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Dear Brendan,

Thank you for the work that you and staff side colleagues have been doing with us over recent weeks. Last week in my speech to the Kings Fund I set out very clearly my position on these matters:

“With quality at its core, I think the NHS can finally move beyond the polarising debates of the last decade over private or public sector provision.

Let me begin with where I stand in this debate, and that is that the NHS is our preferred provider.

But it is the important job of the commissioner to test whether these services provide best value and real quality.

Where a provider is not delivering quality – and the new accountability information will more readily demonstrate that – we will set out a clearer process that will provide an opportunity for existing providers to improve before opening up to new potential providers.

This is fair to all as it means everyone knows where they stand and services stand or fall on the quality they provide.


I have now seen and signed off proposals that set out what I would expect of commissioners in engaging with existing providers and their staff. These draft proposals are attached, and I would like DH and the SPF to work on finalising them along with a brief draft ‘joint statement’. I understand that there is an SPF Staff Passport meeting tomorrow, and would be very pleased if this statement could be signed off at this meeting.

The core principles which commissioners would be expected to follow are:

- **NHS and existing providers should be engaged at an early stage of service development**
- **NHS providers should have the opportunity to bid for any opportunities that are developed.**
- **Early and substantial engagement of existing providers is expected**
- **Early and substantial engagement of staff and their trade union representatives, where applicable, is expected**
- **Decisions are taken locally, but within a clear national guidelines**
- **Commissioners must demonstrate:**
 - Fairness and transparency of process
 - Clear rationale for decision making
 - Needs-driven
 - Proportionality (that the commissioner acts proportionately to the size and seriousness of any problem)
- **Commissioners are expected to secure best value and quality for patients and taxpayers**
- **Commissioners are expected to actively monitor the quality of services and to initiate a process with providers if services are not adequate**
- **The starting point for some scenarios will be the contractual mechanism that currently exists.**
- **Robust oversight and assurance of all the above through:**
 - PCT Boards
 - SHA Assurance
 - World Class Commissioning, Transforming Community Services
 - Partnership oversight through Regional Social Partnership forums

As I said above, I would like the SPF to work with us to sign off a joint statement of policy. We will then work with the SPF and other stakeholders to draft the guidance to supercede Necessity – Not Nicety and the revised PCT Procurement Framework and Principles and Rules of Co-operation and Competition.

I look forward to working with you on this and thank you again with all your help to date.



ANDY BURNHAM

Draft scenarios, to be finalised by DH and SPF

Scenario (ie. the commissioning need)	Process to be followed	Oversight & assurance mechanisms
1 Addressing underperformance	The PCT would raise its concerns and engage with the provider to address these. There would be at least 2 formal chances for the provider to improve before any engagement was made with other alt providers. Judgements would be made on the basis of clear measures of quality, including patient satisfaction. Only if there was insufficient improvement within a reasonable timescale, <i>and</i> the scale of under-performance was significant, would the PCT consider engaging with other potential providers or other solutions (e.g. franchising). If market-testing is subsequently pursued, the PCT would be expected to continue to engage the provider and its staff, and give them the opportunity to compete on a fair and equal basis.	SHA under the NHS Performance Regime; WCC assurance; SHA assurance.
2 Incremental service improvements & increases in capacity	A joint service review would be undertaken, the results of which (if agreed) would be incorporated in a revised contract. Only if provider failed to develop robust and credible plans for service improvement and the shortcomings were serious (in terms of quality and value for money), would the PCT consider engaging with other potential providers. This would only be after full engagement with the provider and its staff, and the provider having been given at least two opportunities to develop and present its service plans. Engagement would continue whilst the PCT considered other options, including market-testing. If the service is ultimately tendered, the provider would be able to bid on a full and fair basis.	WCC assurance; TCS assurance; SHA sign-off of the PCT's strategy; SHA assurance.
3 Risk of Clinical or financial un-sustainability	The PCT would work with the provider to try to address the causes of un-sustainability. If necessary, the PCT would enlist the support and help of other relevant providers within the local health system. If the problems cannot be resolved sustainably, regulatory Intervention and resolution through merger, acquisition or franchising, probably with an existing NHS organisation, is more likely to be a viable solution than the market-testing of services, though this remains an option. The assumption would be that the PCT would be acting under the SHAs' direction as part of seeking a co-ordinated solution, potentially under the oversight of the relevant regulator. The PCT would be expected to engage fully with the provider and its staff throughout this process.	SHA under NHS Performance Regime; WCC assurance; SHA assurance; appropriate regulator (depending on the circumstances).
4 New services or significant redesign of	PCTs would be expected to engage fully with the existing provider(s) and staff at an early	WCC assurance; SHA sign-off of the PCT's

	services	<p>stage, as well as other potential providers, being clear about what outcomes and/or innovation it was seeking, the reasons for change, and the processes to be followed, enabling them to contribute to shaping service specifications. Only after this would a decision on whether or not to openly tender for the new or re-designed service take place.</p> <p>. For certain services, clinical issues or safety may warrant an 'NHS only' tender. In either case, existing providers would have a fair and equal opportunity to bid.</p>	<p>strategy; TCS assurance; SHA assurance; Co-operation & Competition Panel.</p>
5	Increasing patient choice	<p>The PCT would adopt an open or managed 'Any Willing Provider' accreditation process, under which potential additional providers (including other NHS providers) could apply.</p> <p>NB: Under this scenario, existing providers (as long as they continued to meet quality, value for money and registration requirements) would continue to provide services – this is about adding to the number of providers, not displacing existing ones.</p>	<p>WCC assurance; SHA sign-off of the PCT's strategy; TCS assurance; SHA assurance; Co-operation & Competition Panel.</p>
6	Expiry of Independent/Third Sector contract	<p>The PCT would – assuming it wishes to continue to commission such a service – would tender openly. NHS providers would have a fair and equal opportunity to bid, and the PCT would engage with other existing providers beforehand.</p>	<p>WCC assurance; SHA sign-off of the PCT's strategy; SHA assurance; Co-operation & Competition Panel; competition law.</p>