provision

#### **4. Integration with Social Services**

##### **Pros**

Reduces duplication

Potentially seamless service

Pooled budgets may increase resources available

Preserve T&C and pension for transferring staff.

NHS or LA contracts and pensions for new staff

Popular with ministers

Employment remains within the public sector

TU recognition and Strong TU traditions/national bargaining

##### **Cons**

Different organisational cultures

Accountability/line mgt may be problematic

Ambiguity re extent of responsibilities

Differing working practices may be hard to reconcile

CSP not recognised in Social services and there may be difficulties establishing influence

Possible conflicting priorities for funding

#### **5. Social Enterprise**

##### **Pros**

- Potential share ownership offers more influence over the shape of services
- Tend to be driven by dedicated entrepreneurial types who see a gap in the market so can be dynamic innovative organisations
- If led well can allow innovative ideas to flourish
- Govts favoured model so policy tends to favour the approach because they don't want it to fail (Staff given the right to request establishment of SE and detailed guidance produced to support this. £73 million over 4 years government fund)

established to encourage SE and in Jan 07. 26 pathfinder projects could apply for a share of £1million start up funds)

- Social aim so not profit driven
- Usually reduced levels of bureaucracy
- Could get higher wages and better terms and conditions because not governed by national agreements
- Existing staff get transfer with NHS terms and conditions intact, but future changes may or may not apply depending on contract
- Existing staff may get NHS pension as long as SoS agrees and they are undertaking work for the NHS
- May have additional capital available to invest in services
- May provide additional business 'edge' in a more competitive market

### **Cons**

- Demands effective leadership and entrepreneurial skills that may not be available particularly if adopted by staff as 'least worst' option
- Despite social aim still technically a private employer that has to register at Companies house and report to the DTI
- Staff not employed by the NHS
- New staff not entitled to AfC T+C but Cabinet code applies so overall no less favourable
- New staff not entitled to an NHS pension. SE only needs to offer a reasonable pension
- No staff entitled to NHS injury benefits scheme
- Existing staff get NHS T&C under TUPE but not protected forever
- Potential fragmentation of services if PCT provider arm split between SE and other different providers
- Loss of national pay negotiations- become more difficult to sustain with increased number of private employers
- VAT disadvantage compared to NHS providers (independent orgs pay corporation tax on income from NHS funded patients and will not be able to reclaim to the same extent as NHS orgs. Could affect price non NHS orgs can provide services. TCS suggests large orgs could find economies in other ways. No mention of smaller orgs which SEs could be)
- Nothing to compel SE to recognise TUs
- TU organisation and representation more difficult in fragmented service with different employers
- Could go bust if not successful/NHS contracts not renewed. Smaller companies may be less able to survive market instability particularly if competing with multi nationals
- More vulnerable to take over by large multi national private healthcare providers
- Need to be competitive may erode T&C staff numbers and available resources
- Staff and patient suspicion of 'not for profit' in the NHS

## 6. Private Sector

### Pros

- May be able to inject new capital offering better facilities/resources for service provision
- Not governed by national agreements so may offer higher salaries and bonuses particularly for difficult to recruit staff or high performers
- Uni-professional structures can be more attractive to individual professions
- May be more funding available for CPD if it supports business objectives
- Private sector companies have more experience of business marketing so may do better in a more competitive marketplace – more stable employment

### Cons

- Staff not employed by the NHS
- Private sector driven by profits/shareholder demands
- Existing staff get NHS T&C under TUPE but not protected forever. Changes to AfC don't automatically apply
- New staff not entitled to AfC T+C but Cabinet code applies so overall no less favourable
- No staff entitled to an NHS pension. Employer only needs to offer a reasonable pension
- No staff entitled to NHS injury benefits scheme
- Potential fragmentation of services if PCT provider arm split between different providers
- Loss of national pay negotiations- national bargaining becomes more difficult to sustain with increased number of private employers not part of the process
- VAT disadvantage compared to NHS providers
- Nothing to compel private to recognise TUs. Some private companies already involved in health are actively anti-union
- TU organisation and representation more difficult in fragmented service with different employers
- Could go bust if not successful/NHS contracts not renewed
- More vulnerable to take over by other large multi national private healthcare providers. Has been considerable reorganisation/ take over activity in this sector in recent years
- Need to be competitive may erode T&C staff numbers and available resources

TRANSFORMING COMMUNITY SERVICES	Existing staff continue to be employed by an NHS organisation?	Existing staff covered by NHS terms and conditions?	Existing staff continue to have access to NHS negotiating machinery?	Existing staff automatically guaranteed future changes to NHS terms and conditions?	Existing staff's entitlement to NHS pension is protected?	New starters appointed on NHS terms and conditions?	New starters entitled to join NHS pension scheme?
<p><b>Option</b></p> <p><b>(1) Arms-length PCT provider units:</b> PCTs may retain accountability for provider services by maintaining services in a 'provider unit' within the organisation. They will need to develop new governance arrangements that ensure a formal separation between their commissioning and provider functions. This could entail a provider services unit that hosts all PCT provider services, led by a strategic provider board.</p>	😊	😊	😊	😊	😊	😊	😊
<p><b>(2) Social enterprises:</b> PCT staff can use their 'right to request' to set up a social enterprise. PCTs will be obliged to consider requests and if approved by the SHA, a contract for an initial three years will be given.</p>	😞	TUPE: 😊	😞	😞	😞	😞	😞
<p><b>(3) Polyclinics/GP-led health centres:</b> Bring together family doctors, nurses, AHPs, specialists and other services more usually associated with hospitals, such as diagnostic testing, minor surgery, blood tests and X-rays. These could be run by large private companies or consortia of GPs.</p>	N/A	TUPE: 😊	😞	😞	😞	😞	😞
<p><b>(4) Community foundation trusts:</b> Community foundation trusts would provide those community services currently run by PCTs. It is likely that a community foundation trust will be established through a consortium of PCTs. Applications to establish a community foundation trust will need to be approved by the SHA.</p>	😊	😊	😊	😊	😊	😊	😊
<p><b>(5) Vertical integration:</b> This is where PCT provider arm function is integrated with a local acute service. It may involve the outright merger of an acute trust with a PCT provider arm or a looser alliance of primary and community services through multi-</p>	😊	😊	😊	😊	😊	😊	😊

disciplinary team working and joint management.	Existing staff continue to be employed by an NHS organisation?	Existing staff covered by NHS terms and conditions?	Existing staff continue to have access to NHS negotiating machinery?	Existing staff automatically guaranteed future changes to NHS terms and conditions?	Existing staff's entitlement to NHS pension is protected?	New starters appointed on NHS terms and conditions?	New starters entitled to join NHS pension scheme?
<p><b>TRANSFORMING COMMUNITY SERVICES</b></p> <p><b>Option</b></p> <p><b>(6) Horizontal integration:</b> This is where more than one PCT provider arm function is integrated and may involve merger with one or a number of PCT provider arms. This may be a first step towards creating a community foundation trust.</p>	☺	☺	☺	☺	☺	☺	☺
<p><b>(7) Integrated Care Services:</b> This is where joint health and social care services are established. This may be through joint management arrangements between health and social care functions or formally through integrated care organisations or the creation of a 'care trust' model.</p>	☺	☺	☺	☺	☺	☺	☺
<p><b>(8) Private sector or non NHS/ independent sector:</b> This would be as a result of the PCT deciding to transfer individual services, or bundles of services to a private company (or to a community or voluntary sector provider) through the process of tendering and contracting.</p>	☹	☹	☹	☹	☹	☹	☹

**Note**

The symbols in the table cells are intended to provide only a very general assessment of the impact on PCT staff of each provider service structure option as it relates to their employment terms and conditions. Options may vary in specifics from case to case. The document is intended to provide a simple guide to the different provider service structure options and also to give RCN representatives a steer on the questions to ask their PCT's management as Transforming Community Services plans emerge.

Detailed guidance for trade union representatives and full-time officers is available in the document **Transforming Community Services: a trade union guide**

## **Transforming Community Services Key Reference Documents and Web Links**

### ***Transforming Community Services***

[http://www.dh.gov.uk/en/  
Publicationsandstatistics/Publications/  
PublicationsPolicyAndGuidance/  
DH\\_093197](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_093197)

### ***Next Stage Review***

[http://www.dh.gov.uk/en/  
Publicationsandstatistics/Publications/  
PublicationsPolicyAndGuidance/  
DH\\_085825](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085825)

### ***NHS Constitution***

[http://www.dh.gov.uk/en/  
Publicationsandstatistics/Publications/  
PublicationsPolicyAndGuidance/  
DH\\_085814](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085814)

### ***Social Enterprise - Making a Difference: a guide to the Right to Request***

[http://www.dh.gov.uk/en/  
Publicationsandstatistics/Publications/  
PublicationsPolicyAndGuidance/  
DH\\_090460](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_090460)

### ***Transfer of Undertakings (Protection of Employment) Regulations***

<http://www.berr.gov.uk/files/file20761.pdf>

### ***Cabinet Office Code of Practice***

[http://archive.cabinetoffice.gov.uk/opsr/  
workforce\\_reform/code\\_of\\_practice/index.  
asp](http://archive.cabinetoffice.gov.uk/opsr/workforce_reform/code_of_practice/index.asp)

***RCN Website*** <http://www.rcn.org.uk/search?q=tcs>

***UNISON Website*** <http://www.unison.org.uk/pct/tcs.asp>

### ***Unite Website***

[http://www.unitetheunion.org/sectors/health\\_sector/health\\_b4\\_profit\\_campaign.aspx](http://www.unitetheunion.org/sectors/health_sector/health_b4_profit_campaign.aspx)

### ***Department of Health Website***

[http://www.dh.gov.uk/en/AdvanceSearchResult/index.htm?searchTerms=transformin  
g+community+services](http://www.dh.gov.uk/en/AdvanceSearchResult/index.htm?searchTerms=transforming+community+services)

