“A flawed case for privatisation”

A response by UNISON Luton & Dunstable Hospital Trust Branch to the proposals from Luton & Dunstable University Hospital for the privatisation of catering, housekeeping and cleaning services

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Introduction

It's hard to know where to start in responding to the Trust's confused and confusing process of "outsourcing" based as it is on a completely outdated, inappropriate and flawed Business Case drawn up in November 2013. This itself was based on even more outdated data going back to 2012.

The Business Case was for a 15-year contract on the basis that a contractor would be able to recoup the costs of capital investment in new catering facilities. Since then this plan has been discarded. No new business case or update has yet been produced.

The current plan which the Outsourcing Steering Group has put to the Trust Board is for a completely different 5-year plan in which any notion of investment to continue with on-site preparation of food has been discarded in favour of questionable 'cook chill' or steamed food option. Housekeeping, at first left out in the Business Plan, has since been included. No argument has yet been produced for changing domestic services which are registering over 99% success.

UNISON's response will examine the Business Case alongside subsequent documents and information from the Trust as the process of privatisation has evolved.

We will point to the flawed arguments, information and assumptions used throughout, and challenge the initial rejection of the idea that an **in-house solution** might be possible to address the issues that have been raised. UNISON also questions the cost and value for money of the complex tendering process, which is being run on the Trust's behalf by the consultancy service Litmus Partnership, a company committed to the private provision of support services.

UNISON will also press the case for an alternative, superior and more affordable way forward to improve support services in the Trust - delivering much better value and quality of services for patients and the taxpayer by using in house staff.

What is the problem?

The starting point of a serious Business Case should be that it clearly identifies what it aims to achieve or what problems it seeks to solve, and outlines a business plan to address them.

Is the plan to *save money?* If so why reject the idea of an in-house bid, which the Business Case shows to be by far the most affordable option, yielding 50% bigger annual savings over 15 years?

Or is it to *improve services?* If so, some basic questions need to be addressed:

1. Are services below standard?
2. If so what are the reasons? What actions have been taken so far to improve services?
3. Are the problems related to poor management and dysfunctional systems, poor facilities, or inadequate funding?
4. What needs to be done to improve the services and allow staff to work better and more effectively?

In fact the answer to the first question, according to the Business Case, is "no".

Another consideration may be **are *new services* required to meet new circumstances?**

If so what changes need to be discussed with the existing staff to develop these new services?

This approach is entirely absent from the Business Case put forward by the Trust, which is more akin to a case for change.

Indeed it begins by discussing plans for a range of services, including Portering and Housekeeping, and the idea of incorporating them all into a "one stop FM contract".

By page 13 Portering and Housekeeping services have, for good reason, been excluded from the discussion. At that stage they were quite correctly regarded as too closely linked to direct patient care.

Since producing this business case the Trust changed its mind again and added Housekeeping back into the tender, effectively reducing the status and significance of the housekeeping role and workforce. However, the Business Case makes clear that the Trust cannot clearly define the housekeeping role and has made no quality assessment of the existing service which was run on an experimental basis in the Perfect Day project (which ended on 1st April 2014).

The business case itself states that they have no comparison with Best Value and no benchmarks to go on. The Business Case says only that a WTE cost of £18,423 per annum is 'reasonable'.

None of this gives any clear basis for a specification to go out to tender – and the Business Case has still not been updated as of April 2015 – but the Trust has for some reason decided to plough on regardless, even though it could leave them prey to unscrupulous methods from the companies they are seeking to negotiate with.

Back to the 1980s

The whole exercise shows that for some reason Luton & Dunstable Trust has in 2015 decided that, in the worst Thatcherite tradition:

> "delivery of support services ***is not seen as core business*** provided the quality, scope and cost of such services are assured"

Therefore, in Luton & Dunstable Hospital, the provision of nutritious and appetising food to patients, the housekeeping and cleaning of wards are all now seen by this Trust as ***unrelated*** to patient care. As a result these services are regarded as fair game for penny-pinching privatisation in the hopes of reducing the workforce and saving money.

This is a throwback to the 1980s, when the Thatcher government, driving for privatisation, crudely tried to separate off hospital "hotel services" from patient care with disastrous results. The Trust Board is now poised to repeat this process.

In UNISON's view the same concerns for quality and integration of services that have applied each time these services have come up for review since the 1980s – remaining in-house each time -- still apply in 2015.

If the Trust now believes otherwise, the Business Case should explain, with supporting evidence, what new factors mean that these services are no longer so central to patient care that they can be entrusted to a 15-year contract with an external profit-seeking provider previously unknown to the Trust. No such argument is presented.

Instead the Business Case tries its best to imply that private contractors might achieve the double feat of delivering improved services for less money.

In presenting this argument the Trust eschews evidence and resorts instead to desperate levels of abstraction, untested assertions and wishful thinking. In reality this means that in place of proven quality in actual services they have decided to open up to cheap and unsavoury alternatives, whilst at the same time fragmenting the NHS team.

The only way private contractors can generate profits from support services while reducing prices is by employing *fewer* staff, getting staff to cover the same or more work in fewer

hours, worsening terms & conditions of staff, and eliminating more experienced, higher paid staff. These measures have often run along with penny-pinching measures like restricting the use of cleaning materials, watering down the milk, and so on. All of these have happened in hospitals since the drive to privatise support services began in the 1980s.

Nobody working at Luton & Dunstable, and nobody receiving treatment at the hospital or visiting friends or relatives will want such miserly economies undermining the quality of patient care. UNISON urges the Trust to think again and recognise the implications of driving down this road, and to pull back before seriously mistaken policies are adopted.

Benefits appraisal, financial appraisal and affordability

The Business Case offers an obscure "benefits appraisal" apparently carried out by the 'Project Group and the Trust Executive' (p10-11), which duly finds an in-house service offers less benefit than an imagined contractor. However, this contains no details or explanation of how the calculation was carried out, or what assumptions were made about the performance of the hypothetical (and no doubt near-perfect) external contractor.

This is a long way from the real world of actual services in the specific context of Luton & Dunstable Hospital, where we know in-house services have been delivering acceptable or above average quality.

The Business Case makes no attempt to explain what, in the Trust's view, is so inherently bad about the current service and its management, that only a complete change of provider, management and (eventually) staff can put right.

It's not clear from the Business Case whether managers running the catering and domestic services agree with the implication that *they* are part of the problem. They may instead agree with UNISON that they and their staff should be engaged in constructive discussions on the type of developments and new services the Trust wants to see. The Business Case gives no indication that their views have been taken into account at all.

Catering

On the catering service, it appears that the principal weakness has been the Trust's own lack of capital investment. The Business Case states that the 2013 PLACE Audit found the Trust's service just 1% below the national average of 84.98%, although it is not clear what this is a percentage of, or on what basis these comparisons are made (p 24).

The Business Case also concedes that the quality of catering seems to have improved, resulting in even fewer complaints. Private consultants Litmus also admitted food was of an acceptable standard.

So there is no crisis requiring desperate measures, instead there would seem to be a potential basis for the in-house team to continue to provide the service at higher quality with new equipment in the new building.

Domestic services

A similar situation seems to prevail with the domestic services, where again a lack of investment by the trust has held back potential improvements in productivity and cost savings. Again complaints have been reduced by an improving service and according to the Business Case there is not much room for any further improvement:

> "The recent [2013] PLACE audit scored the cleanliness at **99.41%** which ranked the Hospital in the top quartile" (p28).

Surprisingly it seems that 99.4% is not good enough; the Trust also wants savings. The Business Case implies a contracted out service could deliver the same standards but cut 237 hours of cleaning each week whilst saving a staggering 14% of the annual £2.8m budget. Once again all this is *purely theoretical*, comparing abstract "competitive commercial productivity rates" with the existing high quality NHS service running in the conditions prevailing in the Trust.

There is of course no guarantee at all that the same quality service could or would be delivered by a commercial company. Indeed, the Trust carefully ignores the 30 year track record of privatised hospital cleaning in the NHS which has become a by-word for poor quality. In decades of declining standards since privatisation began we have seen a long catalogue of failure and, until specific action was taken, rising rates of MRSA and Hospital Acquired Infection.

Under-valuing staff

UNISON is astonished that a Trust whose in-house services have achieved such high standards appears now to value them, and the staff providing them, so little. We are also surprised that the Trust is willing to put their proven high-quality services at risk in the hopes of securing the most marginal of savings from untested private contractors.

Indeed there is little, if any, evidence of attempts to engage with staff and existing management to address problems or develop proposals for continued in-house provision. The only plan for "consultation" is a minimal exercise to take place after the decisions have been taken and a private bid accepted**.**

The gamble is even greater now that three of the six shortlisted bids have been withdrawn (quite possibly because of the uncertain level of profit to be secured from the contract) leaving a choice between three undistinguished bidders: G4S, Cofely and Compass.

It appears from the Business Case and the PQQ that the Trust intends to take these companies' word for it on their performance in the NHS contracts they already hold. For example Compass Medirest have, in the last few years, been embroiled in strike action over low pay for cleaners.

Cofely is a company that has no real record of engagement in NHS contracts. It recently took over the struggling Balfour Beatty's facilities management service. This is no guarantee of stability, since health care is a tiny odd one out among the various Balfour Beatty contracts. If contracts are not sufficiently profitable, it would be no surprise to see Cofely, which is mainly focused on the energy industry, cutting its losses and pulling out.

G4S of course is best known for its repeated high profile failures on prison service contracts and the failure to fulfil a contract for security services at the 2012 Olympics.

Were any of these companies to secure the contract the Trust would face the task of assuring the local public and patients that this would be an improvement on already good services. They would no doubt take some persuading.

No Plan B

What would happen if the winning bidder were to fail, making Luton & Dunstable simply another one in the growing list of private sector contract failures in the NHS? Trust Board members would be seen as having accepted the PR spin and slick salesmanship of private companies.

But what about the services that would be at risk? It is clear from the very notion of a 15-year contract in the 2013 Business Case that the Trust appears to have no concept of the need for a Plan B.

If **kitchens are not replaced**, and catering services are reduced to warming up cook-chill meals supplied from industrial-sized plants miles away, the present workforce of skilled staff will be lost and the possibility of providing locally-sourced, freshly-cooked food tailored to the needs of individual patients will be lost.

If the **domestic contract** is allocated to a private contractor, the TUPE protection for existing domestic and housekeeping staff will at best offer a limited period of continuity, to be followed by a two-tier workforce as new staff are recruited on the company's inferior terms & conditions, and the more costly transferred staff are gradually eased or bullied out to maximise profit.

What happens if the chosen contractor goes broke or simply chooses to walk away from a failed contract having broken up the existing workforce? Would there be any hope of bringing services back in-house? Or would the Trust be doomed to a future of choosing

between rival contractors seeking a profit out of greater exploitation of their dwindling workforce as happened to some hospitals in the 1980s?

When is a saving NOT a saving?

The Financial Appraisal (p 12) shows the annual cost of the 'Best Value In House' solution is estimated to be just 2% more expensive than the favoured 'One Stop Soft FM Contract' over 15 years.

But on affordability (p 13), the In House costs come out **7.6% *cheaper*** than the One Stop Contract, with **savings from current costs 55% *higher***.

So if the aim of the tendering is to save money, it's not explained why the obscure and purely theoretical calculations of the "benefits appraisal" should so massively outweigh the estimated savings on affordability.

The affordability figures are more remarkable in that they are apparently calculated taking the capital costs of a new kitchen into account – despite the fact that the Business Case for some unexplained reason chooses to assume that a new kitchen would be £1 million ***more expensive*** for an in-house bid than a contractor. Yet still the in-house option would be more affordable. In practice, of course it is cheaper for the public sector to borrow to fund capital investment than for the private sector to do it.

The question that inevitably arises is: what powerful factor could persuade a Trust like Luton & Dunstable to *discard* the more affordable option, and go instead for the *less affordable* private sector route?

The Business Case makes no effort to explain, its bias is clear throughout. **Like a rower with only one oar, the Trust's Outsourcing Steering Group is apparently equipped to steer in one direction only, and the Trust Board is seemingly happy to endorse this approach.**

In these straitened times, it's most unlikely any entrepreneur could raise even the funding for a whelk stall without having a proper and complete Business Case. The Trust's Business Case is flimsy, unconvincing and incomplete. The Outsourcing Steering Group in 2013 wanted to commit the Trust to spending £6.5m or more per year for the next **15 years** (around £100m) with a single contractor on the most tenuous basis. That plan has been abandoned, but now we are facing a new proposal for a 5-year contract for catering and domestic services with not even the pretence of a plan in place.

Back to basics

The Trust has to decide what its objectives are. It would appear from the Case for Change section of the Business Case (page 7) that the Trust wants "soft FM services" which offer:

- Excellent quality
- Support to patients
- Flexibility
- Cost savings and value for money.

Let's look at these:

Quality

The Business Case itself shows that the **Quality** of in-house services is already **as good or even better** than NHS average already, even with limited investment and buildings near the end of their useful life. There is every reason to believe that these services could be improved in the new buildings with appropriate investment in new equipment.

There is hard evidence from best practice by in-house hospital kitchens elsewhere that NHS catering can not only improve but even begin to generate resources for the Trust by offering a variety of more attractive, affordable freshly-cooked food to visitors and hospital staff through a retail cafeteria. (http://goo.gl/l1iQ05)

Work on this in various hospitals by TV chef James Martin, who recently won an award from the Hospital Caterers Association and has continued to campaign on the issues, showed that properly working with in-house teams to develop new and more flexible systems using locally-sourced and less expensive fresh ingredients led to reduced waste, improved nutrition of patients at **no extra costs** – and provided an income stream for the hospital.

This type of service also allows trained catering staff to gain satisfaction from their work, to train junior staff, and to offer specific meals for individual patients with particular needs.

By contrast, once the Trust signs a contract with a private contractor which specifies the service to be provided, there would be no scope to change that service during the lifetime of the contract. The contractor would have no obligation to work in any way or deliver any services not specified. A decision to base the service around externally supplied cook-chill meals would lead to the loss of a hospital kitchen and the skilled staff capable of developing such a service. Staff who remained in post would be transferred under TUPE, but would become employees of a profit-seeking company with no interest, or possibility, of developing and improving services. The Trust would have proved its lack of respect for them, and lost an opportunity to build on the skills available.

There is absolutely no guarantee that a private contractor could even match the current quality of the catering service and no chance at all of it delivering the positive innovations and quality improvements possible through the James Martin approach. Luton & Dunstable's hospital catering would remain, at best, stuck in a 1980s 'cook-chill' rut for the indefinite future.

The same is true of domestic services: contractors work only to the specifications laid down in the contract. They have no interest in innovation unless it enables them to further reduce the workforce. They have no interest in excellence above the level defined as satisfactory: their primary obligation is not to the NHS but to shareholders.

The Trust's Business Case has already suggested cuts in the workforce and redundancies, based on a theoretical "benchmark". With current services assessed as 99.4% of perfect, why run this risk of reducing the quality of service to save a less than 0.5% of the Trust's £250m budget?

The transfer of existing domestic staff and housekeepers under TUPE will break up the teams on the wards and alienate staff who have previously worked hard as part of the NHS but now work for shareholders. Why would they be motivated to put in extra effort to cover the lost jobs and maintain the standards they achieved before?

Support to patients

In-house ward support staff (housekeepers and domestics) are part of the NHS team. Although they have their defined roles, they can also respond to requests from patients or staff, and ensure the smooth running of services. Non-clinical staff who have worked for some time on a ward in the hospital environment can often communicate better with patients and reassure them more effectively than some clinical staff, who tend to be used to using medical jargon or assume patients understand what they have said.

The data in the Business Case shows that the domestic staff have achieved exceedingly high levels of quality, which will inevitably include the positive patient experience of their services.

Reducing the numbers of domestic staff, forcibly transferring them to a private contractor, a new management system and line of accountability separate from the ward staff they have been working with, can only disrupt and undermine what has been achieved, and will inevitably be disturbing and unsettling for patients.

Tighter timings to get the same work done by a reduced workforce will, as in every previous privatisation exercise, result in more stress on front-line staff, more tasks not complete dumped onto nursing staff, more turnover of domestic staff, and a worsened patient experience.

The question comes up again: when your domestic services are delivering 99.4%, why even contemplate a change that is almost certain to undermine it?

Flexibility

The Business Case talks of flexibility, even as it proposes to privatise services that are the most flexible available. If you want flexibility, the last thing you should do is draw up a specification for a 5 (let alone 15) year contract with a private contractor; this defines the very maximum you will get.

Never mind the rhetoric of the sales pitch; private contractors, at best, deliver only what it says in the small print and detail of the contract.

That's why it's especially ill-considered to privatise housekeeping staff for whom there is no clear definition of tasks or benchmarks. It's equally unwise to lock down catering and domestic services into a model that may seem reasonable in 2015, but may well need to evolve in the next few years.

If the Trust wants flexibility, why not start by talking to existing in-house staff and their managers, spelling out what's wanted, and getting them to come up with proposals to move forward?

Why instead is the Trust dismissing all of their experience, knowledge and commitment, by bringing in a private company, with managers who will start by getting rid of the most experienced staff in a bid to cut costs to make the contract more lucrative for its shareholders.

When looking for flexibility why move towards the cook-chill, low skill, rigid, inflexible, no-way-back route and upset staff, when with in-house staff you could go the James Martin route, please everyone, and even make money to help pay back the investment in new kitchen equipment?

Cost savings and value for money

Even the Business Case figures suggest only the most minimal savings could be made from privatisation, and these relatively small amounts could only be saved by risking a drop in standards of cleaning or quality of services.

Given that some of the support services have struggled to retain staff, and had on occasions resorted to more expensive bank and agency staff, transferring staff to a private contractor is likely to make recruitment and retention of the essential workforce even more difficult. Time and again contractors have failed to deliver because people just don't want to work for them, resulting in staff shortages, and poorer standards.

The plain fact is that more savings could be made by Trust investment in a new modern kitchen turning out fresh food that staff and visitors would choose to eat.

Remember the privatisation process is not without cost: how much money that could have been invested in new kitchen equipment (or patient care) has already been wasted commissioning Litmus Partnership or other management consultants to run the whole process for the Trust, including administering the bids and shortlisting of contractors? What will the consultancy bill be by the close of the contracting process?

How much management time, and at what cost, has been squandered on finding ways to contract out the existing workforce without even attempting to engage them in the improvement of services?

Far from showing a commitment to cost savings, the exercise so far has simply made clear to all that at least a part of the Luton & Dunstable Trust Board have decided that non-clinical support services are not important, and have been trying to wash their hands of them by contracting out whatever the cost. This attitude bodes ill for any subsequent monitoring of the contractor's compliance with the specifications.

This attitude explains the initial extraordinary suggestion of a 15-year contract; equivalent to three full parliamentary terms. But also raises questions over the Trust's commitment to other non clinical support services which have also been regarded by some as "non-core" services. The same attitude could result in the piecemeal privatisation of other services, complicating the management task and making it more difficult to guarantee or improve the quality of patient care.

UNISON and its members want to see cost-effective, high quality and flexible services developed because we recognise that they are a key part of the running of the hospital. That's why we oppose privatisation and urge the development of services in conjunction with in-house staff.

Accountability

It's far from clear from information published so far what options may be open to the Trust if a flawed contract is signed with a private contractor as a result of this process.

By bringing in Litmus Partnership to run the process, and effectively tell the Trust what it should do at each step, the Trust Board has left itself disempowered.

For example, how much direct control has the Trust taken over the setting of specifications? Who within the Trust will be responsible for continuous monitoring of the performance of the contractors, and what sanctions would they have at their disposal to deal with contract failures? What would the Trust's options be if the company repeatedly fails to deliver even

the minimum standards set out in the contract, possibly resulting in problems with the CQC and even Monitor?

We could go further and ask how much control Trust directors have taken over the development of the Business Case? Whose fault is it that the Business Case is still far from complete or up to date, even as the Outsourcing Steering Group prepares to urge the Board to press ahead with privatisation? Who will take responsibility for the lack of any clear basis to specify the housekeeping contract?

All of these problems stem purely from the basic determination to privatise established and successful services.

But none of them need arise if the Trust Board pulls back at this stage, and instead opens up discussions with staff over an in-house contract that could maintain high quality domestic and housekeeping services and improve catering, working flexibly with the Trust in the transition to the new building.

Conclusion

Many Trust Boards would be delighted to find that their domestic services were rated at 99.4%: they would be working hard to keep services on that basis.

Not so Luton & Dunstable.

Hospitals elsewhere have begun to heed the calls from the Hospital Caterers' Association, James Martin and other well known chefs to improve the quality of food by cooking fresh, locally-sourced ingredients, and reshaping retail and staff catering to deliver surpluses and satisfied customers. They have improved the food and reduced their carbon footprint.

Not so Luton & Dunstable.

Instead for Luton & Dunstable patients it's back to the 1980s, privatisation and cheap and unsavoury services.

It doesn't have to be like this.

UNISON urges the Trust Board to think seriously about the risks they are being asked to take by the Outsourcing Steering Group that appears able only to steer one way.

We urge the Board even now to instruct the relevant directors to engage with staff who have worked loyally for the hospital, discuss ways to improve and develop services, and to prepare an in-house bid that looks to patient care and the future rather than to shareholder profits and back to the past.