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Health Committee

Changes to Primary Care Trusts

Second Report of Session 2005–06

Report, together with formal minutes, oral and written evidence

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The Health Committee

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Footnotes

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Summary

NHS Primary Care Trusts (PCTs) were created in 2002, and are currently responsible for controlling some 80% of the NHS’s £76 billion annual budget, which they use to commission health services for their local populations. In addition, they have responsibility for public health, and many PCTs also provide community-based health services, such as district nursing and community hospitals.

Commissioning a Patient-Led NHS was published on 28 July 2005. It set out proposals to dramatically reduce numbers of PCTs in order to achieve cost savings of £250 million and to improve commissioning. The paper also announced plans to contract out community health services currently provided by PCTs to non-NHS providers by the end of 2008. At the same time, the number of Strategic Health Authorities (SHAs) would also be substantially reduced.

These proposals were received with widespread alarm, and were described by commentators as ‘incoherent’. Those working in the NHS expressed outrage at the prospect of a further large scale structural reorganisation only three years after PCTs were created in the last round of restructuring, as well as raising serious doubts as to whether the reforms would achieve their stated aims. Against this backdrop we decided to launch this inquiry.

The consultation process

Before examining the substance of the Government’s proposals for changes to PCTs, we first addressed the fierce criticism attracted by the Government’s consultation process, which was described by almost all our witnesses as insufficient and flawed. The NHS was allowed only 11 weeks to put together complex proposals for restructuring local health services. The short timescale was compounded by its inopportune timing at the beginning of the summer holidays. As a result, patients, local people, NHS staff, other NHS organisations, MPs, local councillors, and other key organisations have been unable to contribute meaningfully to the process.

Despite the Government’s repeated reassurances, it is clear from our evidence that the consultation has been a ‘top down’ process: change has been imposed on local NHS organizations by central government for financial reasons and as a result solutions that would best meet local needs are being overruled because they do not yield the required savings.

The Secretary of State has promised that all proposals that have not been subject to extensive local consultation will be rejected. Our evidence indicates that insufficient consultation has taken place in several areas. To ensure that what remains of the consultation process in respect of changes to PCTs is as transparent as possible, offering a genuine choice about how local health services are structured, we have recommended that in statutory local consultations all SHA areas be obliged to consult on at least two options.
Changes to Primary Care Trusts

Equally strong criticism was directed by our evidence at the announcement made in Commissioning a Patient-Led NHS that PCTs should divest themselves of their provider services. This is a major change in policy direction that must be the subject of full and open debate. One channel for such debate might have been the Government’s consultation Your Health, Your Care, Your Say, which was launched in June to shape the Government’s forthcoming White Paper on out-of-hospital care. However, the inclusion of far-reaching changes to PCT primary care provision, well in advance of the consultation’s conclusion, makes a mockery of the consultative process.

In November, four months after the publication of Commissioning a Patient-Led NHS, the Government was still unable to clarify whether or not PCTs would eventually divest themselves of their provider functions; the Government’s numerous announcements and subsequent retractions mean that it is still unclear what its policy is on the divestment of PCTs’ provider services. This clumsy and cavalier approach to NHS staff has had a very damaging effect on staff morale.

There are also important concerns about the consequences of the divestment of PCT provider services. Should this go ahead, it could lead to the fragmentation of community services, and make joined-up care even harder to provide. Moreover, it is unclear whether sufficient alternative providers exist to provide a market in community services.

As well as plans to contract out PCTs’ provider functions, during the course of this inquiry it emerged that proposals were also being made by one Strategic Health Authority to put Oxfordshire PCTs’ commissioning functions out to tender. This raises crucial questions about accountability and transparency. Once again, a significant policy change has been proposed without consultation.

The status of both the divestment of provider services and the Oxfordshire proposals are now unclear following the outcry they engendered. If it is to pursue either of these policies, the Government must learn from the mistakes it has made with Commissioning a Patient-Led NHS and allow sufficient time and opportunity to consult on and debate fully its proposals, both nationally and locally.

Impact on day to day functions, including clinical services

It is clear that the impact of proposed reconfigurations on PCTs’ day to day functions, including clinical services, will be substantial—it takes on average eighteen months for organisations to ‘recover’ after restructuring and to bring their performance back to its previous level. The restructuring of PCTs is likely to have significant effects on their ability to undertake their core functions, including commissioning services, providing community health services, and protecting public health. The destabilising effects are already becoming apparent: clinical staff are moving from PCTs to the acute sector because of uncertainty over their future roles. There are also well-founded concerns that patient care will suffer because of the proposed reforms.

After the immediate disruption of reorganisation, it is thought to take a further 18 months for the benefits to emerge—a total of three years from the initial reforms. Thus, just as the...
benefits of PCTs (established in 2002) are about to be realised, the Government has decided to restructure them. The cycle of perpetual change is ill-judged and not conducive to the successful provision and improvement of health services.

Impact on commissioning

According to the Government the main reason for the reforms is to strengthen PCTs’ commissioning function. We strongly support this aim, but it is clear that improvements in commissioning should have been addressed before, or at least at the same time as powerful incentives were being introduced which strengthened the provider sector. The fact that it was not has given rise to an uneven balance of power in the NHS that may now prove difficult to redress.

The Government’s reforms promise the increased bargaining power of larger organisations. Although they may lose links with departments of district councils such as housing, more of the new PCTs will be co-terminous with county council social service departments. However, such advantages have to be balanced against the loss of local engagement which smaller PCTs provide. The introduction of Practice Based Commissioning will make some amends—it may achieve local clinical engagement—but it will not provide adequate patient involvement.

The evidence suggests that the benefits of larger PCTs are far from certain, and will be offset by the disadvantage of the loss of a local focus for the NHS. Moreover, where there are advantages in becoming larger, PCTs are already capturing them through successful collaborative working with one another. Given this, we have recommended that the Government should allow PCTs to develop organically, enabling them to evolve into larger organisations where this clearly best meets local needs. This would avoid the hugely disruptive and costly impact of another root and branch reform of the NHS.

It is striking that, despite the considerable attention these proposals have attracted in Parliament and elsewhere, debate has focused almost exclusively on the shape of future organisations, the morale of staff, and the consultation process, largely ignoring the critical issue of how commissioning can actually be improved in the NHS. In order to improve commissioning, PCTs need better skills and better information systems. To this end, we have recommended that a central change agency should be established, enabling best practice to be shared more widely, and targeting specific support at developing commissioning in the poorest performing PCTs.

Impact on public health

Another crucial area which has been neglected in debate on changes to PCTs has been the potential impact of these changes on PCTs’ vital public health role. We were very concerned to learn that, prior to the publication of Commissioning a Patient-Led NHS, there was no consultation with public health professionals about its potential impact on PCTs’ crucial public health function at all. In order to safeguard local public health initiatives, we have recommended that, with Directors of Public Health, consultants in public health must be retained with current local responsibilities. Further to this, steps must be taken to provide continuing support to community health professionals who play
an equally important part in securing public health improvements.

Financial impact

The Government has downplayed the financial motivation for its reforms, concentrating instead on its aim of strengthening commissioning. However, cost savings seem to have been the key consideration in the reconfiguration proposals, and plans which would better meet local needs have been discounted because they did not yield sufficient savings. Achieving savings is a very important aim but it should be stated explicitly so that it can be subject to proper scrutiny.

In fact, it is doubtful whether the reconfiguration will yield the £250m savings the Government is hoping for if the costs of restructuring including those incurred by redundancies and by establishing new structures to secure local engagement are taken into account. It is also doubtful whether it makes sense to reduce expenditure on PCTs rather than other parts of the NHS. PCTs are currently responsible for spending 80% of the NHS’s £76 billion budget. At a time when PCTs’ commissioning role is crucial to the success of the NHS, it is probably a false economy to deplete the NHS’s managerial resources in an attempt to save only a fraction of that total amount. It is worth noting that only three years ago, when they were created, the Government thought PCTs good value for money.

Overall impact of restructuring

The Government is proposing another large-scale reorganisation of the NHS only three years after the last, in order to achieve cost savings and improved commissioning. However, while it is far from certain that either of these benefits will be realised, the research evidence is clear that this restructuring will set NHS organisations back by 18 months, with patient services likely to be affected in the interim.

We were told by a senior NHS official that there was no ‘perfect size’ for a commissioning organisation, and our evidence suggests that there is a trade off between larger PCTs, which may have greater bargaining power and co-terminosity with local authorities, and smaller PCTs, which can achieve better local involvement. However, it seems that current, smaller PCTs are already capturing some of the advantages of larger organisations through successful collaborative working with one another, without the need for disruptive organisational change.

Debate on the Government’s proposed changes to PCTs has focused almost exclusively on the shape of future organisations and the divestment of PCTs’ provider services, largely ignoring the critical issue of how commissioning can actually be improved in the NHS. Irrespective of their future size and number, in order to improve commissioning PCTs urgently need better skills and better information systems. To this end, we have recommended that rather than reconfiguring PCTs, which is unlikely of itself to bring about improvements, and which will be hugely disruptive, the Government should allow PCTs to develop organically, and adopt a managed approach to sharing best practice in commissioning, targeting specific support at improving commissioning in the poorest performing organisations.
1 Introduction

1. On 28 July 2005, the Government published *Commissioning a Patient-Led NHS*. The central tenet of these proposals was that Primary Care Trusts (PCTs) would be reduced significantly in number in order to achieve 15% efficiency savings, whilst simultaneously strengthening their commissioning function by devolving more commissioning to GP practices, and contracting out the provision of NHS services.

2. In a damning report of initial reactions to the proposals, the *Health Service Journal*, the generally even-handed NHS trade magazine, described them as ‘intellectually incoherent’:

   The government’s blueprint for primary care trust reform was this week slammed as ‘incoherent’, ‘ill thought out’ and ‘an incredible way to treat important organisations’ by senior NHS managers and policy analysts.

3. In addition to their strong reservations about the content of the Government’s proposals, commentators were appalled at the Government’s specified timescale which allowed the NHS only 11 weeks, largely over the summer break, in which to consult local stakeholders and put together plans for reconfiguring local PCTs. It was initially thought that these plans would also have to cover the divestment of PCT provider services. The divestment of provider services, including community nursing services, to providers outside the NHS, was also greeted with astonishment, as this appeared to anticipate the outcome of a much-vaunted Government consultation on ‘out-of-hospital’ care announced only a month previously.

4. The background to PCT reforms is complex. PCTs were established three years ago, replacing larger commissioning structures called Health Authorities. The intervening three years have seen far reaching change in the NHS, including the establishment of Foundation Trusts, the introduction of the new financial system of Payment by Results, the expanding use of the private sector, the advent of patient choice, the introduction of new pay and contracting arrangements for NHS staff through Agenda for Change and new contracts for consultants and GPs, and the implementation of the European Working Time Directive. PCTs currently have a complex and crucial role in implementing all these policies, and currently control 80% of the NHS budget, which currently stands at £76 billion.

5. While sometimes organisations are abolished or downscaled because their functions are no longer needed and they have effectively become redundant, it is clear that the functions PCTs perform are still highly relevant. In fact, at a time of unprecedented investment in the NHS, PCTs have never been more critical to the success of the NHS in ensuring the provision of high quality, value for money health-care. Reducing their number so drastically while their functions remain strongly implies that PCTs have not proved themselves equal to their significant task. However, at only three years old, PCTs are a new addition to the complex jigsaw of structures that make up the NHS, and arguably have not been given enough time to demonstrate their effectiveness.

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2 Health Service Journal, *PCT reform strategy slammed as ‘intellectually incoherent’*, 4 August 2005
3 Department of Health, *Departmental Report 2005*, Cm 6524, June 2005
6. It is perhaps inevitable that structural changes in the public sector attract a degree of resistance from those working in the organisations which are under threat, who obviously are concerned about their own futures. However, the strength of response to these announcements across the NHS suggested to us something more than a knee-jerk reaction prompted exclusively by thoughts of self-preservation and we, in common with many others, were concerned that the tight timescales might allow insufficient time for debate on these far-reaching reforms. Equally, all organisational change brings significant distraction from core tasks, and the prospect of a further reorganisation only three years after the last significant reform of NHS structures raises inevitable questions about the potential impact on PCTs’ day to day functions, which include providing vital patient care. We were thus persuaded to conduct an inquiry, within a necessarily condensed timescale, into this complex subject.

7. We announced this inquiry on 21 October 2005 with the following terms of reference:

The Health Committee has decided to undertake an inquiry into potential changes to primary care trusts’ functions and numbers arising from Commissioning a Patient-Led NHS, including:

- Rationale behind the changes
- Likely impact on commissioning of services
- Likely impact on provision of local services
- Likely impact on other PCT functions, including public health
- Consultation about proposed changes
- Likely costs and cost savings.

8. During the course of two sessions, we took evidence from the Minister of State for NHS Delivery, Lord Warner of Brockley; John Bacon, Group Director of Health and Social Care Services Delivery at the Department of Health; bodies representing the interests of those working in and with the NHS, including the NHS Alliance, the NHS Confederation, the Royal College of Nursing, the Faculty of Public Health Medicine, London Local Medical Committees, the Local Government Association, and the Association of Directors of Social Services; and from Chairs, Chief Executives and officials working in NHS Strategic Health Authorities and Primary Care Trusts. We also received over 50 written memoranda. We are extremely grateful to all those who gave evidence to our inquiry, many of whom prepared written material and accepted our invitations to give oral evidence at extremely short notice. We are particularly indebted to those witnesses working in the NHS who gave us frank and compelling accounts of the impact of these changes on their own organisations, against a backdrop of extreme political sensitivity and ongoing uncertainty about their own future roles. Their evidence was extremely valuable in shaping our assessment.

9. We would also like to thank our specialist adviser, Dr Richard Lewis, an independent consultant and senior health policy fellow at the King’s Fund, for his detailed and insightful support throughout this inquiry.
10. This report begins by providing some brief background to the proposals set out in *Commissioning a Patient-Led NHS*. It then discusses the implications of these proposals in three separate sections:

- The initial consultation process, including announcements about divestment of provider services
- The likely impact of PCT restructurings, including immediate impacts on PCTs’ day to day functions and clinical services, and longer term impacts on commissioning, on public health and financial impacts
- The impact of divestment of PCTs’ provider services

We have also included a chapter on issues surrounding the potential contracting out of commissioning in Oxfordshire, which is a separate, but related issue.
2 Background

Current PCT functions and configuration

11. There are currently 302 Primary Care Trusts (PCTs) in England, serving an average population of about 170,000 (although they range quite widely in size). PCTs commission health care for their local populations from hospitals, GPs, ambulance trusts, and other providers. PCTs are now directly responsible for spending approximately 80% of the NHS budget.

12. In addition to this commissioning role, some PCTs are responsible for directly providing community health services, including district nursing and health visiting. Approximately 200 (2/3) of PCTs are currently ‘substantial’ providers of community health care.

13. PCTs also have important statutory functions in respect of public health, including improving the health of their local communities and tackling health inequalities.

14. Groups of PCTs within a local area are managed, on behalf of the Department of Health, by Strategic Health Authorities (SHAs). There are 28 SHAs, each of which serve an average population of 1.8 million.

What is ‘commissioning’?

15. According to the King’s Fund, commissioning is a term that is used “liberally and variably within the NHS”. A useful definition of commissioning is given in the King’s Fund 2004 policy paper on Practice-led Commissioning:

- identifying effective and appropriate health service responses to assessed patient needs
- securing national and local health care priorities
- planning the coherent delivery of services
- securing those services through contracts with service providers (or purchasing)
- allocating available resources against competing priorities.

A brief history of NHS commissioning

16. While some PCT functions were entirely new when they were set up in 2002, PCTs were not the first ‘commissioning’ organisations in the NHS. Before 1990 central government ran all aspects of the NHS. With the introduction of the internal market, a
split was established between ‘purchasers’ (health authorities and some family doctors, under the GP fundholding scheme), who were given budgets to commission health care, and ‘providers’ (acute hospitals, organisations providing care for the mentally ill, people with learning disabilities and the elderly, and ambulance services). Thus, commissioning has been a function of NHS organisations for fifteen years, and GP fundholders and Health Authorities of various types and configurations can be seen as PCTs’ predecessors.

17. The internal market was established to address problems, such as growing waiting lists, which had arisen because NHS capacity is limited while demand rises inexorably. While observers credit the internal market with improving cost-consciousness in the NHS, it did have certain unintended negative consequences. The competition it encouraged between ‘providers’ saw unnecessary duplication of services.\(^8\) Equally, GP fundholders used their budget-holding powers to obtain treatment more quickly for their patients than patients of non-fund holders, which led to inequities in access to healthcare.

18. In 1997, the Government announced the abolition of the internal market and GP fundholding. However, GP fundholding had demonstrated the potential of GP-led commissioning to yield cost-savings and innovation, and GP involvement in commissioning persisted in various guises, including total purchasing pilots. In 1999, Health Authorities established Primary Care Groups (PCGs). Primary Care Groups were sub-committees of Health Authorities, made up mostly of local clinicians, and were responsible for managing devolved budgets to commission health for their local populations, under the supervision of Health Authorities. These were seen to have the benefit of securing better local and clinical engagement in local health care decisions than more remote Health Authority structures were capable of. Devolving power to as local a level as possible was a key tenet of government health policy between 2000–2001, and in 2001 Shifting the Balance of Power announced that by 2002 PCGs should grow into statutory bodies in their own right, called PCTs, which would replace Health Authorities, and which would eventually take over management of the entire NHS purchasing budget, placing decision making at a more local level than ever before.\(^9\) Clinical involvement was a central principle of PCTs, which were each required to have a Professional Executive Committee (PEC) made up of local clinicians. In the same wave of reform that replaced approximately 100 Health Authorities with 302 PCTs, the nine Regional Offices of the NHS Executive were also abolished and replaced by 28 new lower-level organisations called Strategic Health Authorities, which would manage the performance of groups of PCTs.

**Market-type reforms—Payment by Results and Patient Choice: the implications for commissioning**

19. At the same time as commissioning structures have changed, other market-type reforms have been introduced, namely Payment by Results and the patient choice initiative. These reforms, in common with previous NHS market reforms, have the ultimate aim of promoting cheaper, better quality health services by making providers of care compete for funding, which will be directly linked to the number of patients treated. However unlike previous market-type reforms, a fixed tariff system has been introduced in

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an attempt to ensure that providers compete on speed of access and quality, rather than price. Under Payment by Results, hospitals are paid for how many patients they actually treat, according to a national tariff. Foundation Trusts began using the tariff in 2004 and, from 2005, all trusts have used it for elective care, representing about 30% of activity. Outpatients, non-elective and A&E services will be covered by the tariff from 2006, and from 2008 the system will cover 90% of significant inpatient, day-case and outpatient activity.\textsuperscript{10}

20. Linked to Payment by Results is the introduction of patient choice, whereby GPs referring patients to a hospital are supposed to give their patients a choice of different providers, one of which must be an independent sector provider. It is hoped that patient choice will function as a lever to service improvement, as patients will not choose hospitals with long waits or poor services, and so these hospitals will be forced either to improve, or to lose resources under Payment by Results.

21. For true choice to exist, a market must be created, which is likely to necessitate oversupply. The market for providing government-funded healthcare has already been opened up to private sector providers, as long as they can offer services at the same NHS tariff prices. The success of market reforms in delivering cost savings and improvements in health care will depend on many things. It is not yet known how far patients will be willing to exercise their powers as consumers—for example, will they be willing to travel considerable distances to access better or faster healthcare? Equally, information systems to enable patients to make meaningful choices will need to be developed rapidly. In some areas, particularly rural or deprived areas, there may be very little choice of provider, and it could be wasteful to build up capacity solely to create a market. Similarly, the market could potentially have unpopular consequences, for example if a local hospital fails to attract enough patients and so is forced to close. It is unclear how far the market will be allowed to dictate important issues like this. The introduction of the private sector into NHS-funded healthcare provision has also attracted considerable criticism from those that believe private sector organisations are being given an unfair advantage in competing for contracts with their NHS counterparts.

22. All the market reforms discussed above pertain to secondary care. However, recent developments mean that choice and competition is likely to be extended into the primary and community care sector. This is discussed more fully later in the report.

23. Whatever the current unknowns about the new markets in healthcare, it is clear that commissioning organisations, which effectively hold the pursestrings for the NHS, will be absolutely integral to their success or failure. In the context of increasing complexity and change in the healthcare market, commissioners, which at the moment are PCTs, will have to manage budgets effectively to secure the best value for money services for their patients; to ensure that adequate provision is available to meet the health needs of their local populations; to ensure that care is as integrated as possible for patients; and to maintain an appropriate balance of spending across all types of health care, in line with Government priorities and local needs.

24. There is already concern that current market-type reforms could give the secondary care sector a strong incentive to promote their own services to secure funding, potentially acting as a magnet to pull patients and resources away from the primary care sector where patients may be able to be treated more appropriately and cheaply. Therefore, the commissioning function carried out by PCTs is more crucial than ever. In order to help bolster it, in the past year the Government has proposed several changes to the NHS commissioning function.

**Practice Based Commissioning**

25. The first of these is Practice Based Commissioning (PbC). In the NHS, patients need a referral from their GP before they can make an appointment to see a specialist in a hospital. In this way, GPs exercise considerable control over access to other parts of the health system—what is known as the ‘gatekeeper’ function. In addition to their influence over referrals, GPs as a group have direct contact with more patients than any other healthcare sector (over 90% of interaction with the NHS is through primary care). Arguably, GPs have a unique knowledge of their patients’ interactions with local health systems, including community health services and social services departments, as well as the acute sector, and are therefore a rich source of knowledge of local patient needs and pathways. Therefore, harnessing these strengths by involving GPs in the commissioning of health care is an attractive option for improving commissioning.

26. GPs have been involved in commissioning for over 15 years, first through GP fundholding, then total purchasing pilots and finally through involvement in local PCT PECs. Under GP fundholding, GP practices were given their own indicative budgets to spend on commissioning care for their patients, together with considerable freedom to develop innovative alternatives to traditional services if this was more cost-effective. With the abolition of GP fundholding, budgets were returned to PCTs, and although some GPs have continued indirect involvement in commissioning through PCT PECs, GPs’ direct influence over local budgets has been reduced.

27. However, in a move that has been described by some commentators as a return to GP fundholding, in December 2004 the Department of Health announced that from April 2005, GP practices that wished to do so would be given indicative commissioning budgets. The document *Practice Based Commissioning—promoting clinical engagement* gave more details:

> The basic right of a practice or locality to have an indicative budget from April 2005 goes beyond this. Practices or localities who wish to do so will receive a firm indicative budget from the PCT that they will use to directly manage the delivery of services for their patients.

> Using the indicative budget, the practice or locality, with support from their PCT, would identify the health needs of the local population and, in conjunction with local stakeholders, identify the appropriate services to be provided. Practices or localities should be encouraged to develop their own local delivery plans. In turn, these local delivery plans, will feed into the PCT’s Local Delivery Plan (LDP). Where PCTs have
pre-existing contractual agreements these should be reflected in the practice and locality plans.

The PCT would continue to hold the actual budget and would be responsible for the service level agreements with the secondary care provider, including monitoring and invoicing functions. However, the practice or localities would make the commissioning decisions and be able to reallocate resources freed up through cost effective commissioning to new patient services. They can also charge reasonable management costs associated with Practice Based Commissioning against resources freed up through effective commissioning.

Resources freed up from effective commissioning may only be used for patient services (with the exception of management costs as outlined above). It is our expectation that this reinvestment will be used to improve clinical services in a substantive way.12

**Recent changes—Creating a Patient-Led NHS, the ‘out-of-hospital’ White Paper consultation, and Commissioning a Patient-Led NHS**

28. Practice Based Commissioning has the potential to significantly alter the commissioning of NHS services. If, in the future, local GPs are to be primarily responsible for commissioning healthcare for their patients, the role of PCTs, who are currently responsible for commissioning, would need to change. *Creating a Patient-Led NHS*, which was published in March 2005, gave further detail on Practice Based Commissioning, and hinted at a possible reorganisation of PCTs.13 The future provision of primary care also came under question with the announcement, in June 2005, of a Department of Health consultation on ‘healthcare outside hospitals’, including GP services and other community healthcare services currently provided by PCTs.14 This consultation is to feed into a White Paper on healthcare outside hospitals, expected at the end of 2005.

29. Before the consultation was complete, *Commissioning a Patient-Led NHS* was published on 28 July 2005. This document brought together previous thinking on commissioning and on the provision of primary care, and for the first time spelt out the Government’s intentions in very clear terms, with a fixed and very rapid timescale for their implementation:

- The implementation of Practice Based Commissioning would be accelerated, with all practices involved by December 2006
- PCTs and SHAs would be reconfigured, generating savings of 15%—PCT reconfigurations would be complete by mid-2006 and SHA reconfigurations by mid-2007.
- PCTs’ role in directly providing patient services would be reduced to a minimum by December 2008

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12 Department of Health, *Practice-based commissioning—promoting clinical engagement*, Dec 2004
14 Hewitt asks the public to help shape care outside hospitals, Department of Health press release, 23 June 2005
30. The document called for SHA Chief Executives to put together plans for their local area and submit them to the Department of Health by 15 October 2005, a total of eleven weeks.

31. Plans for local reconfigurations which were submitted to the Department of Health by SHAs were then considered by an External Panel, appointed by the Department of Health, chaired by Michael O’Higgins, Chair of PA Consulting. Following consideration by the External Panel, proposals for reconfiguring PCTs and SHAs have now been put out to formal consultation. The formal consultation process began on the 14th of December 2005, and will last for 14 weeks, ending on 22 March 2006. SHAs will then prepare and submit the results of the consultation, along with recommendations, to the Department of Health by 12 April 2006. The recommendations will be reviewed by the External Panel, who will advise Ministers on whether the proposals meet the criteria set out in Commissioning a Patient-Led NHS, before final consideration by the Secretary of State. Early assessments of initial plans submitted before the formal consultation suggested that PCTs would reduce in number from 302 to between 70 and 130, and that SHAs would reduce in number from 28 to nine.\textsuperscript{15}

Rationale behind the changes and assessment criteria

32. In many areas, these proposals will result in the formation of organisations similar in size and function to the Health Authorities and Regional Offices that were abolished in 2002. So in what way, then, are these reforms likely to yield improvements that the organisations and arrangements they supersede could not deliver? What has been the Government’s rationale for proposing these changes so soon after the last restructurings of the NHS took place, at such a critical phase in the establishment of new market-based systems, and with such tight timescales?

33. The criteria published by the Department of Health in \textit{Commissioning a Patient-Led NHS}, stipulate that reconfiguration plans will be assessed according to the PCTs’ ability to:

- Secure high quality, safe services
- Improve health and reduce health inequalities
- Improve the engagement of GPs and rollout of Practice Based Commissioning with demonstrable practice support
- Improve public involvement
- Improve commissioning and the effective use of resources
- Manage financial balance and risk
- Improve coordination with social services through greater congruence of PCT and local government boundaries
- Deliver at least 15\% reduction in management and administrative costs.

\textsuperscript{15} \textit{Health Service Journal}, 27 October 2005
34. Although Michael O’Higgins, Chair of the Department’s external panel, said that none of the criteria were ‘hurdle’ criteria that had to be met before plans were agreed, it is widely held that the requirement for 15% efficiency savings is non-negotiable, and it remains to be seen whether any plans will be accepted by the external panel which do not achieve this level of savings.

35. Besides cost savings, the Government has stated that the main aim of these reforms is to strengthen PCTs’ commissioning function, as larger commissioning organisations, similar in size to old Health Authorities, will have increased bargaining power, and can be better aligned to local authority services. The competing justifications for these reforms are discussed in detail in Section 3 of this report. However, before discussing in detail the likely impact of the Government’s proposal to restructure PCTs, it is important to note that PCTs were established only three years ago, at considerable cost to the taxpayer. A return to structures which are similar in size and function to previous Health Authorities raises important questions about why the shortcomings now being identified by the Government, including increased management costs and dilution of bargaining power, could not have been easily anticipated and addressed before PCTs’ introduction three years ago. As we discuss later in this report, all restructurings are hugely disruptive, and to introduce a large scale reconfiguration of NHS organisations only three years after the last root and branch reform of NHS organisations points to an ill thought-out approach to policy-making.
3 The consultation process

36. Consultation on *Commissioning a Patient-Led NHS* has been a two-part process, the first phase of which was described by the Government as the ‘pre-submission engagement’, and which took place between the 28 July and 15 October 2005. During the first phase, SHAs were asked to consult local stakeholders and put together initial proposals for reconfiguring services in their local areas, which were submitted by 15 October 2005 to an external panel convened by the Department of Health. The first phase is now complete, and the second phase of consultation is now underway, during which reconfiguration proposals submitted by SHAs will be subject to a three month formal public consultation. The first phase of consultation, the ‘pre-submission engagement’ has attracted fierce criticism. This chapter looks at a series of concerns about the ‘pre-submission engagement’, which is described as the ‘consultation process’. First this chapter considers ongoing lack of clarity about PCTs’ provider functions; and secondly wider concerns about the first phase of the consultation process including:

- Patient and public involvement
- Timing and timescales surrounding the consultation process
- Are changes being driven by central Government or the local NHS?
- Are the changes being driven by improvement or cost savings?
- Are changes being driven by form rather than function?
- SHAs’ accountability for restructuring.

**Divestment of PCT provider services—continuing confusion**

37. *Commissioning a Patient-Led NHS* stated that in their proposals SHAs should show how:

- commissioners will be actively seeking new and innovative ways to improve new services with a range of providers;
- they have assessed what services should move away from direct PCT provision and at what pace;
- where PCTs continue to manage services, decision-making on commissioning and on provision will be separated in order to enhance contestability.

It went on to state that while the forthcoming White Paper might have an impact on proposals, “the direction of travel is clear: PCTs will become patient-led and commissioning-led organisations with their role in provision reduced to a minimum. We would expect all changes to be completed by the end of 2008.”

16 Department of Health, *Commissioning a Patient-Led NHS*, July 2005
38. The possibility of organisational change had been hinted at in the March 2005 document *Creating a Patient-Led NHS*, and the potential for different models of community service provision was raised in the announcements at the time of the consultation on the ‘out-of-hospital care’ White Paper at the end of June 2005. However, the *Your Health, Your Care, Your Say* consultation events had not even begun when *Commissioning a Patient-Led NHS* was published specifying a rigid and rapid timescale for the divestment of provider services. These proposals were therefore received by the NHS with surprise and in many cases dismay. Karen Rhodes pointed out to us that senior PCT managers had had no briefing on this subject prior to 28 July 2005, and many argued that in making these proposals, the Government was effectively anticipating the outcome of a consultation not due to be complete for a further five months.17

39. The strength of responses to these proposals prompted John Bacon, Group Director of Health and Social Care Services Delivery at the Department of Health, to write again to SHA Chief Executives on the 26 August.18 His letter specified that SHAs need not have all their plans for divestment of services in place by 15 October 2005, but reiterated the commitment that changes to PCT service provision would be complete by December 2008.

40. Against a background of increasingly vocal concern, on 18 October 2005, the Secretary of State for Health issued a written statement announcing that any changes to PCTs’ role in providing services would take place over a longer timescale, and that any staff transferring to a new employer would be entitled to appropriate legal protection of their terms and conditions of employment.19 However, she did not retract the commitment for PCT changes to be complete by December 2008—in fact the chronology attached to her statement reiterated this.

41. Answering questions in the House on 25 October 2005, Mrs Hewitt stated that:

Staff in the community who are now directly employed by PCTs will continue to be employed by their PCT unless and until the PCT locally decides otherwise.20

This was interpreted by some commentators as a U-turn from the previous policy that services would be divested by December 2008. However, in evidence to the Public Administration Committee on 1 November, the Rt. Hon. John Hutton MP, Minister for the Cabinet Office, maintained that it was still government policy to divest provider services from PCTs, but not to the 2008 timescale:

*Mr Prentice:* Is it the case that you would like to see Primary Care Trusts divest themselves of their provider responsibilities?—which was the question I think that Kelvin [Hopkins] was trying to get from you.

*Mr Hutton:* Yes, that is the policy of the Government.

*Mr Prentice:* There was a suggestion, out of three meetings with Patricia Hewitt, that the brakes were going to be put on this part of the policy. Are you telling us that the

17 Appendix 7
18 Letter from John Bacon to SHA Chief Executives, 26 August 2005, www.dh.gov.uk
19 HC Deb, 18 October 2005, Col 30WS
20 HC Deb, 25 October 2005, Col 153
Changes to Primary Care Trusts

Government is as committed as it ever was to see frontline medical staff move away from employment in Primary Care Trusts? Is that what you are telling us?

Mr Hutton: I think we have set ourselves a long-term objective, yes, but I think what was clarified was the removal of the 2008 timetable for that. It is essentially a policy that will be taken forward locally, by agreement, with Primary Care Trusts, about the sensible way forward, and will not be imposed against a deadline ... It is a long-term direction of travel. It is not going to be implemented overnight.\(^\text{21}\)

In evidence to us on 10 November, Lord Warner, the Minister of State for NHS Delivery, did not disagree with Mr Hutton, saying 'the direction of travel is in the direction that John is saying. We are saying it is down to people at the local level to get the timing of that right'.\(^{22}\)

Despite the Government’s numerous assertions that it has sufficiently clarified its position, our evidence revealed that very senior officials within the NHS did not know whether or not PCTs were likely to divest their provider functions. Unlike John Hutton, Dame Gill Morgan, Chief Executive of the NHS Confederation, thought that it was now clear that provision would stay with PCTs.\(^{23}\) However, senior medical representatives thought that the reverse was true, and that the direction of travel towards the divestment of PCT provider functions remained unchanged:

As far as I can understand it, whatever the Secretary of State has slightly pulled back on, there is clearly a direction of travel towards PCTs no longer being the direct employers of what we might loosely call community staff.\(^{24}\)

Dr Michael Dixon, Chair of the NHS Alliance which represents primary care professionals and PCTs agreed that "I think the direction is still quite clear, which is towards a bit more contestability in primary care."\(^{25}\) Alwyn Hollins, Chair of Basildon PCT, went as far as explicitly requesting that we clarify the position for him:

One thing I would like to ask today is if you could get absolute clarity for us as to whether the provider services are in or out but not like "shake it all about" because our provider services have been the poor relations of the NHS for many years. I know some staff in our community that have had different employer names on their pay slips five times in less than ten years. I think it is time to treat them as equal citizens to the acute and the mental health and to build them up so that they can be a solid provider of services. We need to have contracts which are strong and equivalent to the other providers so they can be commissioned from.\(^{26}\)

43. Mr Hollins’ evidence raised a crucial point about the hugely damaging effect these poorly managed announcements and the continuing uncertainty they have created are

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\(^{21}\) Minutes of evidence taken before the Public Administration Committee, 1 November 2005, Qq 96, 98, 101
\(^{22}\) Q 241
\(^{23}\) Q 45
\(^{24}\) Q 118
\(^{25}\) Q 122
\(^{26}\) Q 164
having on the community workforce. Karen Rhodes, Director of Primary Care at North Lincolnshire PCT, who gave evidence to us in a personal capacity, argued that “the impact this has had on highly committed NHS staff within PCTs has been regrettable”.27 According to Philip Barrett, Director of Finance at High Peak and Dales PCT, who also gave us a personal rather than an official viewpoint:

The whole process of Commissioning a Patient-Led NHS to date has been badly handled, with conflicting guidance particularly about timing and the future of Provider Services. This does not help senior managers implement the reconfiguration, with ground rules changing with no notice and all giving a clear impression that the policy is being developed on the hoof.28

44. A crucial issue for staff potentially affected by the divestment of provider services is that of terms and conditions. The Secretary of State stated on 25 October that “any staff transferring to a new employer will, of course, be entitled to appropriate legal protection of their terms and conditions of employment”. However, Dame Gill Morgan told us that in her personal view:

A number of the issues around employment law and TUPE makes it highly unlikely in my working lifetime that you will see large numbers of these staff working for private or other independent organisations, I just do not believe that is a possibility.29

45. Worryingly, Lord Warner and his senior official, John Bacon, were not able to give the Committee any clarity on this crucial point:

**Mr Burstow:** Back to the divestment issue and just to be clear, will staff transferring outside the NHS, including into private sector organisations, be able to retain membership of the NHS pension fund?

**Lord Warner:** Where this has happened in the past, my recollection is—and I will check when I get back and correct if what I am saying is misleading—that staff have a choice. They can actually enter new arrangements for their future pension on terms which are meant to be equivalent in kind to the present arrangements and in effect freeze their current NHS pension where it is. So they have a choice. In some cases they can transfer pensions, as I understand it.

**Mr Bacon:** As Lord Warner, I would need to go back and check this. First of all, of course, under any circumstance employees are entitled to TUPE transfer. We neither can nor would want to do anything to disturb that. There are occasions when pension issues are difficult. It would be wrong for me to deny that. What we are looking at, and always look at, is how we can make the best possible arrangement for individual members of staff in these circumstances, so it will vary, but we are very focused on it. It is one of the things we know staff have greatest concerns about and we will do whatever we can possibly do.30

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27 Appendix 7
28 Appendix 6
29 Q 71
30 Q 262
When this point was raised in the Liaison Committee on 22 November 2005, the Prime Minister was similarly unable to give a definite response. In a subsequent letter the Prime Minister stated that TUPE protection entitles employees to “broadly comparable” pension arrangements, and that some employers, usually not-for-profit companies or charities, are able to operate the NHS pension scheme for their employees under a direction given by the Secretary of State. However, the Prime Minister’s letter also stated that “in general, NHS employees who are compulsorily transferred to a private sector employer cease to be entitled to membership of the NHS pension scheme.”

46. We are appalled at the continuing lack of clarity about whether or not PCTs will eventually divest themselves of their provider functions. This announcement was first made at the end of July, together with a firm timetable for its implementation, which was withdrawn in October. Various ministerial announcements have failed to clarify the position, and even our witnesses, drawn from the senior ranks of the NHS, could not agree about whether or not these changes would eventually happen, with many appearing genuinely bewildered. As far as we can see, the overall direction of travel in fact remains unchanged, and PCTs will ultimately divest themselves of provider services. We urge the Government to either confirm or deny this immediately.

47. We are deeply concerned that neither Lord Warner nor John Bacon were able to give us a confident assurance that NHS staff potentially affected by these changes would be able to retain their NHS pensions. The Government must provide clear information as to whether existing NHS staff who are transferred to other providers, particularly in the private sector, as a result of these changes will be able to retain their NHS pensions.

48. Perhaps most concerning of all is that these announcements about the future of PCT provided community services anticipate the outcome of the Government’s flagship consultation Your Health, Your Care, Your Say, which is supposed to shape the Government’s forthcoming White Paper on out-of-hospital care. For a Government to announce its intended direction of travel a full five months before its consultation on this subject comes to an end makes a mockery of the consultative process. Equally, if the Government is now committed to introducing changes to PCTs to a more relaxed, less prescriptive timescale, it is difficult to see why the announcement would not have been better made in a more measured, informed way, in the expected White Paper.

49. One of our witnesses argued that the Government’s handling of announcements surrounding Commissioning a Patient-Led NHS gives “a clear impression that the policy is being developed on the hoof”. We agree. In our view, the numerous announcements and retractions about the divestment of PCTs’ provider services, in advance of a White Paper consultation designed to canvass views on precisely this area, points to flawed and incoherent policy-making.

50. The consequence of this, which could have easily been predicted before the July announcements, has been the destabilization of a very valuable workforce whose support will prove essential to the implementation of the forthcoming White Paper.

31 Minutes of Evidence taken before the Liaison Committee: the Prime Minister, 22 November 2005, HC 709–i, Q 24
32 ibid., Ev 26
33 Appendix 6
The insecurity and distraction that has been caused within NHS community health services demonstrates how damaging the repercussions of ill-thought through policy announcements can be, and we therefore recommend that the Department of Health carries out an immediate review of its internal systems to ensure that this does not happen again.

**Wider issues about the consultation process**

**Patient and public involvement**

51. The reforms outlined in *Commissioning a Patient-Led NHS* are being taken forward under the banner of creating a health service that is driven by patients’ needs and views. However, our evidence suggests that there has been very little consultation with patients and the public during what was termed the ‘pre-submission engagement’. Although Lord Warner told us he believed there had been “a genuine attempt” to do this, he admitted that this was not consistent across the country, but went on to argue that the fall-back position of the three-month consultation would ensure that the views of patients and the public were adequately captured.  

52. However, it could be argued that patients’ views should feed into the process from an early stage, rather than only once plans have been agreed by the Department of Health. The Commission for Patient and Public Involvement in Healthcare (CPPIH) made this point strongly in their written submission:

> The Commission would expect Strategic Health Authorities to consult with PCT Patient and Public Involvement Forums at an early stage on any proposed changes to the numbers of PCTs, changes in boundaries, mergers and reconfigurations, and give them the opportunity to comment. Ideally this would take place during the pre-consultation stage and prior to proposals being submitted to the Department of Health.

> We would also expect arrangements to have been put in place to canvass the views of the public, NHS staff, local voluntary sector and community organisations and other local stakeholders on possible options.

> With a dedicated infrastructure in place to promote involvement in decision-making, funded by the public purse, it is unfortunate that efforts were not made by the Department of Health to seek the advice of CPPIH and its network of Patient and Public Involvement Forums, especially those with primary care responsibilities, in consulting patients and the public on PCT reconfiguration proposals.  

53. CPPIH also argued that the requirement under Section 11 of the Health Act had in fact been ignored, and cited evidence from their own members that consultation with Patient and Public Involvement Forums (PPIFs) had been scant and inadequate:

> Following letters and telephone calls from PPI Forum members with concerns about local consultation arrangements, CPPIH conducted an on-line poll between 18 and

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34 Q 222

35 Appendix 21
25 October 2005 to find out whether Forum members had been consulted about the reconfiguration. We received 353 responses. The general feeling appears to be that there was inadequate meaningful consultation of patients and the public in many areas.

Only 39% of PPI Forum members said their Forum had been consulted and only 22% said they had found the consultation meaningful. 52% of respondents said that patients and the public had not been consulted over the proposed changes.

We suggest these figures are a cause of concern, particularly as only 14% of Forum members said patients and the public had been consulted and only a minority were aware of any opportunities available to the public to express an opinion.

54. The comments submitted by Patient and Public Involvement Forums to the CPPIH were damning:

“We were actually consulted after the cut-off date for written submissions… This means that I have not been able to discuss the proposals with my Forum or for us to have time to submit any kind of proposal. This seems to be a frequent occurrence where consultation/information by the SHA is withheld until the last possible moment.” (East Staffs PCT PPI Forum)

“Re-organisation has been explained to us… However, to me, consultation means the opportunity for discussion, to put forward opinions and to question the proposals prior to decisions being made. We have not had the opportunity to do this.” (North East Region)

“Our PCT has told us about the process but has made the point that is not their duty, or the duty of the SHA, to ask our views.” (South East Region)

“There has been no official consultation with the Forum or its members or with members of the public… We have strong views on the matter, but meetings with the PCT are cancelled by them at the last minute. Comments from the DH indicate that there is no consultation requirement as this is merely an administrative change.” (East of England)

55. Although the stated aim of these proposals is to design a more patient-led NHS, evidence both from NHS bodies and from Patient and Public Involvement Forums confirms that patients and the public have not been adequately consulted. We find this unacceptable. If the Government truly believes in a patient-led NHS, it should have started its reforms with a patient-led consultation process, rather than the top-down process we are clearly seeing.

**Timing and timescales surrounding the consultation process**

56. Our evidence suggests that as well as preventing patients from having a say in these reforms, time constraints have hampered full consultation in other ways. *Commissioning a Patient-Led NHS* was published on 28 July 2005, one week after Parliament had risen for
the summer recess. The deadline for Strategic Health Authorities to submit their plans to the Department of Health was 15 October 2005, a week after Parliament returned. SHAs were given just over eleven weeks to put together proposals for reconfiguring their local PCTs. For the first four weeks of this period, many SHAs were working on the assumption that their plans also had to include options for transferring PCT-provided services to other providers. During this eleven week period, according to the Minister, SHAs were expected to work with their PCTs and “work with local people and patient groups, NHS organisations, local government, MPs and other stakeholders set against eight criteria.”

57. It seems abundantly clear that eleven weeks, the majority of which were over the summer holiday period, was insufficient time for SHAs to consult properly with all the groups mentioned, particularly considering the need for proposals to be ratified by SHA Boards, giving rise to even tighter deadlines of in some cases as little as three weeks. The evidence we received bore this out, and witnesses were universally and unequivocally critical of the timescale and timing of the consultation process. Caro Millington, Chair of North West London SHA, told us that

I think it has been a flawed process. The pace, for some of us certainly, has been very challenging indeed. I do not think there has been a proper communication plan, either within the NHS or between the NHS and everybody else involved.

58. Dianne Jefferys, Chair of High Peak and Dales PCT, detailed the problems associated with the very tight timescale with which they had to comply, structured around SHA board meetings:

The PCT boards, the local authorities, MPs, and the local strategic partnerships, were part of the pre-submission engagement, but it was not long enough. It was not nearly long enough. Some MPs were not asked at all. They said it was not on their radar. Given that this announcement came out on 28 July after Parliament had risen, when people were going on holiday, when I got my two local MPs together, it was September before they had come back from their holiday. Our submission had to be in by 12 September. What time was there for them? What time was there for the local authority chief executive? Whilst he is being consulted, he could not get his members

59. When asked about this, Lord Warner admitted that the timing of the consultation over the summer period was not “impeccable”, but argued that, as people in the NHS were already speculating about potential change, the proposals needed to be put out as quickly as possible to minimise uncertainty, which can be damaging for morale and organisational functionality. It is perhaps ironic that, in an attempt to minimise uncertainty, the Department of Health issued a poorly thought-through document which raised more questions than it answered.

37 Department of Health, Commissioning a Patient-Led NHS, July 2005
38 Q 10
39 Q 35
40 Q 222
60. Even NHS officials who otherwise supported the proposals to merge PCTs have described the initial consultation process as “flawed”. In some cases, organizations were given less than a month, during the summer holidays when many key figures were absent, to put together proposals for far-reaching changes to local services. The timing also meant that many local MPs and councillors were unable to contribute to the process. We accept that organizational change causes extreme instability, and for this reason it is helpful if periods of uncertainty are kept to a minimum. However, this needs to be balanced against the time needed both to consult local stakeholders, most importantly NHS patients, and to design new organizational structures that are fit for purpose. Our evidence suggests that in this case the Government has got this balance very wrong, particularly as the White Paper has not yet been published.

61. The flawed nature of the pre-submission engagement makes the proper conduct of the formal three month NHS consultation starting on 14 December vital. The letter from John Bacon, Group Director Health and Social Care Services Delivery dated 30 November to SHA Chief Executives instructed them to “ensure that all options are presented fairly and given equal weight in your documentation” and said that “where there are sharply differing views on particular options, it would be desirable to engage the relevant PCT in preparing the document”. But it is not clear how the Department of Health has ensured this has happened as the consultation documents issued by SHAs did not have to be approved by the Department. The Department of Health should ensure that the consultation is fairly conducted by all SHAs, especially where the External Panel has required SHAs to consult on additional or different options than those originally considered in the pre-submission engagement. Not to do so would leave the Department vulnerable to allegations that the result of the consultation process was pre-determined and a sham.

**Reasons for the changes—central Government or the local NHS?**

62. Throughout debate on this subject, Ministers have strenuously denied that this process has in any way been ‘top-down’ or dictated by the Government, arguing that “they will be changes driven by the needs of local areas with the PCT in the driving seat.” However, this view is strikingly out of step with much of our evidence from those working in PCTs, who did not seem to feel that they were ‘in the driving seat’. Dr Michael Dixon of the NHS Alliance told us that reconfigurations were ‘going on above clinicians’ heads, without them being involved at all’. Basildon PCT described themselves as “the ‘victim’ of what is now perceived as a top down process.” Philip Barrett summarised this view:

> It is disingenuous to argue at the centre that the impetus and direction of change has come from the grass roots. We have been left in no doubt that a minimum number of PCTs had to be achieved on financial grounds."
Reasons for the changes—improvement or cost savings?

63. As Philip Barrett suggested, the lack of genuine choice identified by our witnesses stems from criteria the Government has set out, one of which is achieving efficiency savings of 15%. Had cost saving not formed part of these criteria, organisations could have had considerable flexibility to tailor reconfigurations closely to local need. However, in linking these reforms to a specific and challenging level of cost savings, at a time when most PCTs are already managing deficits, in many cases SHAs will have no option but to reduce the number of PCTs. Other evidence from PCTs supported this view. Dianne Jeffreys told us:

One of the drivers for this, which nobody has mentioned, is to release £250 million. It is in the manifesto. That money has got to be released. If you do not reduce the number of organisations, it is hard to see how you are going to release that money. It is true to say that in some places large organisations would not be appropriate and in other places they would.45

64. In their written evidence, Basildon PCT described how in its local area, the push to save costs has overridden the other considerations such as maintaining local engagement:

Basildon PCT’s preferred option is to be merged as part of one South West Essex PCT, as part of a configuration that would give five PCTs across Essex. Our rationale being that collaboration already exists amongst PCTs that share a main acute provider. In our own case this is particularly strong with the jointly appointed Director of Commissioning and joint programmes addressing many common needs … The rationale for five PCTs in Essex seems at least as strong as the rationale for two, indeed the Chief Executive of the SHA said at their Board meeting that he had felt that five was right, until he had considered the cost savings needed.46

65. Karen Rhodes from North Lincolnshire PCT presented a similar picture in her area:

Certainly where I come from our ideal solution would have been to keep one coterminous PCT with our local authority, but because of the financial position that we are in there is no way we are going to be able to achieve the savings that we need to make without reorganisation with another PCT.47

66. When we asked Michael O’Higgins how important the 15% cost savings requirement was in his panel’s assessment of proposals, he denied that this was an “overriding criterion”.48 However it remains to be seen whether any proposals have been submitted, or will be approved, which do not meet the 15% savings target, and this firm directive issued by the Government has clearly had a significant influence on SHAs’ proposals.

67. Despite the Government’s repeated reassurance that this is not a ‘top down’ process, with change being imposed on local NHS organizations from central government, the evidence we have received from those working in the NHS at a local level suggests that it is exactly that. This is because, in their view, the most significant driver of these reforms

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45 Q 32
46 Appendix 3
47 Q 146
48 Q 258
is finance and so solutions that would best meet local needs are being overruled because
they do not yield enough cost savings. Cost savings may be a legitimate and justified
driver for reform, as we discuss later in this report. However, the Government must be
explicit that this is its key objective. It is disingenuous to argue that these changes are
being driven from the grassroots of the NHS when NHS managers have been told that
the solutions that would best meet the needs of their local populations will not be
adopted because they will not produce sufficient cost savings.

Reasons for the changes—form rather than function?

68. Another serious concern raised by our witnesses about the timing of the consultation
process was the danger that this reconfiguration will allow the form of new organisations to
be determined before their function is clear: according to Caro Millington:

I think there has been a danger, as always in any restructure, that form has come
before function. You are trying to design organisations before you have fully worked
out what their new function is going to be.49

69. The profound lack of clarity about whether or not PCTs are going to divest their
provider functions means that PCT reconfigurations have been drawn up under the
assumption that provider functions would be quickly divested, when it is now unclear
whether that will happen, potentially creating solely commissioning organisations that are
no longer fit for purpose. According to Dianne Jeffreys:

It would have been much more helpful had we had the correct story from the
beginning, and it has been very difficult to work through the changes, the reversals,
the tweaks and the amendments. Take, for example, Derbyshire: would we have gone
for one Derbyshire organisation had we known that that would have been a
providing as well as a commissioning organisation? I cannot answer that, but you are
quite right, it has made it very difficult.50

70. The Minister was not able to give us any reassurance on this point, acknowledging that
the announcements of 28 July has shaped some organisations’ approach to
reconfiguration.51 We were particularly concerned to learn from Michael O’Higgins that
this clarification of PCTs’ functions was not being taken into account in his panel’s
consideration of proposals:

**Chairman:** …Has that changed anything because of the decisions later by the
Secretary of State that they may not lose their provider status, that they would be
effectively a party to them losing their provider status in these areas? Has it changed
anything in terms of what they are looking at?

**Mr O’Higgins:** I do not think so in that the criteria were not specifically about
providing *per se* but were about issues such as public health, co-terminosity, business
continuity and so on. It is something I guess, when we get the substantive proposals

49 Q 10
50 Q 73
51 Q 267
at the end of the consultation period, we would need to examine, but as of our review of yesterday, no.\textsuperscript{52}

71. Another very serious concern raised in our evidence is that because of the uncertainty about the divestment of provider services, SHAs are having to design new organizations without a clear understanding of what their ultimate function will be. This could lead to the formation of organizations which are not fit for purpose, necessitating yet more reorganizations.

**Strategic Health Authorities’ accountability for restructuring**

72. SHAs have played the key role putting together plans for reconfigured services in their area. However, SHAs are also set to be reduced in number from 28 to 9, putting many jobs in jeopardy. It is therefore important to note that coupled with the extreme time pressure under which they have had to design proposals for their local areas, the senior SHA staff involved in redesigning services are themselves under threat of redundancy. This means not only that, in Philip Barrett’s words, senior managers charged with this hugely important task are doing it whilst ‘distracted by thoughts of self-preservation’.\textsuperscript{53} It also means that, come next March, many SHA senior officials will no longer be in post and accountable for the reconfiguration decisions they have taken.

73. Because SHA senior managers are currently under threat of redundancy, not only are they having to draw up reconfiguration plans whilst ‘distracted by thoughts of self-preservation’, but also, in all likelihood, will no longer be in post next year to be held accountable for the reconfiguration decisions they have taken. We find this highly concerning. The Government should have taken this into consideration and planned its restructuring accordingly, first ensuring existing SHAs have an ongoing role in overseeing and being held accountable for their PCT reforms, and then changing the configuration of SHAs themselves, rather than reforming both types of organisation in tandem, threatening both the quality of, and accountability for, these reforms.

**Next steps**

74. The external panel has now met to consider initial proposals from SHAs, and Lord Warner has told us that these would be put into the public domain as soon as possible. On 27 October the Secretary of State told us that any proposals that had not been subject to extensive local consultation would be rejected.\textsuperscript{54} We were told by Mr O’Higgins that the external panel had already concluded, on the basis of representations made from within localities, that in certain areas the “pre-consultation process had not been adequate”.\textsuperscript{55} This would appear to confirm the concerns of our witnesses that inadequate time has been allowed to develop proposals. Where consultation has been identified as inadequate, modifications might be recommended by the external panel, other options might also be

\textsuperscript{52} Q 268

\textsuperscript{53} Appendix 6

\textsuperscript{54} Minutes of Evidence taken before the Health Committee, Responsibilities of the Secretary of State for Health, 27 October 2005, HC 623, Session 2005–06, Q 31.

\textsuperscript{55} Q 253
recommended for consultation, or the proposals might be referred back to SHA for further local discussions.

75. We are pleased that Lord Warner has given us a commitment to publish all information submitted to the external panel as soon as possible. It is essential that the external panel’s responses are made public also. We also note that the Secretary of State has promised that all proposals that have not been subject to extensive local consultation will be rejected. From our evidence alone, it would appear that insufficient consultation has taken place in several areas, and we urge the Government to make clear at the earliest opportunity to make clear which proposals have been rejected.

Conclusion

76. In the light of our evidence, we believe that further steps must be taken to ensure that what remains of the formal consultation process in respect of changes to PCTs is as transparent and inclusive as possible, offering patients and other local stakeholders a genuine choice over how their local health services are structured. To achieve this, the Government must publish all documents submitted to its external panel as soon as possible; furthermore Ministers must ensure that all formal consultation is conducted in a fair and unbiased manner.
4 Likely impact of PCT restructuring

77. Although many of our witnesses were clear that financial savings were the overriding factor in these reforms, the Government has stated that the reforms’ main purpose is to improve commissioning. However, it is far from clear that either of these objectives will in fact be achieved by these reforms. This section of the report considers in detail the likely impact of the proposed PCT restructuring, first discussing its immediate effect on PCTs’ day to day functions, and then examining its longer term effects on commissioning and public health functions, as well as financial impacts.

Immediate effects

Impact on PCTs’ day to day functions and on clinical services

78. Written evidence from the King’s Fund provides a helpful summary of the background of other large scale change against which these reforms have been announced, and points out the significant risks to organisational performance, and also, crucially, to patient care:

The changes heralded in *Commissioning a Patient-led NHS* represent a major structural reorganisation of the NHS over a very short period of time at a time when the health service is struggling to get to grips with all the other major reforms it has been tasked with introducing … We are already seeing the huge financial strain that new reforms, such as the implementation of Agenda for Change, patient choice and Payment by Results, are placing on the service. The demands of the service set out in *Commissioning a Patient-Led NHS* will unfortunately divert the attention of managers and health professionals from this demanding agenda, as well as from improving services to patients. There is a danger that patient care will suffer as a result.56

79. Evidence from numerous officials working in the NHS, in both PCTs and SHAs, strongly supported the view that these reforms will present a significant distraction from the crucial work currently going on to maintain and improve patient services. According to Karen Rhodes, in her PCT the impact is already being felt, with “major project structures” being set up to manage it. In terms of impact on her own personal workload, she told us:

It has taken an enormous amount of my time and my staff’s time to work with the staff that are affected by this, particularly in provider services. In a lot of meetings that you go to, whether this is on the agenda or not, part of the meeting is always taken up with a discussion about this.57

Dr Tony Stanton, Joint Chief Executive of Londonwide Local Medical Committees, argued that the hugely disruptive impact of these announcements was even less defensible in areas

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56 Appendix 28
57 Q 144
such as London where, after three months of uncertainty and disruption, it is now likely
that there will be no change after all.\textsuperscript{58}

80. It seems that the impact will be felt across all areas of PCTs’ work. Colchester PCT
argued that in their area, a successful drive to move services away from traditional hospitals
was likely to lose focus, and that benefits for patients will be lost or put in jeopardy.\textsuperscript{59} Karen
Rhodes was amongst many to mention “planning blight”, fearing that no decisions for the
future would be taken between now and next March, when the new PCT will be formed.\textsuperscript{60}
Clearly SHAs are fearing the impact of these reforms on day to day functions as well. We
were told that Bedfordshire and Hertfordshire SHA have decided to manage all
commissioning centrally at an SHA level for the next year.\textsuperscript{61} Philip Barrett argued that the
financial positions of PCTs will also be detrimentally affected by the reorganizations:

The distraction this exercise will generate, together with the demoralising impact on
staff, will certainly make it more difficult to address the financial positions of the
PCTs over the next twelve months. Trust Boards with a limited life expectancy may
not be over interested in making the necessary service reconfigurations for long term
benefits but with short term pain.\textsuperscript{62}

81. Mr Barrett helpfully quantified the likely scale of this distraction, suggesting that it was
likely to take at least 18 months to restore the effectiveness of systems back to their current
level, an estimate which is well supported by research evidence. We were most surprised
that Dame Gill Morgan, Chief Executive of the NHS Confederation, a body which
represents the interests of NHS managers, refuted this and suggested that ‘the NHS has
become very good at...actually not having the dip [in performance following merger].’ \textsuperscript{63}It
is not clear what her evidence was for this statement and it is contradicted by the BMJ
study of 13 NHS organisations.\textsuperscript{64}

82. According to our witnesses, continuing uncertainty about the divestment of provider
services and about the future of PCTs is already leading to loss of staff in both managerial
roles and clinical roles. Philip Barrett presented two stark examples of this:

I was talking last week with one of my matrons in a community hospital in Buxton.
She has lost four qualified nurses in the last few weeks to the local foundation trusts
and they have gone because of uncertainty about their future, fear about effectively
being privatised. Even though clearly we try and dispel the rumours as best we can,
the rumours are out there. Let me give another example. One commissioning
manager with 32 years NHS experience, aged 56, has decided to take early retirement
because he cannot face another NHS reorganisation.\textsuperscript{65}

\textsuperscript{58} Q 100
\textsuperscript{59} Appendix 4
\textsuperscript{60} Q 144
\textsuperscript{61} Q 11
\textsuperscript{62} Appendix 6
\textsuperscript{63} Q 68
\textsuperscript{64} Fulup et al., Process and impact of mergers of NHS trusts: multicentre case study and management cost analysis, BMJ; 2002; 325:246–253.
\textsuperscript{65} Q 170
83. As Karen Rhodes argued, this cannot help but have an impact on patient services:

I think there is a very serious risk in destabilising some essential community services. Where I come from, at the moment we have not seen a drift of staff, but they are so uncomfortable about their futures that it is only a matter of time. It will happen, I am sure.66

84. The organisations which are benefiting from the uncertainty facing the community sector could be Foundation Trusts and the acute sector more generally. This is an ironic development given that the main thrust of Government policy is now towards delivering more care at a community level, and strengthening community resources. It is concerning that as well as clinical staff, the uncertainty generated by these proposals is also having an effect on senior managerial staff. Mr Barrett’s example of an experienced manager leaving is very worrying at a time when commissioning experience is vitally needed.

85. The evidence is clear: the distraction caused by these reconfigurations will set back the development of PCTs’ core functions, which include commissioning services, providing community health services, and protecting public health, by at least 18 months. We consider that imposing a further structural change on organizations that are only three years old, at a time when pressure on those very organizations to perform well has never been higher, is ill-judged in the extreme.

86. There are also well-founded concerns that patient care will suffer as a direct result of the distraction caused by these reforms, and our evidence suggests that the destabilising effects are already being felt across the NHS, with clinical staff moving from community hospitals to the acute sector because of uncertainty over their future roles. It is highly ironic that while a key plank of Government health policy is now to move services away from the acute sector and strengthen community health care services, the uncertainty generated by these mismanaged policy announcements is having precisely the opposite effect, causing a drift of staff away from community health services back to the acute sector, which is now perceived as more stable. That some of these outcomes could, with more rational and coherent planning, have been predicted and avoided, makes the Government’s actions in this area even more indefensible.

**Longer term effects**

**Impact on commissioning**

87. According to the Government, the main benefit of PCT reconfiguration is that it will strengthen the NHS’s ability to commission services. As explained previously, commissioning organisations have existed in the NHS in various guises for the past fifteen years. Although little research evidence exists to verify this, their poor performance has often been blamed for the failure of the commissioning process to yield significant improvements in provider services. Commissioning organisations have also been subject to more frequent reorganisations than provider organisations. The need for stronger commissioning is now greater than it has ever been. This is because reforms in the acute hospital sector, in particular the introduction of Payment by Results, mean that the hospital

66 ibid.
sector now has increased in power relative to primary care and is likely, in the words of the Department of Health to ‘suck resources towards it, unless it is counter-balanced by an equally strong commissioning function’. These concerns are borne out by research evidence.

88. While the need to strengthen commissioning is in little doubt, our evidence argued that it would have been more effective to introduce reforms to strengthen commissioning before, or at least at the same time as Payment by Results and other provider-side reforms. The Government has described the reconfiguration of PCTs and the strengthening of commissioning as the ‘next phase of the reform’ after working to improve hospital services. However, given that powerful new financial incentives such as Payment by Results and new freedoms for hospitals through foundation status are already being implemented, turning the focus to commissioning now may prove too late, as demand for and cost of hospital services could begin to rise before PCT and practice based commissioners have developed the skills and capacity to counter this, leaving commissioners forever struggling to catch up with the more well established power of the provider sector.

89. When we put this to Lord Warner, he argued that the Government’s priority had been to respond to the public’s concerns about the NHS which were largely to do with improving capacity in the acute sector. While we do not question the need to respond to these concerns as a priority, it is not clear why commissioning reforms could not have been developed in tandem with provider-side reforms. John Bacon of the Department of Health gave, in our view, a more considered and refreshingly honest answer to this question:

My personal view is that we have taken insufficient action since 1990 to strengthen the commissioning side, and you can debate why that is but what we are now saying is that the way in which we want the system to work absolutely demands that the commissioning function is as equally strong as the provider function. You could criticise us over many years for being tardy in that, what we are now doing is addressing it in a meaningful way … You can argue that we should have got all this in place first, and in an ideal world we would have, but we are trying to be very careful to ensure that we incentivise the right things and we have the right control mechanisms as we move the system into other areas.

90. We strongly support the Government’s desire to improve commissioning in the NHS, but believe that this should have been addressed before, or at least at the same time as powerful incentives were being introduced which strengthened the provider sector. The fact that it was not has given rise to an uneven balance of power in the NHS that may now prove difficult to redress. We are pleased that the Department of Health has acknowledged this, and we hope that in future it will make efforts to ensure that the wider impacts of its policies are considered at a system level to avoid such a situation arising again.

67 Appendix 1
68 Appendix 28
69 Appendix 1
70 Q 279
71 Q 280
91. It is clear that reforms to strengthen commissioning are both necessary and overdue. The key question, then, is whether the Government’s proposed structural reforms are the best way of strengthening commissioning. We were concerned to note that, according to the King’s Fund, these structural reforms will in fact “do very little to strengthen commissioning, which is their ultimate goal”.\textsuperscript{72} To examine the potential impact of these reforms on commissioning in greater detail, this section considers benefits and risks of larger PCT structures, before considering whether any of the hoped for benefits could be achieved without large scale organisational change.

**Increased size of PCTs**

92. The Government argues that merging PCTs into larger organisations, many very similar in size to the Health Authorities they replaced only three years ago, will enable them to strengthen their bargaining power and counterbalance the acute sector more effectively.\textsuperscript{73} Larger budgets may put organisations in a stronger position to negotiate contracts. However, an analysis of recent research evidence suggests that increases in PCT size beyond populations of 100,000 patients will not automatically generate substantial improvements in overall performance or economies of scale, and that one size will not suit all—bigger may be better for some functions, but worse for others. Optimal population size for commissioning, according to the authors, varies widely depending on the services being commissioned.\textsuperscript{74}

93. Supplementary information from the Department of Health cited eight separate pieces of research on commissioning, but stated that there was no clear consensus amongst them about ideal population size for commissioning. The Department’s decision to move to larger commissioning structures seems to be based on a single study commissioned by them from PA consulting, which suggested that after the implementation of Practice Based Commissioning, commissioning could function effectively at population levels of 1 million people or more.\textsuperscript{75}

94. It should also be remembered that new PCTs will be same size as old Health Authorities that were themselves larger organisations focussing solely on commissioning. However, despite their larger size Health Authorities were not able to demonstrate highly effective commissioning, suggesting that ‘weak’ commissioning may not be a structural issue at all, and that in fact other types of intervention might achieve greater improvements in commissioning than simply increasing organisations’ size.

95. With the introduction of Payment by Results, it is clear that commissioners now need tools and incentives to help them keep care local and balance the incentives of the acute sector to draw resources towards them. However, while the need for good commissioning, and alternatives to the acute sector is not in question, arguably Payment by Results in fact reduces the need for commissioning organisations to be as large as possible. Traditionally, ‘commissioning clout’ through increased organisational size was seen as helpful because,
before the introduction of Payment by Results, acute hospitals would only reduce minimal marginal costs if activity was moved away from them, on the grounds that commissioners were not dealing in sufficient activity to allow the hospital to restructure its care. However, the introduction of Payment by Results allows PCTs, as commissioners, a new flexibility to withdraw money at will, and at full cost, from hospital providers, reducing the need for large commissioning arrangements. According to John McIvor, Payment by Results is already enabling his PCT to wield more commissioning power:

I think a lot of the context in the NHS has changed over the last year or so, particularly this thing called Payment by Results, which has meant that, from my PCT’s point of view, we feel we have a much greater ability to commission services in the right place and see the money move, if that is appropriate, from the acute sector into the primary care sector.  

While larger PCTs may be able to wield greater bargaining power over the acute sector, research evidence demonstrates that increases in PCT size beyond populations of 100,000 patients do not necessarily generate substantial improvements in overall performance, and that optimal size for commissioning varies widely according to services being commissioned. Health Authorities were large commissioning organisations, and their size does not seem to have made them effective commissioners. Arguably, the introduction of Payment by Results may already be giving PCTs the levers they need to commission effectively from the acute sector, without the need for restructuring.

Retrenching commissioning expertise

Another argument for increasing the size of PCTs was put to us by Dame Gill Morgan who claimed that it would enable the NHS to “retrench” its commissioning expertise by concentrating it in larger centres. In Dame Gill’s view, the move from 100 Health Authorities to 300 PCTs meant that management expertise was currently “spread very thinly”.

To move back to a smaller number of PCTs may seem a logical move, as locating commissioners together in larger organisations may increase the opportunity for sharing experience. However, restructuring may not be the only way in which this consolidation of expertise could be achieved. The Modernisation Agency has had considerable success in developing acute management skills in the last few years, with a programme of visits and workshops designed to spread best practice. A similar change agency approach to building commissioning skills might be an alternative way to improve performance without large scale organisational change.

Equally, it is important to bear in mind that concentrating commissioning skills in fewer, larger organisations is not the same as actually increasing commissioning capacity, in terms of the number of managers involved in commissioning, their ability, and the resource devoted to this. The NHS clearly needs experienced and talented managers to manage its commissioning function, which is currently responsible for spending £76

76 Q 17
77 Qq 42, 43
billion of public money. However, a considerable body of evidence, including two reviews by the Audit Commission, suggests that the NHS has currently far fewer managers than other health systems or comparable sectors, and that it is in fact undermanaged: Caro Millington, Chair of North West London SHA, was one of several witnesses to express this view, voicing concern about the risks of cutting management numbers at this time of major change:

I think you are right and that it is a risk. What you are capturing here is a snapshot of major change in the NHS. It is a huge change and it is a huge organisation, as you know. To cut the number of managers in particular—and managers do need administration as well—at a time of major change is a risky thing to do … It is something to be aware of. It always distresses me, coming from outside the NHS, that the NHS is under-managed rather than over-managed.78

100. The Government hopes that as a result of these reforms, £250 million less will be spent on PCTs, which currently provide the NHS commissioning function. However, given the importance of commissioning, and the fact that even under existing funding PCTs have experienced difficulties in recruiting appropriate staff, it is possible to argue that the NHS should in fact be spending more rather than less on its commissioning function.

101. We recognise the need to improve commissioning skills within PCTs. However, we remain unconvinced that instigating large-scale structural reform in order to ‘retrench’ commissioning expertise in larger centres is the only, or indeed the best, way to achieve this. Equally, it seems illogical that, at precisely the time the Government has committed to improving NHS commissioning, it is currently planning to spend £250 million less per year on this crucial function, further depleting management expertise from an already under-managed health system. This is more likely to weaken rather than strengthen NHS commissioning.

Improving co-terminosity

102. According to the Government, another reason for these reforms is to align PCT boundaries to social care boundaries. Many of our witnesses were in favour of improving co-terminosity:

One of the great strengths and successes of PCTs over the last few years has been the development of a whole set of new community services, intermediate care services, with social services. We think the opportunity to get the boundaries more closely aligned is an important opportunity we should be taking.79

103. However, Dr Reader, Medical Director of Islington PCT, argued that although this might bring benefits, it was not a “panacea”,80 and Basildon PCT pointed out that this may not be as straightforward as it appears:

78 Q 44
79 Q 6
80 Q 97
Achieving co-terminosity with social services authorities in a large shire County like Essex sacrifices District Council or Borough co-terminosity where most of the partnership work actually happens, and where true public sector integration around community strategy/LSP priorities is possible. In addition the factor of two smaller unitary councils in the south of Essex needs to be considered.\(^\text{81}\)

104. Although re-aligning PCTs with social services departments may remove some organisational boundaries, it is likely to create others. Links forged with providers of services at a district council level, such as housing, may founder if there is a return to larger, county-based structures, and several unitary councils, including Luton, Milton Keynes and Reading, have argued that moving back to large county-based structures would be a retrograde step, undoing much good work that has been done locally to address health inequalities.\(^\text{82}\)

105. **In principle, we support the aim of improving joint working between the NHS and local authorities, both in respect of social services, and other crucial local functions including housing, regeneration and education services. However, we are concerned that these reforms, while offering an opportunity to better align some boundaries, may risk setting up new barriers in other areas, and may threaten existing joint working arrangements.**

**Loss of local focus, clinical engagement and patient involvement**

106. The Government argues that reconfiguring PCTs will bring benefits through creating larger organisations which will be better at commissioning, which will be cheaper, and which will bring the benefit of co-terminosity of local authorities. We remain unconvinced that increasing the size of PCTs will necessarily strengthen their commissioning function. Clearly reducing the number of PCTs has the potential for cost savings, which we discuss in greater detail later in the chapter. Our evidence suggests that co-terminosity may bring benefits, but there will be new risks to be managed. However, setting aside these potential although uncertain benefits, there are a number of significant risks that will also arise from the dismantling of local PCTs, in particular the loss of local focus.

107. In support of the Government’s proposals, we were told by John de Braux, Chief Executive of Bedfordshire and Hertfordshire SHA, that it was perfectly possible for a larger central organisation to receive intelligence from its periphery.\(^\text{83}\) This was arguably how old Health Authorities operated before 2002, with local Primary Care Groups reporting to a central board. However, the Primary Care Trusts which evolved from PCGs and eventually replaced Health Authorities were introduced precisely because it was hoped that this would strengthen the local focus of the NHS, and introduce improved clinician and patient engagement into the planning and commissioning of healthcare.

108. Therefore, merging PCTs back into larger organisations, similar in size to those they replaced, could risk undoing much of the local focus that PCTs have achieved. According to Nigel Edwards, the Director of Policy at the NHS Confederation, “if we end up with

\(^{81}\) Appendix 3

\(^{82}\) Health Service Journal, 20 October 2005

\(^{83}\) Q 36
county-wide Health Authorities they will really struggle to get clinical engagement—
exactly the problem that killed them off in the first place.” Mr Barrett told us that in his
view, the proposed programme of reform “has significant dangers in terms of losing the
benefit of local focus”, an argument echoed by Mr Hollins:

The big strength of the PCT has been the locality and focus, really getting down to
the health needs of the local population. For the first time we have been able to get
genuine clinical engagement right at the coal face. If we lose that then we have
potentially lost the benefit of the PCTs for the last four years.

109. Robert Sloane, of the NHS Alliance, added that the process through which PCG
boundaries were developed, from which PCTs grew, was in fact a unique process designed
to established ‘natural’ health communities, and that this risked being lost:

Reference was made to the establishment of primary care groups in 1999. That was a
process that was quite unique in the history of the NHS because it required the
organisation to identify what were then termed natural communities, and natural
communities were known to the people who lived there, whether that was in Bristol,
Birmingham or anywhere else beginning with B. It was actually a process of
identifying where people lived, where people worked, where people related and
where people felt they belonged. We managed to carry some of that sense of
localness through into the evolution that constituted primary care trusts.

110. There is currently local involvement in PCTs at three levels—the Board, which has a
majority of Non-Executive Directors (NEDs) drawn from the local community; the
Professional Executive Committee (PEC), a powerful committee made up of key local
clinicians; and the PPIF, which is supposed to represent the views of patients and the local
population. Under current proposals, local involvement at each of these levels risks being
reduced.

111. According to the Government, putting patients’ views and wishes first is at the heart
of all current NHS reforms. However, the proposed restructuring of PCTs looks set to
weaken patient involvement in the NHS. Currently, all 302 PCTs have a PPIF. Although all
acute hospital trusts also have one, the PCT PPIFs provide the only forum for patients to
express views on primary and community care as well as secondary care. Under current
proposals, PPIFs are likely to be absorbed into one large PPIF, potentially serving a
population of over a million people.

112. Our witnesses were unanimous in their view that NEDs added considerable value to
the NHS. Larger, merged PCTs will result in fewer Non-Executive Directors to take
accountability for the commissioning of healthcare for their local populations. When it was
suggested that by reducing the number of NEDs in the NHS this might leave a ‘democratic
deficit’, the Minister argued that this would not be the case, as NEDs would still have to be
in a majority on every board, thus retaining their influence. Some of our witnesses argued that although there will be fewer NEDs in the NHS, they will perhaps be “of better quality.”

113. However, besides their corporate governance role, a key element of the NEDs’ role is to bring local opinion and flavour to decision making—hence all NEDs of local organisations must live within that local area. All of our evidence acknowledged the risk that the linkages with local communities that PCT NEDs have helped foster could be destroyed. Colchester PCT described the potential impacts of this:

There is also a concern that with a geographically remote and very large PCT the Non Executive Directors (NEDs) will be remote—this was the case with the former North South HAs. We have since the inception of the PCT had the benefit of NEDs who are local and County Councillors and NEDs who “live on the patch” and know the issues through living and breathing them locally. This will be a significant loss in a remote PCT model, with a locality structure without NEDs who hold the PCT to account but also have useful other roles or experience.

114. Strong clinical engagement in health service planning is also seen as essential to all PCTs’ functions, and our evidence suggested that this was an area in which many PCTs had achieved significant improvements on previous structures, as Mr Barrett described:

We have the PEC in place which includes GP representatives, representatives from allied health professions and other clinical groups and that is one of the key ways. We also have at the PCT level a whole number of subgroups, things like prescribing subgroups, primary care subgroups, which GPs particularly attend. In our PCT over half our GPs take some part in either the PEC or some of the subgroups and that is the sort of clinical engagement that is so vital.

115. An enduring concern in debate about these reconfigurations is how to prevent a return to previous large structures which were too remote to have good clinical engagement:

I am also concerned that we do not lose any of the clinical engagement that we have got set up within the structures that are currently around because I think it would be very sad if we did. I think there is the potential with Practice Based Commissioning for us to develop that further with GPs, but I think there is a risk that the other healthcare professionals, if they are moved out to other providers, might get lost in that process.

116. As the current more locally focussed PCTs merge to form larger organisations, individual Professional Executive Committees (PECs) within those PCTs may be replaced by one overarching PEC, leading to less, rather than more, formal clinical engagement in
PCT structures. The NHS Alliance argued that if these big PCTs come into existence, a number of locality-based, PEC-like structures will be needed in each PCT, linking up into the PEC as well as down into more local Practice Based Commissioning structures.94

117. PCTs were established to ensure that decisions about the NHS were made locally. By reverting back to the more remote structures that were abolished only three years ago, this localism will be lost. At the moment, each of the 302 PCTs in England has several Non-Executive Directors; a Patient and Public Involvement Forum; and a Professional Executive Committee of key local clinicians. While these structures clearly have a cost, they were introduced to add value. It is not clear why the Government is now unwilling to meet the cost of securing an enhanced level of local input into the NHS, only four years after this was identified as a key aim of Government health policy in *Shifting the Balance of Power*. Whatever the size of future PCTs, it is essential that structures to ensure clinical engagement and, most crucially, patient and public engagement are retained at their current levels, covering each natural community.

**Practice Based Commissioning—a means of overcoming the risks?**

118. Practice Based Commissioning is a key policy underpinning proposals to restructure PCTs. It is possible that the introduction of Practice Based Commissioning will make PCTs, as currently configured, redundant as commissioners. Although under Practice Based Commissioning PCTs will retain a key management role, it is hoped that the majority of commissioning will be carried out at a local, practice level, meaning that if PCTs were left in their current configuration, in some places there would be an unnecessarily high number of people commissioning services within a small area. Equally, it is hoped that in devolving commissioning decisions down to an even more local level, clinical and patient engagement will be enhanced.

119. While it may well have the potential to enhance clinical engagement, we strongly dispute the Minister’s view that Practice Based Commissioning will improve patient and public engagement, unless there is a specific requirement on practice based commissioners to establish local patient and public involvement forums.

120. Also, according to our evidence, there are number of important issues that need to be urgently resolved if Practice Based Commissioning is to be successfully implemented. The King’s Fund argued that:

> The need to engage practices and GPs is critical and urgent if there is to be effective demand management rather than cosmetic responsibility for managing a budget. But again our work in this area has shown that much stronger incentives are required if this to be a reality—perhaps even going so far as linking GP income with effective management of a commissioning budget. In particular, practices that operate in areas that are already financially challenged will face few incentives to take a budget. At present few practices across the country are actively engaged.95

94 Appendix 36
95 Appendix 28
121. Dr Tony Stanton complained about a “woeful lack of information from the Department of Health” about Practice Based commissioning. According to Dr Stanton, technical guidance about Practice Based Commissioning was promised earlier this year, but “when it eventually came was not worth the paper it was written on”. A new edition was expected in October, but has still not been published. He detailed some of the major unanswered questions:

If we take Bexley ... the PCT is in deficit, the hospital is in deficit. If groups of practices take overall responsibility for the commissioning budget, who is going to be responsible for that budget? There is the pump-priming money to help practices get involved, but where are the promises of adequate management costs, where are the promises about size of and purposes to which savings made can be put? They are totally absent.

In his view, the Government must:

- Provide clear guidance as to what they mean by Practice Based Commissioning
- Make the provision of adequate preparation funds compulsory
- Very clearly define a range of management costs
- Give clear guidance about the use to which savings can be put, and
- Deal with the problem of inherited deficits.

122. Dr Reader also raised the issue of commissioning skills for GPs, arguing that “the small localist is not going to be able to instantly be effectively a good commissioner at any level”, and that an intensive developmental process will need to go on to equip GPs with these skills. He anticipated that it would take two to three years to get Practice Based Commissioning up to an effective level and develop those people with those skills, a considerably longer timetable than the Government’s proposals which assume full implementation across all practices in a year’s time.

123. The Minister, when questioned, was not able to give us any indication of the number of practices currently involved in Practice Based Commissioning, which was surprising, given that in a little over a year he expects all GP practices in England to be actively involved. Supplementary information from the Department of Health revealed that according to a survey of 30 PCTs conducted in June 2005, only 20% of practices were actually participating in Practice Based Commissioning. The Department has also confirmed that Practice Based Commissioning remains a voluntary activity for practices, and suggested that additional financial incentives to encourage GPs to participate would form part of the Government’s current GMS contract negotiations. Given that major
questions about this policy remain unresolved, and that according to the NHS Alliance fewer than 50% of their practices will be involved in Practice Based Commissioning by the end of 2006, it seems highly unlikely that this ambitious target will be met.\(^{102}\)

124. Getting Practice Based Commissioning to work successfully is crucial to plans to have fewer PCTs: without Practice Based Commissioning, there will be limited clinician engagement and weaker, more distanced commissioning. However, many witnesses have argued that, ironically, the disruption of reforming PCTs at the current time is threatening the successful implementation of Practice Based Commissioning. Dr Reader told us:

> There is at least one example I know of where there has been a very large buy-in to Practice Based Commissioning prior to the *Commissioning a Patient-Led NHS* document came out and, subsequent to it, an awful lot of cold feet and back-pedalling from the local GPs because it is going to destroy their local clinical leadership that they know and trust and have actually been building up over three years; they just do not know who they are going to be working with.\(^{103}\)

125. In addition to the practical problems surrounding implementation, there are also concerns about the unintended consequences of this policy that the Government has not addressed. Under Practice Based Commissioning, GPs will have clear incentives to provide services ‘in house’, that they would otherwise have commissioned from elsewhere. They could bring health services ‘in house’ either by expanding the role of their GPs or nurses, or through employing outside specialists. The Government hopes that this will bring many advantages—GPs can design services to meet patients’ needs, patients can be treated closer to home, and, crucially, costs will be saved if GPs can treat patients more quickly and cheaply ‘in-house’.

126. However, GPs will also have incentives to direct patients to their own in-house services rather than to those offered by other providers. This is particularly the case if practices have invested new capital (e.g. in new operating facilities or diagnostic suites). This has the potential to compromise patient choice, as GPs are often closely involved in patients’ decision making about where to have treatment. Interestingly, separating the provider and commissioner functions is one of the key reasons given by Government for the divestment of provider services, which is discussed in more detail later in this report. If the need to separate these two functions to avoid perverse incentives applies to PCTs, it is difficult to see why it does not apply to GP practices.

127. When we raised the problem of choice with the Minister, he told us that “patients will certainly not have their choices limited in areas like elective surgery, they will make their own judgments with their GPs about where they go”.\(^{104}\) However, despite his confidence on this point, Lord Warner did not actually address the key issue. In fact, his evidence re-emphasises the conflict of the issues, which is that patients will make their choices *with their GPs*. At present, many patients rely heavily on their GP’s recommendation when making choices. Solutions to the potential conflicts of interest might include an increased role for PCTs in ensuring that GPs are offering their patients genuine choice. However,
while technical guidance published by the Department in February 2005 stated that GPs should ensure that “patients should be given a choice of other providers and not feel pressured to choose the practice as provider”, the Department does not seem to have taken any further steps to guarantee that patient choice will be preserved.105

128. Practice Based Commissioning may also give GP practices a perverse incentive to save money by selecting healthier patients onto their lists, a process known as ‘cream skimming’. As GPs determine their own practice lists, it is difficult to see how this can be practically prevented, particularly if reconfigured PCTs are having to work with large numbers of general practices.

129. As with any type of devolution to a local level, Practice Based Commissioning also has the potential to lead to inequities between patients living within the same PCT area. For example, one practice based commissioner might negotiate access to a better range of services for their patients than others. A potential solution to inequities might be to allow competition between different groups of practice based commissioners, allowing patients to move and register with a different group of commissioners if they were dissatisfied with their own. However, current developments of locality clusters of Practice Based Commissioning meant that in many localities there may be only one group of practice based commissioners for patients to choose from, and therefore this form of consumer protection will not apply. Equally, patients may want to move to a different commissioning group, but be reluctant to actually change their general practitioner. On this point, the Minister replied that ‘it is a possibility but it is probably no different from where we are now’.106

130. Practice Based Commissioning is a crucial policy which underpins the Government’s proposals for restructuring PCTs, which the Government hopes will both strengthen commissioning and secure greater local engagement. However GPs, who will be responsible for implementing Practice Based Commissioning, have described a ‘woeful lack of information’ about the scheme, with key questions still unanswered. We therefore consider it highly unlikely that this system will be functioning effectively in all areas by the end of next year, and are concerned at the Government’s complacency and unwarranted optimism over the implementation of Practice Based Commissioning. We urge the Government to address this lack of information immediately.

131. The Minister’s view that Practice Based Commissioning as it is currently conceived will improve patient and public involvement in health care is not firmly based on any evidence. In fact, there is a significant gap in this area. We recommend that the Government places a specific requirement on all practice based commissioners to establish regular, formal arrangements for securing the input of their patients and local populations in the commissioning and provision of local services, just as PCTs and other NHS trusts are obliged to.

132. We are also concerned at the complacent attitude that the Government is displaying towards the very real possibility of Practice Based Commissioning.

106 Q 285
introducing perverse incentives that could threaten patient choice and access to health care. It seems to us that these problems have not yet been fully anticipated or considered by the Government, which is worrying given that they hope Practice Based Commissioning will be universally implemented within a year. These potential problems need to be addressed before they arise, and to this end we recommend that the Government publish details of what actions it intends to take to counter these risks before Practice Based Commissioning is universally implemented next December.

Other ways to improve commissioning

133. As discussed previously, organisational restructurings are hugely disruptive and distract organisations from their core functions. It is striking that, despite the considerable attention these proposals have attracted in Parliament and elsewhere, debate has focused almost exclusively on the shape of future organisations, the morale of staff, and the consultation process. While these are important issues, they arguably distract the focus of managers and policy-makers from the critical issue of how commissioning can actually be improved in the NHS.

134. As we have already mentioned, measures to improve commissioning are long overdue. The King’s Fund provided a helpful analysis of the specific areas in which improvements to commissioning are needed, but was amongst many to seriously question whether large-scale structural reform of PCTs was likely to achieve these improvements. Rather it stressed the need for better skills and information systems:

PCTs need to develop skills in [commissioning] (for example, in analysing likely demand for care and how unnecessary hospital admissions could be prevented). They also need to sort out currently poor information systems. PCTs have always needed to do this, but they have been very slow in developing these skills. The answer in our view is not structural reform, but more that there need to be far stronger incentives designed to prompt commissioners to develop the skills they need, in particular to manage patient demand effectively.\(^{107}\)

Is restructuring the best solution to improve commissioning?

135. David Nicholson, Chief Executive of Birmingham and the Black Country SHA, argued very eloquently that the “holy grail” of the perfect sized commissioning organisation does not exist:

I have been in the NHS now for nearly 30 years and this is my eighth or ninth major structural change.

We have got to judge what sort of arrangements we have against those sorts of criteria to make sure that whatever we do set up is fit for purpose. I think Liz [Railton] is absolutely right, whichever geography you go for there are a variety of levels of function we need to operate at and it is a matter of judgment as to where you set the statutory board.

\(^{107}\) Appendix 28
What I know is that the pursuit of the Holy Grail or the perfect geographical organisation for health services does not exist. Whatever you do is some kind of compromise in relation to what the local circumstances are.108

136. As we have seen, restructuring is always a highly distracting and time-consuming process and, given the challenges currently facing PCTs, it would be difficult to find a less opportune time at which to place this additional burden on them. And although increased critical mass may be helpful for some PCT functions and improved partnership arrangements with local authorities would bring benefits, it is also clear that moving back to more remote commissioning structures will reduce local engagement, undoing the very benefits PCTs were intended to bring, and potentially threatening the implementation of Practice Based Commissioning. In the light of this, and recognising the fact that no perfect geographical organisation for health services exists, we would suggest that wholesale restructuring should only be considered as an option of last resort, particularly if there are other ways of achieving the perceived benefits of larger organisations.

137. In fact, much of our evidence from managers and clinicians working in the NHS suggests that many of the anticipated advantages of this reorganisation could be achieved simply by better joined-up working between PCTs and between PCTs and local authorities. Some witnesses felt that mergers might be appropriate at some point in the future, and others did not. However, there was agreement that a centrally imposed reorganisation to a tight timescale driven by financial considerations would not yield the best results for their local populations. Basildon PCT was amongst many to articulate this view:

> Although we have no argument with the overall policy direction we do not believe this required the wholesale reconfiguration of PCTs. In our case, which is not uncommon in the NHS, we have already set up strong partnerships with neighbouring PCTs for commissioning, modernisation of services, risk sharing, and the implementation of PbC and capability is being strengthened daily.

> As a group the PCTs in this area have almost two years experience of being a commissioner of a first wave Foundation Trust (Basildon and Thurrock University Hospitals NHS Foundation Trust) within the enhanced Payment by Results (PbR) financial regimen.

> We believe we would have achieved fitness for purpose ourselves over a relatively short period of time, bringing local stakeholders with us, rather than being ‘victim’ of what is now perceived as a top down process.109

138. Philip Barrett told us that prior to 28 July 2005, “the process of consolidation of PCTs was happening at a fairly sensible pace and PCTs from the ‘bottom up’ were coming together and deciding that they could do things better in partnership and we were seeing, where it was appropriate, that joint working was being developed often through common management teams”.110 Karen Rhodes of North Lincolnshire PCT echoed this, asking “why
is the Government making these changes when PCTs’ efforts to improve services are only just taking effect? Indeed, according to the NHS Confederation, there is not a single PCT that is not already working with another in some sort of collaborative arrangement.

139. Far from portraying failing organisations in urgent need of wholesale reform, our witnesses described PCTs delivering genuine improvements, particularly in the last year, in terms of clinician engagement, increased bargaining power with the acute sector, and the development of innovative community services to rival secondary care. According to John McIvor, Chief Executive of Rotherham PCT:

I know the GPs, nurses and allied health professionals who are part of my PCT have seen real investment in out-of-hospital services … I know that the majority of PCTs feel that there is much better clinical engagement than there ever has been.

140. Dianne Jeffreys gave a similarly optimistic view:

What has happened since the development of the primary care-led NHS has been a coming together of community and primary care and, most of all, clinical engagement in both the commissioning and the management of the NHS by GPs. What we have seen, in terms of trying to prevent, if you like, over-activity in the acute sector has been a range of initiatives, really innovative initiatives, in both primary and community care to prevent people needing non-elective or emergency or urgent admission in the first place.

141. Dame Gill Morgan of the NHS Confederation told us that according to research in industry, it takes at least three years after reorganisations for their benefits to become visible. As the majority of PCTs were introduced a little over three years ago, in April 2002, this may explain why their benefits are now becoming apparent.

142. When we put these arguments to Lord Warner, he replied that the had been “a certain patchiness” in terms of the quality of PCTs, suggesting that the improved joint working we received evidence of was perhaps not happening across the country. However, in a health system with responsibility devolved to a very local level, a degree of variability in approach as well as in performance is to be expected. It is perhaps worth noting that the performance of Foundation Trusts could also be described as “patchy”, given that half of the first wave of 31 Foundation Trusts are in deficit, and four have significant deficits.

143. Evidence from those working in the NHS suggests that PCTs are collaborating with one and other and, as a result, bringing about improvements without the need for large-scale reorganization. In our view, Lord Warner’s suggestion that improvements in PCTs have been “patchy” does not constitute a valid argument for imposing radical
structural reform across the board, dismantling organisations that are performing well as well as those that are performing badly. A more rational, constructive approach would be to support the evolutionary changes that are already taking place.

**Conclusion**

144. As a senior NHS chief executive told us, there is no such thing as a ‘holy grail’ of a perfect size for a commissioning organisation. There is a clear trade-off between the increased bargaining power and better co-terminosity of larger organisations, and the enhanced local engagement of smaller PCTs. Practice Based Commissioning may achieve local clinical engagement, but will leave serious gaps in terms of patient involvement. In order to improve commissioning, PCTs need better skills and information systems. Restructuring is not necessary to achieve this.

145. Given our evidence that the majority of PCTs are already involved in successful collaborative working, we believe that the most effective way to improve commissioning is to allow PCTs to develop organically, enabling them to evolve into larger organizations where this clearly best meets local needs. A managed approach to sharing best practice should be adopted to ensure that the poorest performers learn from the expertise of the best performers, and support should be specifically targeted towards developing commissioning in the poorest performing PCTs.

**Impact on public health**

146. The potential impact of proposed reconfigurations on PCTs’ public health role has not featured strongly in debate on this subject, but is a vital consideration. We were very concerned to learn from the Faculty of Public Health Medicine (FPHM) that prior to the publication of *Commissioning a Patient-Led NHS* on 28 July 2005 there had been no consultation with senior public health experts about the likely impact of these announcements on PCTs’ public health role. 117

147. In fact, the FPHM’s evidence suggested that there may be advantages to introducing larger PCTs aligned with local authority boundaries. The organisation argues that “this could really strengthen joint working and might even lead to shared public health teams with Local Authorities”. 118 Moreover if PCT public health departments get bigger, there would be an opportunity to “restore critical mass” to PCTs’ public health functions, and might improve support for newly accredited public health consultants, as larger departments could enable them to be mentored by more senior figures, rather than having to work alone. 119

148. However, alongside these advantages, reorganisation poses several potential risks to PCTs’ public health functions. The FPHM told us that in their view the achievement of the public health aims set out by the Government in its public health white paper, *Choosing Health*, was “a potential vulnerability through this change”. 120 Although they were

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117 Qq 214–215
118 www.fphm.org.uk
119 ibid.
120 Q 207
Changes to Primary Care Trusts

reassured by the Department of Health’s statement that public health departments would be excluded from the £250 million cost saving, they felt more needed to be done to preserve the funding which has been allocated for Choosing Health. They told us that although in certain ‘spearhead’ PCTs in particularly deprived areas of the country funds have been allocated for public health, in the context of other financial pressures, including managing deficits and achieving management savings, that money could be siphoned away from public health. The FPHM pointed out that where public health initiatives take years or even decades to bring about measurable improvements, they are a very easy opportunity for cost savings if other targets have to be met within a single financial year and financial balance has to be produced within a single financial year.121

149. Concerns have also been raised that larger PCTs may lose local focus and become too remote from local communities for public health teams to engage successfully with them and deliver public health initiatives closely matched to local needs. Equally, reorganisation may destroy partnerships established with other local organisations, and may undo good work already initiated, as Basildon PCT suggested:

It is unclear what has happened to the ‘Choosing Health’ White Paper and delivery plan in this debate about the size and shape of PCTs. There is a risk that unless mechanisms to implement this vital part of policy are explicit, the very thing that can have the most impact on health, especially in a deprived community like Basildon Town, is lost in an organisation that is too large to relate to local communities and too involved in strategic commissioning to really put in the investment that is needed to promote healthy living.122

150. Dr Reader supported the arguments for continued localism in PCTs from a public health point of view:

Within very close proximities to each other you can have huge differences in health needs of the population. The bigger those get the more difficult it is to focus on those. What PCTs have increasingly been getting into over the last year or so is ways of focusing down on their communities and because of the close links that they have with the practice and the other services around that they are able to set up schemes which will address those health needs in a small localised way. I would be quite concerned that the enlarging would actually lose that focus and you would go back to the more sweeping, larger public health-type approach that we had in the health authorities.123

151. The FPHM also suggested that if, through these reconfigurations, PCTs end up solely as brokers of health services, the public health function, which includes health improvement, health protection and health services, could end up being fragmented. A FPHM discussion paper went on to ask:

How will PCTs succeed in improving health and reducing inequalities when they are simply managing the commissioning process for GPs? This reconfiguration could be

121 www.fphm.org.uk
122 Appendix 3
123 Q 133
a major risk to the whole delivery agenda, such as health improvement and reducing inequalities and health protection services.124

152. Fewer PCTs will inevitably mean fewer Directors of Public Health. While this may offer an opportunity to consolidate the public health workforce currently dispersed amongst 302 PCTs, it obviously raises important issues concerning staffing. In their discussion paper, the Faculty of Public Health Medicine concluded that “this reconfiguration will probably affect retention, with specialists taking early retirement, rather than relocating or re-applying for positions. It may also result in de-motivation amongst those that stay.”125 Training programmes would also be affected by the reconfigurations and the loss of staff.

153. In oral evidence, the Faculty of Public Health Medicine argued that local strategic partnerships must continue to have senior public health leadership.126 This, they suggested, could be through two levels of director of public health support: one to PCTs which will be more focused on NHS commissioning; and the second to local strategic partnerships which will be more focused on public health delivery and working closely with local authorities.

154. However, even if appropriate public health leadership can be maintained, it takes more than directors of public health to actually deliver good public health services. Lynne Young of the RCN pointed out that community health professionals, including amongst others school nurses, health visitors and community midwives, currently have a major public health role.127 However following the Government’s announcements about the divestment of provider services, this role is in danger of being fragmented.

155. We were very concerned to learn that, prior to the publication of Commissioning a Patient-Led NHS, there was no consultation with public health professionals at all about its potential impact on PCTs’ crucial public health function. In our view, debate about Commissioning a Patient-Led NHS has also given insufficient prominence to this. In order to safeguard local public health initiatives, we recommend that where PCTs merge leaving only one Director of Public Health, other consultants in Public Health are retained with responsibility for public health delivery, working with local authorities and local strategic partnerships. Further to this, steps must be taken to provide continuing support to community health professionals who play an equally important part in securing public health improvements.

Financial impacts

156. The Government’s election manifesto set out a commitment to reduce NHS management costs by £250 million and, as previously discussed, the 15% savings specified by Commissioning a Patient-Led NHS have been a prime factor in dictating the new PCT structures that are now being proposed.
Are PCT cost-savings desirable?

157. In looking for ways to rein in NHS budgets, ‘management overheads’ are often an obvious first target, as they are not seen as directly affecting patient care, although they may have important indirect impacts. All management structures have a financial cost, which means that they should only be introduced and maintained if their benefits justify their cost. While some of our evidence questioned whether or not 302 PCTs were ever affordable in the first place, Philip Barrett helpfully made the point that these management costs together with their associated benefits must have been considered before they were established:

When PCTs were established it must have been recognised at that time that there would be some financial costs in exchange for the benefits of a local focus and therefore there possibly is an argument that there is some sort of premium that is worth paying for those benefits.\(^{128}\)

158. Our evidence suggests that PCTs have been able to secure local engagement more effectively than their predecessor organisations. According to the Government, retaining clinician and patient engagement in the NHS is more important than ever. It has also emphasised repeatedly that strengthening commissioning is now its key aim for the NHS, in order to improve services for patients and to control healthcare spending. It is therefore unclear on what basis the Government has now decided that local PCTs are no longer worth the level of investment of public funds that was seen to be justified only three years ago. It is similarly unclear why it has decided to disinvest £250 million from this very sector.

Are PCT cost-savings achievable?

159. Another key question is whether or not the reforms will achieve the level of savings the Government anticipates. Savings will undoubtedly be made by abolishing many SHAs and PCTs. Practice Based Commissioning may also, in time, yield savings by offering cheaper alternatives to hospital-based services. However, as previously discussed, the costs of mergers are high, and research evidence suggests that they do not usually deliver the savings hoped for.\(^{129}\) The economic benefits of merger are typically modest and these savings may be outweighed by a combination of unanticipated costs. These include the direct costs of merger, as well as the unintended negative consequences such as loss of morale and productivity resulting from disrupted relationships and communication patterns.

160. As a starting point, the NHS will have to bear costs of redundancy payouts arising from mergers of SHAs and PCTs, which could result in a net loss of as many as 200 NHS organisations, each with their own Chief Executive and executive management team. On 20 October 2005 the *Health Service Journal* reported that the Department will not have a central fund for redundancies, and that SHAs will be expected to finance redundancy costs’ where possible from in-year management cost savings’.\(^{130}\) This is in contrast to the changes

\(^{128}\) Q 159


\(^{130}\) *Health Service Journal*, 20 October 2005
of three years ago when a 'transition fund' was made available. More recent reports suggest that as many as 6,000 jobs may be lost from PCTs and SHAs, with a total cost of at least £320 million.\textsuperscript{131} This could conceivably result in a vicious cycle where more job cuts are continuously required to fund the redundancy costs of the first round of job cuts.

161. In addition to this, further investment will be required to establish and sustain Practice Based Commissioning, although the level of investment is not yet clear. This is a significant gap in information regarding costs savings. Supplementary information from the Department suggests that PCTs are currently planning to pay GPs between 50p–£2 for each patient on their list.\textsuperscript{132} We presume that this will be a recurring cost rather than a one-off start-up cost. Assuming that approximately 52 million people in England are registered with a GP, the total costs could therefore range from £26 million–£104 million per annum.\textsuperscript{133} Equally, if locality structures are established at a sub-PCT level to maintain local clinical and patient engagement, these will also have costs, as Karen Rhodes explained:

> I think we are going to have to set up locality structures to maintain the local focus and clinical engagement and that is not going to be done without funding. Some of the savings that we will make by reorganising PCTs, taking out a board, taking out a PEC, taking out directors, will have to be reinvested at locality level in order to get the engagement and the structures that we need so we do not lose our integrated services and our engagement with our GPs.\textsuperscript{134}

162. Basing his calculations on data extrapolated from his own PCT, Philip Barrett told us that, worryingly, he did not think that the proposed savings of £250 million could be achieved:

> I have some concerns in terms of whether the scale of savings that have been discussed can be achieved. In my own particular PCT, when I look at the costs of my own board and PEC and the two senior executives who are most at risk out of this process, which is the director of finance and the chief executive, we are probably looking at a total cost of £400,000. If you multiply that by 150 PCTs that might disappear out of this process, the most we are looking at could be £60 million. There is not yet published an HR policy for this process. In order to save that full £60 million there would have to be redundancies, which are costly and not built into those numbers.\textsuperscript{135}

163. Basildon PCT gave us a slightly higher figure of £900,000 worth of savings per PCT, but even that more generous estimate only produces a total saving of £135 million, well short of the intended £250 million.\textsuperscript{136} And, as Karen Rhodes pointed out, whether or not financial savings of that order are achievable may depend largely on the existing financial position of an organisation.\textsuperscript{137} She told us that, as her own PCT was in deficit, these savings

\textsuperscript{131} Health Service Journal, 24 November 2005
\textsuperscript{132} Appendix 1
\textsuperscript{133} Department of Health, \textit{General Personal and Medical Services Statistics}, www.dh.gov.uk
\textsuperscript{134} Q 147
\textsuperscript{135} ibid.
\textsuperscript{136} Q 154
\textsuperscript{137} Q 157
might not be possible. In London, where the existing number of PCTs is set to remain the same (31) or perhaps even increase to 32, savings of 15% are likely to be very difficult to realise, as they will have to be achieved without being able to save on Board, PEC and back-of-house costs.

164. The Government has downplayed the financial motivation for these reforms, concentrating instead on its aim of strengthening commissioning. However, our witnesses were clear that this was the key consideration in drawing up plans for reform, to the extent that plans which would better meet local needs were discounted because they did not yield sufficient savings. While achieving efficiency savings is a legitimate aim, this needs to be stated explicitly so that it can be subject to proper scrutiny.

165. In fact, the evidence to date suggests that this reconfiguration is unlikely to yield the savings the Government is hoping for. Figures put to us by PCT officials suggested that current proposals for reconfiguration might save between £60 and £135 million, well short of the target figure of £250 million. If proper clinical and patient involvement is to be retained, further local structures will need to be put in place at a sub-PCT level, which will generate additional costs. Equally, the costs of Practice Based Commissioning, which are at present unclear, will need to be taken into account. The NHS will also have to bear costs associated with redundancies, as well as the cost of reduced productivity over the next 18 months.

166. It is vital that NHS organisations deliver value for money. However, while the enhanced local perspective PCTs have brought to the NHS clearly has a cost, the benefits they have brought may well justify this cost. In addition to this, PCTs are currently responsible for spending 80% of the NHS’s £76 billion budget. At a time when PCTs’ commissioning role is crucial to the success of the NHS, it is a false economy to deplete the NHS’s managerial resources still further in an attempt to save only a fraction of that total amount.
5 Impact of divestment of provider services

167. *Commissioning a Patient-Led NHS* generated huge controversy when it proposed that PCTs should divest all their direct service provision by 2008. We have already discussed the considerable problems that confused and badly managed announcements about this have generated. The broader question of whether or not PCTs should divest their provider services is very complex and could easily be the subject of a separate inquiry. The issues it raises are so numerous that much of our evidence expressed surprise and concern that the Government chose to announce such a significant change to the delivery of NHS services as an ‘add-on’ to the administrative reorganisation of PCTs, rather than waiting to produce a more considered policy position in the forthcoming White Paper.

168. We have not had time to fully investigate the complex question of divestment of provider services within the confines of this short inquiry. However, inevitably our evidence raised many important concerns about the divestment of PCT provider services, and we feel that it is appropriate to commit these to the record here, in the hope that they can be revisited more fully as debate on these issues develops.

How will divestment affect commissioning?

169. The most widely cited potential benefit of removing provider functions from PCTs is that it will improve commissioning by turning PCTs into solely commissioning organisations. John de Braux argued that:

> If you spend 80 per cent of your time and concerns worrying about the provision of services, then you do not have the energies to put into commissioning, and what we know in primary care trusts is that most of the staff are involved in providing services, so there is a real desire to make sure that these new organisations focus on commissioning.138

170. There may be some logic to the argument for creating a firm divide between commissioning functions and providing functions. Senior management teams of commissioning-only organisations will not have the distraction of having to focus on operational delivery, and can concentrate on the strategic planning and commissioning of services. A second advantage is that PCTs will not face perverse incentives to commission their own services, where in fact externally provided services might offer better quality or value for money.

171. However, these advantages are not as clear cut as they seem. Firstly, while commissioning-only organisations may seem sensible in theory, there is little evidence that this separation of functions will, of itself, necessarily deliver improvements—after all, Health Authorities were also commissioning-only organisations, and did not manage to yield significant improvements in commissioning. It may be that, as previously discussed, other changes will be needed to support improvements in commissioning besides simply separating PCTs’ commissioning and providing functions.

138 Q 62
172. Equally, while separating commissioning and provision may reduce the potential for perverse incentives in commissioning, under plans to introduce Practice Based Commissioning across the country, groups of GP practices will soon both provide services and commission them, forming new organisations with exactly the same multi-functionality that the Government argues could hinder PCTs’ success as commissioners. If the Government genuinely believes that the key to successful commissioning is for organisations to focus solely on that, then it is difficult to see why this rule should not be applied equally to all organisations that commission care. The current position, where GP practices may both commission and provide care but PCTs may not, appears entirely incoherent.

173. Further to this, Dr Reader argued that divesting provider services at the same time as introducing Practice Based Commissioning was actually likely to weaken rather than strengthen commissioning, as whole sections of community staff who could contribute to Practice Based Commissioning were now being excluded from the process:

The original point of this paper was about strengthening commissioning. The devolvement of those provider organisations actually cuts that whole section of community staff out of that loop and out of Practice Based Commissioning possibilities. As Practice Based Commissioning came in other professional staff have been champing at the bit to get involved, but it has been more complex to see where that fits in and people have been trying to work on that. As soon as the divestment to providers came along lots of PCTs’ doors—including my own—suddenly closed on thinking about them because somebody else was going to be running them. There is a whole raft of skills and knowledge and involvement that can be used there in Practice Based Commissioning in different ways to evolve and change services that would be lost.139

Wider impact of market-type reforms in primary care

174. As well as the aim of strengthening commissioning, the Government’s proposals to divest PCTs’ provider services to alternative services providers are clearly also driven by the desire to introduce market-style incentives into the primary and community care sector, as has already happened in the secondary care sector. The Government hopes that by encouraging alternative providers into the community care market, including private and voluntary organisations, quality will be improved and costs will be reduced as a variety of different providers compete to win NHS contracts.

175. The likely impact of market-type reforms on the NHS is a huge and complex subject, and there are still a great many unknowns in this area. The tangible benefits of contestability are uncertain, and may be constrained by limits imposed on the healthcare market by Government. Equally, the benefits of contestability may not be realised if it is not possible to generate enough supply to ensure contestability—this may be particularly the case in remote or deprived areas. Moving to a market-type system also brings its own risks. Some of our evidence suggested that growth in plurality of providers will inevitably bring about an increase in transaction costs.140 Another risk is that of over-provision of

139 Q 124
140 Q 87
services, which is ultimately very expensive. There is also the risk of private companies going bankrupt, potentially leaving the NHS with no alternative provision, as has happened in the past with nursing homes, which, according to one of our witnesses, are sometimes closed down at very short notice.\footnote{141}

176. It is beyond the scope of this inquiry to conduct an exhaustive assessment of the complex subject of market reforms in healthcare. However, our evidence did raise several concerns relating specifically to the introduction of market-type reforms in community health care, which is in many respects very different from the acute sector. Yvonne Sawbridge explained the unique value of healthcare delivered in the community:

In the community we deal with people not disease ... we want the chaos and the richness that come from helping people live their lives. It does not fit neatly into “You’ve got diabetes” or “You’re having your hip replaced”. People have all sorts of things happen to them at the same time and that is a core value … [community staff] are very anxious about losing that and going into organisations that do not understand that difference, which is intangible.\footnote{142}

177. She went on to argue that fragmenting the joined up services that community health professionals currently strive to deliver is a real risk associated with introducing a plurality of providers:

\textit{Charlotte Atkins}: This is supposed to be patient focussed. Do you think it will fragment the so-called patient pathway?

\textit{Ms Sawbridge}: Yes. Seamless care is difficult enough to do at the moment and the more fragmentation the more people you are going to have knocking on the same door to deliver different aspects of care.\footnote{143}

178. Introducing non-NHS providers into the community sector also raises questions about workforce development and training. Yvonne Sawbridge asked “Who is going to train our future workforce? Who is going to plan across the health and social care when you have got plurality of provision? I just do not understand how that will happen. It is hard enough now.”\footnote{144}

179. Currently, there is little contestability in community health services. However, in attempting to increase contestability, a new range of alternative providers will need to be found to provide the services currently provided by PCTs. By their nature, community health services are often long-term and involve complex interaction between different health and social care agencies. In this respect, they are different from the types of health services that have so far been provided by organisations outside the NHS, which have tended to be mostly ‘stand-alone’ episodes of treatment or diagnosis, such as day case surgery or diagnostic services. It is thus uncertain whether or not alternative providers will see community health services as a worthwhile market to expand into. Other potential
providers could include hospital trusts or GP practices expanding to provide community health services. However, while this could improve clinical collaboration and minimise the fragmentation of services, it carries the risk of simply creating an even greater monopoly than currently exists. If PCT monopolies are broken up into smaller (geographically overlapping) new organisations that will compete with one another, this may increase contestability, but at the risk of oversupply.

180. A final, pressing concern is that the NHS will become “providers of last resort”, only providing services that are not profitable or attractive enough for other organisations. John de Braux seemed to suggest that this would be the case:

There will always be some services for which I believe PCTs will say there is no alternative provider, much as we have tried to find an alternative provider it will not be safe to do so, or nobody is interested in providing that bit of the market or whatever, and I think it will stay with PCTs.\[145\]

However, some of our witnesses objected very strongly to this idea: Dianne Jeffreys told us:

I think it would be very sad if PCTs ended up as providers of last resort; in other words, we only provided that rump of services that nobody else, that the housing associations, that the private sector, that the voluntary sector, that the community sector did not want to provide. That would not be the best outcome for patients and I for one will try hard to see that that does not happen.\[146\]

Yvonne Sawbridge agreed:

Obviously you will get people looking at bits of the patient pathway. People are unlikely to bid for the old lady with Alzheimer’s disease needing full leg compression bandaging. There were comments made earlier about how we should not leave PCTs with the services that nobody really wants to do; that is not a very exciting place for anybody. You need to make sure we have got a variety of things that people can do that matter.\[147\]

181. **Whether or not PCTs should divest themselves of their provider services is a huge question which is outside the scope of this short inquiry.** However, inevitably our witnesses raised many important concerns about the divestment of PCT provider services, most notably that it would lead to fragmentation of services, and make joined-up care even harder to deliver. Equally, it is not clear whether sufficient alternative providers exist to provide a market in community services. We urge the Government to address these crucial questions in its forthcoming White Paper on out-of-hospital care.

\[145\] Q 63
\[146\] Q 76
\[147\] Q 121
6 Contracting out commissioning in Oxfordshire

182. In a further recent development, in October 2005 Thames Valley SHA decided to put forward a proposal to the Department of Health to contract out the management of its proposed Oxfordshire-wide PCT, including the commissioning function. In an interview with the Health Service Journal, the SHA Chief Executive Nick Relph said it would be “fantastic” if an NHS team proved they were up to the challenges of Commissioning a Patient-Led NHS, but added that “the skills and capability required for the new PCTs are quite different from the current PCTs. That is not to diminish those running the current organisations, but the skill set for commissioning needs to be different”. 148

183. We invited Nick Relph to give oral evidence to us on this subject, but he declined. However, we received a frank and compelling analysis of the proposals from Dr Helen Groom, a member of Oxford City PCT PEC. Dr Groom told us that while she supported the need to have the best possible management for the future PCT, she felt that it was very important to question whether the NHS should be tendering out to a private sector company the commissioning of services for Oxfordshire:

We are saying that a private sector company would actually come and hold the purse strings for the £600 million of money that is spent on healthcare services in Oxfordshire, and whilst I think we can debate whether private sector involvement in the way we run our buildings might be appropriate, and private sector involvement in the provision of hip operations, cataracts, of MRI scans may be appropriate, this is a much, much bigger step that has actually been taken with no discussion and no consultation.149

184. According to Dr Groom, the SHA’s rationale for putting the management out to tender was that the proposed single PCT would be a very large organisation needing “unusual management expertise”. However, she pointed out that the proposed new PCT would in fact be the same size as the former Oxfordshire Health Authority.150 She went on to tell us that staff had received very little notice of these proposals, and the SHA have been very clear that they did not propose to consult on the tendering out process, because it did not constitute a service change.151

185. Dr Groom also argued, crucially, that if SHA plans to the tender advertisement out in November 2005 went ahead, there would effectively be no Board level involvement in or accountability for this process, as the new PCT Board would not be appointed until March 2006.152 When we put this to Lord Warner and his official, he reassured us that this would not be allowed to happen, and we are relieved to see that Thames Valley SHA has now reconsidered its plans.

148 Health Service Journal, 20 October 2005
149 Q 78
150 Appendix 39
151 Q 78
152 ibid.
186. However, we have further concerns surrounding commercial confidentiality, which may limit the amount of information on health spending that is made publicly available. This issue is already raising concerns in respect of private sector providers; if private sector companies could potentially be charged with spending public money as well, than transparency will be even more crucial. Although the issues surrounding the contracting out of the NHS commissioning function are too complex and numerous for us to take an informed view on at this stage, it is crucial that they are properly debated and consulted upon if and when the Government decides to proceed with this policy.

187. We were extremely concerned at evidence we received about proposals to tender out the commissioning function in Oxfordshire before the new PCT Board has even been appointed. When we put this to Lord Warner he reassured us that this would not be allowed to happen, and we are relieved to see that Thames Valley SHA has now reconsidered its plans. However, we believe that the idea of outsourcing commissioning represents a significant departure from current policy, which has the potential of reducing transparency about the disposal of public funds. Further consultation and discussion is absolutely crucial before the Government allows any PCT to proceed down this route.
7 Conclusions

188. The publication of *Commissioning a Patient-Led NHS* in late July 2005 caused dismay throughout the NHS. Many aspects of the proposals were criticised. We were told that the initial consultation process was flawed, the impact of the proposed reconfiguration had not been adequately analysed, the risks had been underestimated, the potential savings overestimated and alternatives not canvassed. During this short inquiry we examined these claims and conclude that they are well-founded.

The consultation process

189. There have been many failings in the consultation process, namely:

- NHS organisations were expected to consult and put together proposals for far-reaching changes to local services to a timetable which was impossible to meet; as a result patients, local people, NHS staff, other NHS organisations, MPs, local councillors, and other key organisations have been unable to contribute meaningfully to the process;

- despite the Government’s repeated reassurances, the consultation has been a ‘top down’ process: change has been imposed on local NHS organizations by central government for financial reasons; as a result solutions that would best meet local needs are being overruled because they do not yield the required savings;

- the provisions about the future of PCT-provided community services are especially unsatisfactory, in particular:
  
  - *Commissioning a Patient-Led NHS* was published five months before the end of the consultation on *Your Health, Your Care, Your Say*, which had been launched in June to shape the Government’s forthcoming White Paper on out-of-hospital care—its publication made a mockery of the consultation;
  
  - in November, four months after publication, the Government was still unable to clarify whether or not PCTs would eventually divest themselves of their provider functions;

190. The Government’s numerous announcements and subsequent retractions mean that it is still unclear what it’s policy is on the divestment of PCTs’ provider services. This clumsy and cavalier approach to NHS staff has had a very damaging effect on staff morale.

191. The Secretary of State has promised that all proposals that have not been subject to extensive local consultation will be rejected. Our evidence indicates that insufficient consultation has taken place in several areas. To ensure that what remains of the formal consultation process in respect of changes to PCTs is as transparent as possible, offering a genuine choice about how local health services are structured, we recommend that in statutory local consultations all SHA areas be obliged to consult on at least two options.
The impact of reconfiguration

Impact on day to day functions, including clinical services

192. We were told by a senior NHS official that it takes on average eighteen months for organisations to ‘recover’ after restructuring, i.e. to bring their performance back to its previous level. The restructuring of PCTs is likely to have significant effects on their ability to undertake their core functions, including commissioning services, providing community health services, and protecting public health. The destabilising effects are already becoming apparent: clinical staff are moving from PCTs to the acute sector because of uncertainty over their future roles. There are well-founded concerns that patient care will suffer because of the proposed reforms.

193. After the immediate disruption of reorganisation, it is thought to take a further 18 months for the benefits to emerge – a total of three years from the initial reforms. Thus, just as the benefits of PCTs (established in 2002) are about to be realised, the Government has decided to restructure them. The cycle of perpetual change is ill-judged and not conducive to the successful provision and improvement of health services. Major restructuring should only be undertaken if there is an overwhelming argument in its favour; in this case there is not.

The long term impact on commissioning

194. The Government claims that the main reason for the reforms is to strengthen PCTs’ commissioning function. We strongly support its aim, but it is clear that improvements in commissioning should have been addressed before, or at least at the same time as powerful incentives were being introduced which strengthened the provider sector. The fact that it was not has given rise to an uneven balance of power in the NHS that may now prove difficult to redress.

195. The Government’s reforms promise the increased bargaining power of larger organisations. Although they may lose links with departments of district councils such as housing, more of the new PCTs will be co-terminous with county council social service departments. However, such advantages have to be balanced against the loss of local engagement which smaller PCTs provide. The introduction of Practice Based Commissioning will make some amends—it may achieve local clinical engagement—but it will not provide adequate patient involvement. Moreover, the Government in initiating its reforms has not properly thought through the consequences: for example, there are real concerns that the implementation of the public health improvements announced in Choosing Health might be threatened.

196. The evidence presented to this inquiry indicates that there is a practical alternative way forward which does not require restructuring. It involves focussing on the most effective ways of improving commissioning. It does require managers with better skills and better information systems. The Department should ensure that the poorest performers become better commissioners by offering central support to them and by facilitating the adoption of the best practice from good performers.

197. In so far as there are advantages in becoming larger, PCTs are already capturing them through successful collaborative working with one another. The Government should allow
Changes to Primary Care Trusts

PCTs to develop organically, enabling them to evolve into larger organisations where this clearly best meets local needs. This approach would avoid the hugely disruptive and costly impact of another root and branch reform of the NHS.

**Financial savings**

198. The Government has downplayed the financial motivation for its reforms, concentrating instead on its aim of strengthening commissioning. However, cost savings seem to have been the key consideration in the reconfiguration proposals. Plans which would better meet local needs were discounted because they did not yield sufficient savings. Achieving savings is a very important aim but it should be stated explicitly so that it can be subject to proper scrutiny.

199. In fact, it is doubtful whether the reconfiguration will yield the £250m savings the Government is hoping for if the costs of restructuring including those incurred by redundancies and by establishing new structures to secure local engagement are taken into account.

200. It is also doubtful whether it makes sense to reduce expenditure on PCTs rather than other parts of the NHS. PCTs are currently responsible for spending 80% of the NHS’s £76 billion budget. At a time when PCTs’ commissioning role is crucial to the success of the NHS, it is probably a false economy to deplete the NHS’ managerial resources in an attempt to save only a fraction of that total amount. It is worth noting that only three years ago, when they were created, the Government thought PCTs good value for money.

**Contracting out PCT provider services and commissioning**

201. There are also important concerns about the consequences of the divestment of PCT provider services. Should this go ahead, it could lead to the fragmentation of community services, and make joined-up care even harder to provide. Moreover, it is unclear whether sufficient alternative providers exist to provide a market in community services.

202. During the course of this inquiry, it emerged that proposals had been made to put commissioning in Oxfordshire out to tender. These proposals raise crucial questions about accountability and transparency. Once again, a significant policy change was proposed without consultation.

203. The status of the divestment and the Oxfordshire proposals are now unclear following the outcry they engendered. If either policy is to be introduced, it will now be done more slowly than originally intended. If it is to pursue either of these policies, it will be vital that the Government learns from the mistakes it has made with *Commissioning a Patient-Led NHS*: it must allow sufficient time and opportunity to consult on and debate fully its proposals, both nationally and locally.

**General lessons**

204. The unhappy episode which this report has recounted provides a number of lessons for the management of the NHS. The risks of the proposals contained in *Commissioning a Patient-Led NHS* are high and there is little evidence that the costs will be outweighed by
the benefits. The Department must more carefully consider the impact of its proposals on its staff, which are its most valuable asset. They should not be shoved around like the pieces on a chess board. Major changes to the NHS have large costs and should not be embarked upon lightly.
Conclusions and recommendations

1. Besides cost savings, the Government has stated that the main aim of these reforms is to strengthen PCTs’ commissioning function, as larger commissioning organisations, similar in size to old Health Authorities, will have increased bargaining power, and can be better aligned to local authority services. However, before discussing in detail the likely impact of the Government’s proposal to restructure PCTs, it is important to note that PCTs were established only three years ago, at considerable cost to the taxpayer. A return to structures which are similar in size and function to previous Health Authorities raises important questions about why the shortcomings now being identified by the Government, including increased management costs and dilution of bargaining power, could not have been easily anticipated and addressed before PCTs’ introduction three years ago. As we discuss later in this report, all restructurings are hugely disruptive, and to introduce a large scale reconfiguration of NHS organisations only three years after the last root and branch reform of NHS organisations points to an ill thought-out approach to policy-making. (Paragraph 35)

2. We are appalled at the continuing lack of clarity about whether or not PCTs will eventually divest themselves of their provider functions. This announcement was first made at the end of July, together with a firm timetable for its implementation, which was withdrawn in October. Various ministerial announcements have failed to clarify the position, and even our witnesses, drawn from the senior ranks of the NHS, could not agree about whether or not these changes would eventually happen, with many appearing genuinely bewildered. As far as we can see, the overall direction of travel in fact remains unchanged, and PCTs will ultimately divest themselves of provider services. We urge the Government to either confirm or deny this immediately. (Paragraph 46)

3. We are deeply concerned that neither Lord Warner nor John Bacon were able to give us a confident assurance that NHS staff potentially affected by these changes would be able to retain their NHS pensions. The Government must provide clear information as to whether existing NHS staff who are transferred to other providers, particularly in the private sector, as a result of these changes will be able to retain their NHS pensions. (Paragraph 47)

4. Perhaps most concerning of all is that these announcements about the future of PCT provided community services anticipate the outcome of the Government’s flagship consultation Your Health, Your Care, Your Say, which is supposed to shape the Government’s forthcoming White Paper on out-of-hospital care. For a Government to announce its intended direction of travel a full five months before its consultation on this subject comes to an end makes a mockery of the consultative process. Equally, if the Government is now committed to introducing changes to PCTs to a more relaxed, less prescriptive timescale, it is difficult to see why the announcement would not have been better made in a more measured, informed way, in the expected White Paper. (Paragraph 48)
5. One of our witnesses argued that the Government’s handling of announcements surrounding Commissioning a Patient-Led NHS gives “a clear impression that the policy is being developed on the hoof”. We agree. In our view, the numerous announcements and retractions about the divestment of PCTs’ provider services, in advance of a White Paper consultation designed to canvass views on precisely this area, points to flawed and incoherent policy-making. (Paragraph 49)

6. The consequence of this, which could have easily been predicted before the July announcements, has been the destabilization of a very valuable workforce whose support will prove essential to the implementation of the forthcoming White Paper. The insecurity and distraction that has been caused within NHS community health services demonstrates how damaging the repercussions of ill-thought through policy announcements can be, and we therefore recommend that the Department of Health carries out an immediate review of its internal systems to ensure that this does not happen again. (Paragraph 50)

7. Although the stated aim of these proposals is to design a more patient-led NHS, evidence both from NHS bodies and from Patient and Public Involvement Forums confirms that patients and the public have not been adequately consulted. We find this unacceptable. If the Government truly believes in a patient-led NHS, it should have started its reforms with a patient-led consultation process, rather than the top-down process we are clearly seeing. (Paragraph 55)

8. Even NHS officials who otherwise supported the proposals to merge PCTs have described the initial consultation process as “flawed”. In some cases, organizations were given less than a month, during the summer holidays when many key figures were absent, to put together proposals for far-reaching changes to local services. The timing also meant that many local MPs and councillors were unable to contribute to the process. We accept that organizational change causes extreme instability, and for this reason it is helpful if periods of uncertainty are kept to a minimum. However, this needs to be balanced against the time needed both to consult local stakeholders, most importantly NHS patients, and to design new organizational structures that are fit for purpose. Our evidence suggests that in this case the Government has got this balance very wrong, particularly as the White Paper has not yet been published. (Paragraph 60)

9. The flawed nature of the pre-submission engagement makes the proper conduct of the formal three month NHS consultation starting on 14 December vital. The letter from John Bacon, Group Director Health and Social Care Services Delivery dated 30 November to SHA Chief Executives instructed them to “ensure that all options are presented fairly and given equal weight in your documentation” and said that “where there are sharply differing views on particular options, it would be desirable to engage the relevant PCT in preparing the document”. But it is not clear how the Department of Health has ensured this has happened as the consultation documents issued by SHAs did not have to be approved by the Department. The Department of Health should ensure that the consultation is fairly conducted by all SHAs, especially where the External Panel has required SHAs to consult on additional or different options than those originally considered in the pre-submission engagement. Not to
do so would leave the Department vulnerable to allegations that the result of the consultation process was pre-determined and a sham. (Paragraph 61)

10. Despite the Government’s repeated reassurance that this is not a ‘top down’ process, with change being imposed on local NHS organizations from central government, the evidence we have received from those working in the NHS at a local level suggests that it is exactly that. This is because, in their view, the most significant driver of these reforms is finance and so solutions that would best meet local needs are being overruled because they do not yield enough cost savings. Cost savings may be a legitimate and justified driver for reform, as we discuss later in this report. However, the Government must be explicit that this is its key objective. It is disingenuous to argue that these changes are being driven from the grassroots of the NHS when NHS managers have been told that the solutions that would best meet the needs of their local populations will not be adopted because they will not produce sufficient cost savings. (Paragraph 67)

11. Another very serious concern raised in our evidence is that because of the uncertainty about the divestment of provider services, SHAs are having to design new organizations without a clear understanding of what their ultimate function will be. This could lead to the formation of organizations which are not fit for purpose, necessitating yet more reorganizations. (Paragraph 71)

12. Because SHA senior managers are currently under threat of redundancy, not only are they having to draw up reconfiguration plans whilst ‘distracted by thoughts of self-preservation’, but also, in all likelihood, will no longer be in post next year to be held accountable for the reconfiguration decisions they have taken. We find this highly concerning. The Government should have taken this into consideration and planned its restructuring accordingly, first ensuring existing SHAs have an ongoing role in overseeing and being held accountable for their PCT reforms, and then changing the configuration of SHAs themselves, rather than reforming both types of organisation in tandem, threatening both the quality of, and accountability for, these reforms. (Paragraph 73)

13. We are pleased that Lord Warner has given us a commitment to publish all information submitted to the external panel as soon as possible. It is essential that the external panel’s responses are made public also. We also note that the Secretary of State has promised that all proposals that have not been subject to extensive local consultation will be rejected. From our evidence alone, it would appear that insufficient consultation has taken place in several areas, and we urge the Government to make clear at the earliest opportunity to make clear which proposals have been rejected. (Paragraph 75)

14. In the light of our evidence, we believe that further steps must be taken to ensure that what remains of the formal consultation process in respect of changes to PCTs is as transparent and inclusive as possible, offering patients and other local stakeholders a genuine choice over how their local health services are structured. To achieve this, the Government must publish all documents submitted to its external panel as soon as possible; furthermore Ministers must ensure that all formal consultation is conducted in a fair and unbiased manner. (Paragraph 76)
15. The evidence is clear: the distraction caused by these reconfigurations will set back the development of PCTs’ core functions, which include commissioning services, providing community health services, and protecting public health, by at least 18 months. We consider that imposing a further structural change on organizations that are only three years old, at a time when pressure on those very organizations to perform well has never been higher, is ill-judged in the extreme. (Paragraph 85)

16. There are also well-founded concerns that patient care will suffer as a direct result of the distraction caused by these reforms, and our evidence suggests that the destabilising effects are already being felt across the NHS, with clinical staff moving from community hospitals to the acute sector because of uncertainty over their future roles. It is highly ironic that while a key plank of Government health policy is now to move services away from the acute sector and strengthen community health care services, the uncertainty generated by these mismanaged policy announcements is having precisely the opposite effect, causing a drift of staff away from community health services back to the acute sector, which is now perceived as more stable. That some of these outcomes could, with more rational and coherent planning, have been predicted and avoided, makes the Government’s actions in this area even more indefensible. (Paragraph 86)

17. We strongly support the Government’s desire to improve commissioning in the NHS, but believe that this should have been addressed before, or at least at the same time as powerful incentives were being introduced which strengthened the provider sector. The fact that it was not has given rise to an uneven balance of power in the NHS that may now prove difficult to redress. We are pleased that the Department of Health has acknowledged this, and we hope that in future it will make efforts to ensure that the wider impacts of its policies are considered at a system level to avoid such a situation arising again. (Paragraph 90)

18. While larger PCTs may be able to wield greater bargaining power over the acute sector, research evidence demonstrates that increases in PCT size beyond populations of 100,000 patients do not necessarily generate substantial improvements in overall performance, and that optimal size for commissioning varies widely according to services being commissioned. Health Authorities were large commissioning organisations, and their size does not seem to have made them effective commissioners. Arguably, the introduction of Payment by Results may already be giving PCTs the levers they need to commission effectively from the acute sector, without the need for restructuring. (Paragraph 96)

19. We recognise the need to improve commissioning skills within PCTs. However, we remain unconvinced that instigating large-scale structural reform in order to ‘retrench’ commissioning expertise in larger centres is the only, or indeed the best, way to achieve this. Equally, it seems illogical that, at precisely the time the Government has committed to improving NHS commissioning, it is currently planning to spend £250 million less per year on this crucial function, further depleting management expertise from an already under-managed health system. This is more likely to weaken rather than strengthen NHS commissioning. (Paragraph 101)
20. In principle, we support the aim of improving joint working between the NHS and local authorities, both in respect of social services, and other crucial local functions including housing, regeneration and education services. However, we are concerned that these reforms, while offering an opportunity to better align some boundaries, may risk setting up new barriers in other areas, and may threaten existing joint working arrangements. (Paragraph 105)

21. PCTs were established to ensure that decisions about the NHS were made locally. By reverting back to the more remote structures that were abolished only three years ago, this localism will be lost. At the moment, each of the 302 PCTs in England has several Non-Executive Directors; a Patient and Public Involvement Forum; and a Professional Executive Committee of key local clinicians. While these structures clearly have a cost, they were introduced to add value. It is not clear why the Government is now unwilling to meet the cost of securing an enhanced level of local input into the NHS, only four years after this was identified as a key aim of Government health policy in Shifting the Balance of Power. Whatever the size of future PCTs, it is essential that structures to ensure clinical engagement and, most crucially, patient and public engagement are retained at their current levels, covering each natural community. (Paragraph 117)

22. Practice Based Commissioning is a crucial policy which underpins the Government’s proposals for restructuring PCTs, which the Government hopes will both strengthen commissioning and secure greater local engagement. However GPs, who will be responsible for implementing Practice Based Commissioning, have described a ‘woeful lack of information’ about the scheme, with key questions still unanswered. We therefore consider it highly unlikely that this system will be functioning effectively in all areas by the end of next year, and are concerned at the Government’s complacency and unwarranted optimism over the implementation of Practice Based Commissioning. We urge the Government to address this lack of information immediately. (Paragraph 130)

23. The Minister’s view that Practice Based Commissioning as it is currently conceived will improve patient and public involvement in health care is not firmly based on any evidence. In fact, there is a significant gap in this area. We recommend that the Government places a specific requirement on all practice based commissioners to establish regular, formal arrangements for securing the input of their patients and local populations in the commissioning and provision of local services, just as PCTs and other NHS trusts are obliged to. (Paragraph 131)

24. We are also concerned at the complacent attitude that the Government is displaying towards the very real possibility of Practice Based Commissioning introducing perverse incentives that could threaten patient choice and access to health care. It seems to us that these problems have not yet been fully anticipated or considered by the Government, which is worrying given that they hope Practice Based Commissioning will be universally implemented within a year. These potential problems need to be addressed before they arise, and to this end we recommend that the Government publish details of what actions it intends to take to counter these risks before Practice Based Commissioning is universally implemented next December. (Paragraph 132)
25. Evidence from those working in the NHS suggests that PCTs are collaborating with one and other and, as a result, bringing about improvements without the need for large-scale reorganization. In our view, Lord Warner’s suggestion that improvements in PCTs have been “patchy” does not constitute a valid argument for imposing radical structural reform across the board, dismantling organisations that are performing well as well as those that are performing badly. A more rational, constructive approach would be to support the evolutionary changes that are already taking place. (Paragraph 143)

26. As a senior NHS chief executive told us, there is no such thing as a ‘holy grail’ of a perfect size for a commissioning organisation. There is a clear trade-off between the increased bargaining power and better co-terminosity of larger organisations, and the enhanced local engagement of smaller PCTs. Practice Based Commissioning may achieve local clinical engagement, but will leave serious gaps in terms of patient involvement. In order to improve commissioning, PCTs need better skills and information systems. Restructuring is not necessary to achieve this. (Paragraph 144)

27. Given our evidence that the majority of PCTs are already involved in successful collaborative working, we believe that the most effective way to improve commissioning is to allow PCTs to develop organically, enabling them to evolve into larger organizations where this clearly best meets local needs. A managed approach to sharing best practice should be adopted to ensure that the poorest performers learn from the expertise of the best performers, and support should be specifically targeted towards developing commissioning in the poorest performing PCTs. (Paragraph 145)

28. We were very concerned to learn that, prior to the publication of Commissioning a Patient-Led NHS, there was no consultation with public health professionals at all about its potential impact on PCTs’ crucial public health function. In our view, debate about Commissioning a Patient-Led NHS has also given insufficient prominence to this. In order to safeguard local public health initiatives, we recommend that where PCTs merge leaving only one Director of Public Health, other consultants in Public Health are retained with responsibility for public health delivery, working with local authorities and local strategic partnerships. Further to this, steps must be taken to provide continuing support to community health professionals who play an equally important part in securing public health improvements. (Paragraph 155)

29. The Government has downplayed the financial motivation for these reforms, concentrating instead on its aim of strengthening commissioning. However, our witnesses were clear that this was the key consideration in drawing up plans for reform, to the extent that plans which would better meet local needs were discounted because they did not yield sufficient savings. While achieving efficiency savings is a legitimate aim, this needs to be stated explicitly so that it can be subject to proper scrutiny. (Paragraph 164)

30. In fact, the evidence to date suggests that this reconfiguration is unlikely to yield the savings the Government is hoping for. Figures put to us by PCT officials suggested that current proposals for reconfiguration might save between £60 and £135 million,
well short of the target figure of £250 million. If proper clinical and patient involvement is to be retained, further local structures will need to be put in place at a sub-PCT level, which will generate additional costs. Equally, the costs of Practice Based Commissioning, which are at present unclear, will need to be taken into account. The NHS will also have to bear costs associated with redundancies, as well as the cost of reduced productivity over the next 18 months. (Paragraph 165)

31. It is vital that NHS organisations deliver value for money. However, while the enhanced local perspective PCTs have brought to the NHS clearly has a cost, the benefits they have brought may well justify this cost. In addition to this, PCTs are currently responsible for spending 80% of the NHS’s £76 billion budget. At a time when PCTs’ commissioning role is crucial to the success of the NHS, it is a false economy to deplete the NHS’s managerial resources still further in an attempt to save only a fraction of that total amount. (Paragraph 166)

32. Whether or not PCTs should divest themselves of their provider services is a huge question which is outside the scope of this short inquiry. However, inevitably our witnesses raised many important concerns about the divestment of PCT provider services, most notably that it would lead to fragmentation of services, and make joined-up care even harder to deliver. Equally, it is not clear whether sufficient alternative providers exist to provide a market in community services. We urge the Government to address these crucial questions in its forthcoming White Paper on out-of-hospital care. (Paragraph 181)

33. We were extremely concerned at evidence we received about proposals to tender out the commissioning function in Oxfordshire before the new PCT Board has even been appointed. When we put this to Lord Warner he reassured us that this would not be allowed to happen, and we are relieved to see that Thames Valley SHA has now reconsidered its plans. However, we believe that the idea of outsourcing commissioning represents a significant departure from current policy, which has the potential of reducing transparency about the disposal of public funds. Further consultation and discussion is absolutely crucial before the Government allows any PCT to proceed down this route. (Paragraph 187)
Formal minutes

Thursday 15 December 2005

Members present:

Mr Kevin Barron, in the Chair

Mr David Amess
Charlotte Atkins
Mr Paul Burstow

Mr Ronnie Campbell
Dr Doug Naysmith
Dr Richard Taylor

The Committee considered the draft Report (Changes to Primary Care Trusts), proposed by the Chairman, brought up and read.

Ordered, That the Chairman’s draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 204 read and agreed to.

Conclusions and recommendations read and agreed to.

Summary read and agreed to.

Resolved, That the Report be the Second Report of the Committee to the House.

Ordered, That the Chairman do make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the Provisions of Standing Order No. 134.

Ordered, That the Appendices to the Minutes of Evidence taken before the Committee be reported to the House.

Several Memoranda were ordered to be reported to the House.

[Adjourned till Thursday 12 January at 9.30 am.]
Witnesses

Thursday 3 November 2005

Dame Gill Morgan, Chief Executive, NHS Confederation, Mr John McIvor, Chief Executive, Rotherham PCT, Ms Dianne Jeffrey, Chair, High Peak & Dales PCT, Caro Millington, Chair, North West London SHA, Mr John de Braux, Chief Executive, Beds & Herts SHA

Dr Helen Groom, GP, member of PEC, Oxford City PCT

Dr Michael Dixon, Chair, NHS Alliance, Mr Robert Sloane, NHS Alliance, Dr Peter Reader, NHS Alliance, Yvonne Sawbridge, NHS Alliance, Dr Tony Stanton, Joint Chief Executive, Londonwide Local Medical Committees, Lucy Marks, Tower Hamlets PCT, PEC Chair

Thursday 10 November 2005

Mr Alwyn Hollins, Chair, Basildon PCT, Mr Philip Barrett, High Peak & Dales PCT (appearing in a personal capacity), Mrs Karen Rhodes, Lincolnshire PCT (appearing in a personal capacity)

Lynn Young, Royal College of Nursing, Dr Tim Crayford, Faculty of Public Health and Association of Directors of Public Health, Liz Railton, Association of Directors of Social Services, Councillor David Rogers OBE, Local Government Association, Mr David Nicholson CBE, Chief Executive, Birmingham and the Black Country SHA

Lord Warner, a Member of the House of Lords, Minister of State for NHS Delivery, Mr John Bacon, Group Director of Health and Social Care Services Delivery, Department of Health, Mr Michael O’Higgins, Chair, External Review Panel (Commissioning a Patient-Led NHS)
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Changes to Primary Care Trusts
Oral evidence

Taken before the Health Committee

on Thursday 3 November 2005

Members present:

Rt Hon Kevin Barron, in the Chair
Mr David Amess
Charlotte Atkins
Mr Paul Burstow
Mr Ronnie Campbell
Anne Milton
Dr Doug Naysmith
Mike Penning
Dr Howard Stoate
Dr Richard Taylor

Witnesses: Dame Gill Morgan, Chief Executive, NHS Confederation, Mr John McIvor, Chief Executive, Rotherham PCT, Ms Dianne Jeffrey, Chair, High Peak & Dales PCT, Caro Millington, Chair, North West London SHA, Mr John de Braux, Chief Executive, Beds & Herts SHA, examined.

Q1 Chairman: Good morning. May I welcome you to this first session on our inquiry into the changes to Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs). I realise you do not all represent one organisation. After an answer you may offer your view, if it is different, to the committee. We start by looking at organisational change. Everybody who works in the NHS falls back two or three paces when that is mentioned. PCTs and strategic health authorities were introduced in 2002 when health authorities and regional offices were disbanded. Do you think under the current proposals we are now moving back essentially to similar structures to the ones that were abolished just three years ago?

Dame Gill Morgan: I think superficially you could say that we are but there are some fundamental differences. The nature of practice-based commissioning is quite different from the nature of fundholding: it much more akin to what we used to call locality commissioning where you get groups of practices, not just GPs because you have to have a broader clinical engagement, coming together really to influence what is best for their patients. Because of the nature of how that is set up, that is quite different from fundholding. The other thing that is very important about this is that some of the changes are built on things that the service itself wanted. If you look today, there are 43 PCTs that felt for some reason they were too small and already had shared management arrangements. Some of this is about implementing the learning that has come from PCTs. There were a number of PCT which had already begun to develop shared ways of doing things—for example, the Manchester commissioning group of GPs—because they felt that if you were very small as a PCT, you could not get the leverage with the acute sector. They have tried to put together the learning of the last three years. In many cases, this is about implementing that learning at a local level.

Q2 Chairman: Does anyone have another view or an alternative to that?

Mr de Braux: With some of the other changes that are likely to happen to providers, particularly the introduction of organisations like foundation trusts and other alternative providers, and with the responsibility for performance management when they are moving to Monitor (an independent regulator) rather than strategic health authorities, there is a very good argument for the future that strategic health authorities perhaps need to get bigger and have a bigger span of control. I think we are also seeing, in terms of developing services, the need to look over a much wider area than just the areas that some of the strategic health authorities cover. The need to have a strategic view about what health services should look like so that the local commissioning can work within that is another reason why strategic health authorities probably need to be larger and fewer.

Q3 Dr Taylor: If PCTs are already doing this and coming together in larger groups, why ever do we need this huge big bang approach to make this tremendous change?

Dame Gill Morgan: Where the 43 organisations have shared arrangements, they need to be allowed formally to merge to produce the changes and the benefits. What you have at the moment are organisations maintaining two boards but one set of management teams. There is the necessity for some structural change where we are at the moment. For the others, where they are developing shared commissioning arrangements, they tend to be small unitary authorities which are co-terminous with metropolitan boroughs and therefore have some very good reasons for staying small because of that co-terminosity. They are trying to develop models that allow them to have more leverage when they talk to the bigger trust. Without doubt, when you are very small and you are one of very many PCTs buying services from an acute trust, you could be at a disadvantage. PCTs have been trying to get those shared commissioning arrangements. Many of those will persist after the current changes.
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Q4 Charlotte Atkins: Could we have that list, please, of the 43 and of the shared arrangements? In your experience, if you take the 43 and those that have already the shared experience, what numbers does that come to out of the 300?

Dame Gill Morgan: I could not give you a number now but we could find that out.

Q5 Charlotte Atkins: Is it your impression that it is half or what is the number?

Dame Gill Morgan: We think it is 43, plus 40, plus 8; that makes 91.

Q6 Charlotte Atkins: That is less than one-third that you are talking about. If we are led to believe that it may come down to about 100, we are still talking about very significant change, as Dr Taylor mentioned, in those areas not covered by the shared arrangements and the other arrangements you spoke about?

Dame Gill Morgan: But some of that is about the learning from the areas where they have put in shared arrangements and some of that is about this issue of scale and size to work with acute trusts. One of the difficulties with this is that there is not a single right answer. We are very supportive of the direction of travel which takes primary care trusts and makes them co-terminous as far as possible with local government. We think that is a really important opportunity. When you go back four years, many of the primary care trusts that were set up were not co-terminous with social services; they crossed boundaries. We believe that one of the great strengths and successes of PCTs over the last few years has been the development of a whole set of new community services, intermediate care services, with social services. We think the opportunity to get the boundaries more closely aligned is an important opportunity we should be taking.

Mr McIvor: I do not think there would be any PCT in the country that is not part of some shared arrangements. Often those shared arrangements are around the health improvement agenda because of a need for a greater co-terminosity with the local authority; to take the example of Sheffield, next door to me with four PCTs, it is very much working very closely together with that one local strategic partnership on the whole of the health improvement agenda but equally on the commissioning agenda.

Q7 Charlotte Atkins: When you are talking about co-terminosity there, are you talking about co-terminosity with the authority that provides social services or are you talking about co-terminosity with an equally important local authority, maybe in the district or the LSP boundaries?

Mr McIvor: I am talking in that case about a co-terminosity with the local authority that provides social services, but equally importantly provides for education and leisure and those other services, housing and so on, which are very important determinants of health. Therefore it is important that those boundaries are, wherever possible, and obviously this is a holy grail you would never get, co-terminous as well.

Q8 Anne Milton: You are going to miss some of them and gain others. Where there are not unitary authorities, you are going to lose some co-terminosity and you are going to have a problem with size. Are we not going to see huge problems with size?

Dame Gill Morgan: I think the conundrum that faces this is that you have two scenarios happening in parallel. If you believe that the holy grail that you really need to get is social services co-terminosity and that is the number one priority, that could leave you with some very small metropolitan unitaries. Simultaneously, it could leave you with some very large shire counties. One of the things we believe in trying to assess this is that you cannot set a national template; you have to make an assessment at local level. Where people are going for small unitaries, the question we have to ask is: how do you share services to get the best, to get the leverage? If it is a very big shire county, the question has to be exactly what was asked, which is: how do you then get the leverage you need with local government at the second tier level? It is that level that a lot of the health promotion activity and health improvement agenda, particularly with housing and things like that, is focused. If it is big, we are going to have to think local. If it is small, we are going to have to think shared. That is the sort of conundrum that is facing people at the moment.

Q9 Chairman: Moving on further, we have received evidence from one PCT official that, following PCT reorganisation, it will take as long as 18 months to restore systems to their current levels of effectiveness. Given that the NHS is at a crucial stage in implementing payment by results and developing practice-based commissioning, are you concerned that these reorganisations will impact on your ability to develop commissioning skills and fulfil your current statutory functions as well?

Mr McIvor: I think we need to be concerned and take on the fact that reorganisation always takes time. However, I think we are building on a lot of good practice and experience to date. I would be very concerned if it did take 18 months. That is just far too long. This reorganisation has to happen when it happens. It is not a question of when it happens; it has to happen quickly. We need to put in place the right people to continue to ensure that we continue to deliver. I do not think that should be a problem. There are some very good and experienced people out there who can continue to do that. We are, after all, going down from a large number of organisations to a smaller number, whatever that may be.

Ms Jeffrey: It is interesting that you mention payment by results because small PCTs that are operating in a full payment by results economy, which some of them are, do not really have enough bargaining power and muscle to cope with that. It is a completely new regime. We are all learning. Inasmuch as we think that perhaps 303 PCTs were not really affordable in the first place with all the management on-costs and board costs that those entail, in the same way 303 PCTs probably did not
have enough bargaining muscle, commissioning power, strength of commissioning tools and equipment to cope with the new payment by results regime. I think there will be a great deal of attention paid to keeping the show on the road. Obviously business continuity plans are very important, but a smaller number of PCT will, I think, be in better shape to do that.

Q10 Chairman: Quite clearly, there is some support for this. I suppose the obvious question is: would you have initiated this yourselves if it were not for Sir Nigel Crisp’s letter of 28 July?

Mr de Braux: Within the strategic health authority that I manage, we had already moved towards that model because of the difficulty PCTs were finding. If you take Hertfordshire, for instance, there are eight PCTs in Hertfordshire averaging about 100,000/120,000 people each that they cover, which are trying to commission from two very powerful providers. They spent most of their time, in terms of commissioning, bargaining with each other rather than with the two providers that did rather well out of their inability to get their act together quickly. We had already started to move to a model where we were already at four teams instead of eight; I think we had recognised that we had to take that even further than we were taking it. We were doing it on a step-by-step basis rather than in one large attempt. My own view of that is that it was better than staying at eight, but in fact the time taken on each step was not terribly valuable time when you could have done it all in one go. Whilst it does lead to some disruption—all reorganisation is disruptive—I think, as we have already said, if we make the decision to do it, we need to get on with it and do it quickly and make sure we retain the good skills we have in the many organisations into the fewer organisations in the future.

Ms Millington: It is patchy in the health economies around the country. As to direction of travel, I have not met anybody who is against it, but I think it has been a flawed process. The pace, for some of us certainly, has been very challenging indeed. I do not think there has been a proper communication plan, either within the NHS or between the NHS and everybody else involved. I think there has been a danger, as always in any restructure, that form has come before function. You are trying to design organisations before you have fully worked out what their new function is going to be. There is a huge passion and commitment to making it work, as you would expect, and to making sure that improved patient services come out of this. That is what it is about, but it has been a flawed process. I think there would be very few people who would not acknowledge that. It is easier for a non-executive to say, this however.

Q11 Mr Burstow: That is a useful insight perhaps into evidence sessions like this. On this 18-month period of disruption which we have had put to us in some of the evidence, and I hear what Mr McIvor has said to us, I wonder if you could give us some sense of what you think the best case would be in terms of loss of focus on day-to-day running of organisations and what you think the worst case could be? What are the parameters in terms of how long there will be a disruption to normal service and in terms of trying to make sure the commissioning now is being done well?

Mr de Braux: May I say what we are doing in my strategic health authority? Recognising that business continuing is very important during this process. In working with our primary care trust, we have agreed with them that the strategic health authority will be the level at which we manage commissioning for the next year. We are bringing people from the PCTs together in a “commissioning team” to work on the commissioning for our four main providers. Whilst the PCTs will retain responsibility for that commissioning, the actual management of it will be done by a larger team working out of the strategic health authority. The role of the strategic health authority is to make sure during this process of change that business continuity is maintained.

Q12 Mr Burstow: That is helpful. It gives us an insight into process. It does not answer the question which is about the worst case and the best case. It would be very helpful to gain some sense of what those might be?

Dame Gill Morgan: You have to remember that many PCTs will not change at all. The best case is that there will be no disruption because people will continue to work in their own patch. There are significant numbers of PCTs in that category.

Q13 Mike Penning: How many are there?

Dame Gill Morgan: I cannot answer that because the things are being looked at. For example, if you take London where there are currently 32 PCTs, the current proposals are that that will continue. There will be large areas. If you take Manchester, the scale of the change is probably from 14 down to 10.

Q14 Mike Penning: Both of those PCTs are metropolitan. Lots of the small PCTs are not metropolitan.

Dame Gill Morgan: Absolutely. The places that are going to have the most difficulty will be the big shire counties, which is where the sort of solution that John is talking about, which is trying not to have any delay in terms of commissioning by having the strategic health authority take a key lead, should reduce. It may take 18 months for the PCT to be up and fully running, but that does not mean we drop the ball in the meantime.

Q15 Mike Penning: That is the risk.

Dame Gill Morgan: Of course that is the risk and that is why each submission is being assessed for its business continuity and how it will deliver the current agenda, as well as what the organisation boundaries are.
Q16 Dr Stoate: When this Government came to office in 1997, the plan was for a primary care led NHS. Is it primary care led? I should ask the PCT to start with.

Mr McIvor: In the majority of cases there is a huge amount of primary care involvement in leading and setting the direction for the NHS. The challenge of this change, it seems to me at the moment, is to balance this desire for co-terminosity while keeping that clinical engagement and ownership of what happens in the NHS.

Q17 Dr Stoate: What about the power structure between the primary care and secondary care sectors? How do you think that currently pans out?

Mr McIvor: I think a lot of the context in the NHS has changed over the last year or so, particularly this thing called payment by results, which has meant that, from my PCT’s point of view, we feel we have a much greater ability to commission services in the right place and see the money move, if that is appropriate, from the acute sector into the primary care sector. I know the GPs, nurses and allied health professionals who are part of my PCT have seen real investment in out-of-hospital services.

Q18 Dr Stoate: But the Government does not see it that way because the Department of Health’s view is that there is currently an unequal power structure between primary care and secondary care, which is one of the reasons for your reorganisation. I am slightly concerned that you think things are going pretty well.

Mr McIvor: Perhaps I am talking about my area and perhaps they are going well there, and it may not be the same across the country, but I know that the majority of PCTs feel that there is much better clinical engagement than there ever has been and that the context means that we are actually seeing much greater investment in out-of-hospital services.

Q19 Dr Stoate: Most of the PCTs I speak to, and it is a fair number, are very concerned indeed in the hospital sector about gaining power at the expense of PCTs, which is one of the driving factors, I am told, behind the reorganisation and the mergers. Is that the case?

Mr McIvor: My own view on that, and it is a personal view, is around the context in which we are operating and the fact that the biggest driver for this is about the way we pay for hospital services. I can give you an example. I know that every time an emergency admission goes into my local hospital, it is going to cost me round about £2,000. If that emergency admission does not go in, I do not pay £2,000. That is a great incentive for my primary care professionals to look at better alternatives and to invest in them.

Q20 Dr Stoate: How are we going to rein in the current big hospitals then that effectively are going to have hello nurses in the outpatients department rather than goodbye nurses there? It will simply pay them hugely to admit the patient.

Mr McIvor: There are two things. First, I think practice-based commissioning is critical to this. That is to say that those people who have responsibility for referring the people into the hospital also have the responsibility for the money and can use it differently.

Q21 Dr Stoate: I am not talking about referrals. From next year, A&E and emergency treatment will come under payment by results. How are you going to control the hospital’s power in that situation?

Mr McIvor: South Yorkshire it has been under payment by result for the last two years for A&E and emergencies. In A&E, I think you are right, there could be a perverse incentive for hospitals to say, “Hello, come in”, and to lie you on a bed. We are doing two things in South Yorkshire: firstly, there are sets of criteria that say that unless patients have these things wrong with them, there are other alternatives to admission; secondly, why do I not have a GP in A&E? why do I not have my community response team in A&E? They operate in there at various points in the year. From this Christmas, they will be in there permanently.

Q22 Dr Stoate: Perhaps I ought to ask some of the others? The evidence I am getting from PCTs I speak to is that they are extremely concerned that payment by results, particularly when it becomes universal for A&E and emergencies, will mean that it is almost impossible for primary care trusts and organisations to have any control over the hospital whatsoever. Maybe the others have a different view or maybe I have got the wrong ideas.

Ms Jeffrey: You are absolutely right but I think it is unhelpful to regard this as a power struggle between the secondary and the primarily care sector. It is not a power struggle. It is about recognising the importance of patient care pathways. You are right to say that when the Government set this up, it was supposed to be a primary care-led NHS. Is it? The difficulty then was that the primary and community efforts did not speak very well together. They were trying to cope with sucking of patients, if you like, in the acute sector in separate ways. What has happened since the development of the primary care-led NHS has been a coming together of community and primary care and, most of all, clinical engagement in both the commissioning and the management of the NHS by GPs. What we have seen, in terms of trying to prevent, if you like, over-activity in the acute sector has been a range of initiatives, really innovative initiatives, in both primary and community care to prevent people needing non-elective or emergency or urgent admission in the first place. Could I just give you two excellent examples from my part of the country, which is North West Derbyshire? One is that, in collaboration with our local authorities, local strategic partnerships and local area agreements, we have put citizens advice bureaux into GP practices. This is the answer to your question about shire counties and how you make the smaller PCTs able to operate on a much wider shire county basis with all the local authorities. Once a week in every GP
practice there is a CAB session in all our surgeries, in all our practices, so that people can consult on things like benefits. We have managed to established that there is about half a million pounds of unpaid benefits throughout our population of 100,000 each year which can be accessed by people being able to speak to the CAB in this way. This is an initiative which we would now like to roll out over the whole of Derbyshire. The second thing is that we are a rural farming community and in those isolated areas 33% of the population is involved in farming or secondary farming activities where farming does not pay any more. The farming community has very high health needs. One of the major reasons for that is because they do not seek help. Traditionally, they do not seek help. We have put a walk-in clinic staffed by physiotherapists, a nurse and a health visitor actually in the agricultural centre where people come to sell their beasts on a Monday morning, and it is full. That has made a great deal of difference. That is a primary care led initiative, which has prevented those people from having to seek maybe orthopaedic or major surgery in the secondary care sector.

Q23 Dr Stoate: I am very pleased about that. The final question is this. Those PCTs that genuinely feel that they are being bankrupted by payment by results are either wrong or they are just badly organised, are they?

Ms Jeffrey: No. We have been operating in a full payment by results regime for the nearly last 18 months. We contract with four major providers, all of whom are foundation trusts on PBR. It is extremely difficult. Our financial situation is very challenging, not totally because of that but also because of the rural factors and because we are above equity. However, that is a very good signal to us that we need to highlight what is going wrong; we need to make sure that behaviours around payment by results are properly controlled, codified and monitored; that there is a code of behaviour here; and that when it is rolled out to the rest of the country, we have already understood and established what the pitfalls might be. That is so that when payment by results is rolled out to the rest of the country, we can make sure it happens in a controlled and managed fashion.

Dame Gill Morgan: There are two further matters. We should not be talking about one bit of the NHS leading another bit of the NHS. The NHS is there for patients and we have much more to put patients at the centre and be much more listening to what they want. I think that change has happened and so we do not talk about being a patient-led NHS now; we talk about trying to put the patient at the centre. It is an aspiration; we are not there. We really do have to remember what the service is there for. It is not for doctors, nurses and the hospital; it is for patients. That is the first point. The second point on payments by results is that there is a lot of international experience which says exactly what you suggest. When you start to introduce a payments by results system, it puts a real set of pressures on the commissioners. The commissioners have to find new ways of doing things to prevent admissions. What the international evidence also says is that after it has run for a couple of years, you find that the alternatives to admission start to bite on the hospital. After a few years, it is the hospitals that find there is a real challenge to them. What we have here is a transition pathway to introducing a new system. It is quite right and natural that PCTs have real, genuine concern about how to management payment by results, but that incentive needs to be there to get people to change the way they deliver and to have this whole set of new alternatives, which would keep people out of hospitals and in their own homes, which is where they want to be, and which will deliver better outcomes for them. This is really important.

Q24 Mike Penning: This is very important. What you are saying here is to do with the pressure on the hospitals. That is only possible really if there is the capacity within the hospitals to offer the services you are talking about. I am fascinated to hear how well you are doing in your part of the world. I declare an interest here. John de Braux is the Chief Executive of my strategic health authority. We do not have the capacity, and John knows this; we have a major problem with capacity. That is partly to do with deficit. It is all about structure. How is this going to work in our part of the world, in the south-east, where there is a particular problem with capacity and where the pressure is going to come on to the commissioner and there will be more pressure on the hospitals? The hospitals cannot survive now under the pressures. How is it going to work?

Mr de Braux: We probably have more capacity in and around an area like Hertfordshire, which not only has hospitals within the county but also in all of the counties around it, and more choice for people than many other parts of the country. I think we are not talking here about trying to stop people going into secondary care or staying in primary care; it is for patients to be treated where that is most appropriate. In some parts of Hertfordshire what we are seeing, and this demonstrates how it should work and will work in the future, is that where we have good GPs, those that have done best on their quality and outcome framework points this year, we have very strong evidence in one or two PCTs that for patients with chronic conditions like diabetes and COPD, chest problems, we are seeing an increase in admissions to hospital, or referrals to hospital. This might seem perverse but these are planned referrals for a specialist opinion that is appropriate for these patients. We are also seeing a corresponding reduction in emergency admissions. This is not about stopping patients going to hospital but about making sure patients get the right and appropriate treatment, led and helped by their primary care practitioner.

Q25 Mike Penning: I beg to differ with you on the first point.

Dame Gill Morgan: It is important for people to recognise that already 90% of interventions happen in primary care. That is where most people make
their contact. We are talking here about how you strengthen those opportunities that keep people as near to their homes as possible.

Q26 Mr Campbell: When we talk about patients and what they want, in my view, they want to get in to see their general practitioner very quickly but sometimes they have to wait a week; they want to be seen by a specialist at a hospital very quickly. Will a system, such as you are referring to, help the situation where you cannot get to see your GP and you cannot get to see a specialist, let alone have an operation? You have to wait a long time. Is this going to help that situation? That is what I hear in my surgery.

Dame Gill Morgan: Yes, it should. That is what patients say, if you ask the question that way. If you ask a patient with back pain, “What do you really want?” Do you want to go to the hospital and sit in a clinic to be seen by an orthopaedic surgeon who will refer you back to your GP for some physiotherapy, or would you rather have extra physiotherapy provided in your practice that treats you without ever having to go to the hospital?” I think people would come up with different solutions. This is about how we answer the question. If all you have ever known is that a referral to hospital is the right pathway, that is all you will ever know. We are trying to stimulate more developments outside hospital of alternatives. For example, general practice has been very innovative in setting this up. There is a whole set of GPs with special interests. There are now services run by physiotherapists for back pain and the PCTs have actually trained people to do different things and manage this differently. This is a revolution in how we deliver care. Part of that has to be about how we explain to the patient and to the staff that things will be different, but that that is good. The knock-on effect or the benefit of that, if we start giving physiotherapy outside, is that when you do go to the hospital because you need the time, there is more time, less pressed clinics, and you can get a better and more tailored expert opinion than you currently do at the moment. This all takes time because there is a big revolution in how we deliver service.

Ms Jeffrey: Mr Campbell, may I add that in the part of the country where I come from, most people cannot get to hospital for an outpatient appointment and back in the same day by public transport. Think about that. Some of us forget about that. Therefore, it is vitally important that primary and community care services are there for those people and are able to provide other ways for their back pain, for example, or any other kind of musculoskeletal problem, to be dealt with. By the way, Mr Barron, I do not believe the service will fall over for 18 months. I do not believe it will fall over at all. Managers are used to this. They will cope as they always have done in the past.

Q27 Dr Taylor: How will larger PCTs keep their local focus?

Mr McIvor: There is a balance, as I said previously, between size and clinical engagement and clinical engagement goes with a local focus. They will find structures and work in ways which perhaps go down to localities and neighbourhoods. Practice-based commissioning, after all, is that way of getting down to that neighbourhood level. I think there is a balance between their desire for co-terminosity in clinical engagement so that we actually make practice-based commissioning and real neighbourhood involvement work properly. That is the one we have to try to find.

Q28 Dr Taylor: If there is a merger, will local groups like professional executive committees still exist for local groups? Will patient forums still exist for localities? Mr McIvor: My understanding, and I am from a PCT where there are no proposals for mergers, is that professional executive committees will continue. I have not seen anything from the Department of Health that says anything contrary to that.

Q29 Mike Penning: It will happen in your part of the world. What is going to happen then, John?

Mr de Braux: We will be moving probably from eight to one PCT in Hertfordshire. We are consulting on whether it will be two or one. Most people are saying that one would be better. Our preference for one rather than two is that both probably manage to be significantly large enough to take on the commissioning agenda, but, if you go to one rather than two, you can release more funds to develop your local services. You have a smaller core to do the large-scale planning of commissioning, monitoring, et cetera. You can release more money to be at your local district council practice-based commissioning type level to keep that local focus.

Q30 Dr Taylor: I think Gill Morgan said that many PCTs will not change. Could we possibly have a list of the numbers that will not change at some time? Dame Gill Morgan: We can give you a list of the submissions that have gone in to the Department. Those are subject to consultation, so it does not necessarily mean that that is how it will end up. I have a document here from the Health Service Journal which has a complete summary. I will leave that with you. It gives you the scale and range of what people are looking at.

Dr Taylor: We already have that.

Q31 Charlotte Atkins: I believe that the emergency panel is meeting next Tuesday to look at those issues. Earlier on, of you said that where you have a number of PCTs, the SHAs would lead the development. Do you not really mean that the SHAs are dictating to PCTs what the future will be, particularly in places like the shire counties, to go back to an earlier point, where the messages come from on high about “you will merge into a giant shire county PCT”, which is even more remote than the health authorities we got rid of several years ago?

Mr de Braux: I do not think we are dictating to PCTs. We have arrived at our conclusion in consultation with PCTs and many other groups, particularly local authorities and social service
authorities. I do not think we are dictating. In this instance, in helping them through this change, it was something one of the PCTs suggested to us that we should do. It seemed a sensible way forward and we have taken it on with them. This is working together and not working in a dictatorship.

Q32 Charlotte Atkins: That is very interesting because in my patch SHAs, having received hostile responses from virtually everyone within the pre-consultation period, then progressed to put exactly the same recommendations to the Secretary of State. I am talking, of course, about Staffordshire. Understandably, a social services authority would want to promote co-terminosity because, of course, they have everything to gain from that. The issue is one Richard Taylor raised. You have a shire county PCT of 800,000 in terms of Staffordshire or one million in other areas. Given that PCTs were set up to have a local focus, an intimate relationship with GPs, and to work with other local authorities within the LSP area, to have that intimate knowledge and non-executive directors working with the community they know so well, how do you do that when you put six PCTs into one huge PCT, especially where, as in Staffordshire, there is a natural north Staffordshire health economy and you lump these together just because of the accident of the fact that social services happens to operate on a county-wide basis?

Ms Jeffrey: I come from a neighbouring county, Derbyshire, where exactly the same thing is proposed. We have 8.5 PCTs and the proposal is to move to one, or possibly two. The same thing goes for Nottinghamshire and Lincolnshire. Across the centre of the country we have the same thing with the shire counties. To answer your question, Ms Atkins, I do not think that this has been dictated by the SHA in terms of configuration. What has been unhelpfully dictated has been timescale and process. We are experienced people and we are able to do something like this ourselves. Personally, I have experience of organisational change and huge massive reconfiguration in a variety of other sectors, and I know what the rules of engagement are. One of the drivers for this, which nobody has mentioned, is to release £250 million. It is in the manifesto. That money has got to be released. If you do not reduce the number of organisations, it is hard to see how you are going to release that money. It is true to say that in some places large organisations would not be appropriate and in other places they would. In Derbyshire, we have always worked as north of the county and south of the county in the past. Those very disparate communities have worked together. We had a community trust covering the north and a community trust covering the south.

Q33 Charlotte Atkins: You have two separate organisations?

Ms Jeffrey: Yes, but that would have been an option: we could have had two PCTs for Derbyshire. Absolutely nobody in Derbyshire thought that would be a good idea. We thought that inasmuch as the north of the county could work together and the south could work together, so could the whole county.

Q34 Charlotte Atkins: How did you consult them?

Ms Jeffrey: As I have said to you, it has been very unhelpful that we did not have a very great deal of time to consult.

Q35 Charlotte Atkins: You have just told me that in Derbyshire nobody wanted a north-south divide. How did you consult them? How did you come to that decision?

Ms Jeffrey: The PCT boards, the local authorities, MPs, and the local strategic partnerships, were part of the pre-submission engagement, but it was not long enough. It was not nearly long enough. Some MPs were not asked at all. They said it was not on their radar. Given that this announcement came out on 28 July after Parliament had risen, when people were going on holiday, when I got my two local MPs together, it was September before they had come back from their holiday. Our submission had to be in by 12 September. What time was there for them? What time was there for the local authority chief executive? Whilst he is being consulted, he could not get his members—

Q36 Charlotte Atkins: It is interesting that you said you document had to be in by 12 September. In Staffordshire, the pre-consultation finished on 16 September. It is interesting that you had a different timespan than others.

Ms Jeffrey: I think it was to do with strategic health authority board meetings, for example. To answer the second part of your question, how can we make a PCT for the whole of Derbyshire locally relevant? How can we make sure we have clinical engagement in all those local areas? I think we can because this is a commissioning organisation which needs to have, as I said at the very beginning, bargaining power; it needs to have muscle; it needs to have the best tools; it needs to have the best organisational development to be able to deal with the multiplicity of providers around the patch. That does not mean to say that a large central organisation cannot receive intelligence from its periphery and those locality directorate arrangements or locality public involvement arrangements or locality clinician arrangements. This is not just about GPs; we are talking about multi-professional clinical engagement in commissioning. It is perfectly possible to do. This is a large corporation with subsidiary organisations feeding in.

Q37 Charlotte Atkins: Then why did we bother to create PCTs in the first place? We may as well just have stayed with health authorities?

Dame Gill Morgan: There is already a model because in many of the shire counties, if you look at performance for social services, they run their social services already broken into localities. That is the way they deliver service. They manage both to have a corporate whole across a large geographical area and local sensitivity. If you were going to design a
system, the localities within the large PCTs are going to want to work very closely with the same geographical boundaries that social services work on. I do not know any shire county that does not work with social services through a series of sub-components.

Q38 Charlotte Atkins: That is absolutely right, but then to put the PCT on a county-wide basis means that you have the same problems with remoteness and with lack of focus from GPs. You were talking about commissioning. It is important, if you are going to get commissioning right, that they know what the local situation is. You spoke very movingly about the situation in a rural area like the High Peak. Exactly the same issue arises in places like Staffordshire. You have a very different set of problems in South Staffordshire from North Staffordshire, just as in Derbyshire. How do you overcome that?

Dame Gill Morgan: This is no different from positions we have been in before. What you need to understand if you are commissioning are not the needs in large geographical areas but those in small neighbourhoods. PCTs and strategic health authorities map their population needs at very small areas. If you go to an area I know well, Devon, most of our mapping is around individual towns. You have to be as sensitive at that level. There is no reason why you cannot have a big organisation with governance in terms of covering geographically and be incredibly sensitive at a local level and have partnerships that actually bind all the different bits together. They are not in conflict. It is just about how you structure yourself.

Q39 Charlotte Atkins: But that is why we created the PCTs in the first place because those structures did not work in the past. Is that not right?

Mr de Braux: I think we created them in the first place because what we really wanted to do was engage primary care practitioners in commissioning and planning services for patients. They had no previous experience of doing that, other than fundholding. I know PCTs were set up in order to get that engagement from clinicians into this because, without that engagement, we would never really meet the needs of patients and for patients to have the confidence in what their clinician was saying to them. I think we have moved on now. We have a body of clinicians in most primary care areas that want to take on this agenda. It is absolutely appropriate to move some of the bureaucracy away from this and have a governance structure that fits with the larger commissioning planning requirements but leaves the local focus for groups of general practitioners and other primary care practitioners to develop. I think they are ready to do that.

Q40 Charlotte Atkins: I think we are turning back the clock.

Mr McIvor: What is new in what we are doing now is practice-based commissioning. That is probably the bit that allows us to go to that much larger level if we get that right and allow a much more local ownership, local accountability and local responsibility around groups of perhaps 30,000 to 40,000 population, which, after all, is half the size of some of the current PCTs.

Q41 Dr Naysmith: If this is a change that is going to take place partly because we have this situation where some people at least believe that PCTs have not been doing a particularly good job in some areas or in some places, helping practice-based commissioners to do the job is something that PCTs are going to have to do. What makes you think that you will be able to do that any better than you have done as PCTs commissioning directly?

Mr McIvor: You have quite rightly referred to "some PCTs". I think a large number of PCTs have done a very good job. What has changed is the context we are now operating within, which means there is need for a change now. I could show you that we have done a good job in our part of the world in both GP engagement, nursing engagement, clinician engagement and giving them greater responsibility now through practice-based commissioning. It is something about which they are saying, “Yes, we want to explore and try that as well because it will allow us to do better for our patients and that is what we are here for”. I think there is the experience. The question, though, is about where it has not worked well and what would give you the confidence. Then we come to what is the future role of the strategic health authority and how are they going to performance manage the PCTs that are not doing well?

Ms Jeffrey: Dr Naysmith, you are absolutely right that one of the first problems is persuading practices that practice-based commissioning is something that they ought to be involved in and that will give benefit to their patients. That is step one. That is the role of the PCT as well. It is by no means universally the case that all practices want to do this. Particularly for single-handed practices, it presents significant challenges where they are going to have to operate in groups. Therefore, you need a PCT to bring that together and make it happen to enable them to do it.

Q42 Dr Naysmith: Looking at the history of all this a bit, when primary care groups were first set up, they were pilots for all this. They were going along at their own pace. Some groups were doing this and some doing that. Then, all of a sudden, the Department decided that everyone had to move into primary care trusts. That strikes me as one of the big mistakes that happened because we were going to develop many kinds of things we are starting to develop now and that is what this is all about. Since I have the floor I want to ask a quite different question. We are going to reduce the number of managers in the National Health Service by quite a large amount. As Gill Morgan says, even if the majority of places do not change; there is still going to be quite a big reduction. At the same time, we are reducing management skills in the National Health Service by 40%, in Richmond House or at national level. I am not somebody who believes that
managers are a waste of money and time. I think they are absolutely essential so that we get good management in the National Health Service. How are we going to be able to deliver this when we are losing lots of good managers? Have we got jobs for them elsewhere?

Dame Gill Morgan: I think there will be some real loss of management. If you had to look and define the management cohort in the NHS, we did expand very rapidly with the number of organisations. To expand, you not only need chief executives but you need directors of finance and various other things. We spread the management skills and capacity we had very thinly, without a doubt. That is not a criticism of any one individual.

Q43 Dr Naysmith: You are suggesting some PCTs were badly managed then?

Dame Gill Morgan: No, I am suggesting that some PCTs had very little management capacity, which is fundamentally different. You might have had someone quite inexperienced. This gives us an opportunity to retrench and to make sure that the best managers are there and can begin to answer some of your earlier questions about how you develop these different structures. We did spread the management capacity very thinly, and large numbers of PCTs did not and were not able to appoint to their posts until fairly late on in the process. It has been a very difficult and challenging time for PCTs to retain and appoint managers of the calibre they would like. That would be an overall conclusion. We did spread ourselves too thinly. That is no criticism of any one manager or any one organisation; it is collective.

Q44 Dr Naysmith: So you are quite confident that we will have the management capacity at this reorganisation?

Ms Millington: I think you are right and that it is a risk. What you are capturing here is a snapshot of major change in the NHS. It is a huge change and it is a huge organisation, as you know. To cut the number of managers in particular—and managers do need administrators as well—at a time of major change is a risky thing to do. I think, as far as keeping good people is concerned, there is a lot of churn; people change jobs a lot and come in and out of the system. With a bit of luck and a bit of management, we will manage to retain the good people, not necessarily where they are at the moment but they will pop up elsewhere in the system. It is something to be aware of. It always distresses me, coming from outside the NHS, that the NHS is under-managed rather than over-managed. Proportionately in percentage terms I think the Audit Commission has twice put in reports saying the NHS is seriously under-managed at under 4% of the total staff. It is a risk that needs to be recognised. I think it can be managed but it is part of the business continuity which is really important.

Q45 Anne Milton: May I challenge this business about how long it will be before the new organisations get up and running? I cannot accept that we will just move on because what nobody has talked about is the staff. If you are going to cut eight PCTs down to one, at this moment and for the last six months, the staff have been more concerned, rightly so, about how they are going to pay the bills after the reconfiguration takes place. They are concerned about their jobs. The one thing that creates a huge loss of function and focus is people worrying where they are going to be working because they do not know. For as long as that uncertainty is there, and so certainly for the whole of this year and certainly for the next six to nine months or maybe even a year, there will be loss of function and loss of focus by the staff because they have something else to think about and that is what job they will be working in and where that will be.

Dame Gill Morgan: What you have to remember is that if you look at the people who work in primary care trusts, the vast majority of staff are working on the provision side, not the commissioning side. Commissioning is already the smallest component of most PCTs. We are now clear that provision will stay with PCTs. There is some reassurance, therefore, for the vast majority of staff working in PCTs that the provision will remain in the PCT. You are talking about the people involved in the commissioning function who need to have these new relationships. That is why having a proper system of continuity plan can help. I am not saying that in no part of the country will it all be dropped, because that would be overly brave, but I think that in the majority of strategic health authority areas there are very strong plans being developed about how to manage the interim around the commissioning function. Sometimes, because of the sheer numbers of staff, people believe that most people in PCTs are doing commissioning. Actually, most people are doing provisioning and there is no change for them.

Anne Milton: At this stage, unless you can say to staff, “I guarantee you will have a job in this town”, they are going to be worried. Until that uncertainty goes, services will suffer.

Q46 Chairman: I think that is pretty obvious, by and large, in this whole process and the submissions we have had from various organisations and representatives of staff. May I ask about this issue? Dianne Jeffrey, you spoke about the consultation process you had in Derbyshire. You did not mention patients or patients’ organisations in that consultation. Was there any?

Ms Jeffrey: This is not the major consultation. Once the submissions have been received by the Department, the strategic health authorities will arrange a full 90-day consultation for everybody who is involved with health care delivery and in receipt of health care.

Q47 Chairman: Including MPs?

Ms Jeffrey: Yes.

Q48 Chairman: You included MPs in the first one but not patients.
Anne Milton: Exactly. What I was talking about was the pre-submission engagement. It is not really a consultation. We had very little time but we did the very best we could to engage with those people locally who could give us the best of their opinions about what was being proposed. In our case, we did manage to consult with patients. We have an older people’s congress in Derbyshire.

Ms Jeffrey: We did actually because one of the proposals was for three organisations. You will understand that there are North Derbyshire, South Derbyshire and Derby City. We felt that because we had worked so well together in North Derbyshire across a really disparate area of the country with urban and rural areas, then why could we not work equally well together across the whole of Derbyshire, which had the same sort of patchwork and tapestry of differences? The more we took out of the overhead, the more there would be to channel into front-line services for patients, in particular palliative care and cancer care.

Q49 Charlotte Atkins: Did you change your views as a result of that pre-consultation?
Ms Jeffrey: Absolutely. One of the things the Confederation believes very strongly is that you do not get good governance unless you have strong corporate boards. Strong corporate boards means having good chairs, good non-executives and engaged executives. That is one of our passions. We argue all the time that you will not get good governance unless you build up and strengthen the chairs and the non-executives. We are on record as having said that if you look over the last few years, one of the things that has been weakened because of there being lots of small PCTs is the strength of the corporate board. One of the things that we will push for very hard is proper corporate board development of the new PCTs so that boards can be properly held to account and begin to deal with this issue of locality and what is shared and do the things that a good board does.

Q50 Chairman: Does anyone else have anything to say on the issue of patients’ consultation?
Mr de Braux: I could leave you a list of all the people we spoke to in this pre-consultation phase, including patients’ forums and the process we went through. I am happy to leave that. You did ask about whether we changed our views. We had a public board meeting, a three-hour discussion, and, by the end of that, the board came to the conclusion that one of its recommendations would change because of the representations.

Ms Millington: Perhaps I can speak for London because I chaired the steering group of the five London SHAs? We collectively engaged, rather than consulted, with the list that has been gone through already and with patient forums and patients’ organisations. We originally came up with two options for the London PCTs. We have recently revised that and said we should have one option, which is the status quo. In fact, it is 32 rather than the current 31 PCTs, just to go against the grain there. Yes, there has been a lot of discussion. I think it is easier, frankly, in the cities than it is in the country. It is much easier to get people together. People worked very hard in the time allowed to get as many voices heard and listened to as possible.

Ms Jeffrey: I did not say that they were not that good. Ms Jeffrey: I did not say that they were not that good.

Q51 Anne Milton: Can I ask whether you feel that non-executives and PCT chairs add value to the PCTs currently?
Dame Gill Morgan: Absolutely. One of the things that the Confederation believes very strongly is that you do not get good governance unless you have strong corporate boards. Strong corporate boards means good chairs, good non-executives and engaged executives. That is one of our passions. We argue all the time that you will not get good governance unless you build up and strengthen the chairs and the non-executives. We are on record as having said that if you look over the last few years, one of the things that has been weakened because of there being lots of small PCTs is the strength of the corporate board. One of the things that we will push for very hard is proper corporate board development of the new PCTs so that boards can be properly held to account and begin to deal with this issue of locality and what is shared and do the things that a good board does.

Q52 Anne Milton: Do you feel that the current non-execs of PCTs have not been effective?
Dame Gill Morgan: I think we have had a very managed system which has actually made it more difficult with a whole series of central imperatives that have had to be delivered, it has left less space for local organisations than in the past.

Q53 Anne Milton: Are you emasculated?
Dame Gill Morgan: Yes, but I think we are in a time of transition though, which has been going on for the last year, although there is a recognition that you cannot drive a system like the NHS from the top and you have to begin to put the power back where it needs to be, closer to patients, and that is beginning to happen. We have seen a reduction in the amount of central reporting and the amount of bureaucracy, it is beginning to dribble through and I think this set of changes will see the corporate board become important and powerful again.

Anne Milton: But if we are going to have mergers, maybe eight down to one, we are going to have less non-execs in the system.

Q54 Mike Penning: There will be less accountability.
Ms Jeffrey: Maybe there will be fewer but maybe they will be of better quality.

Q55 Anne Milton: Just correct me if I am wrong—and I would be interested to hear others’ views—you feel that they did not have enough power, the system was too centrally controlled which did not allow them any room to breathe and you do not think that they were that good.

Ms Jeffrey: I did not say that they were not that good.

Q56 Anne Milton: You said maybe they will be better.
Ms Jeffrey: I think it has been difficult to find enough people to put on the number of boards that we have had, with the experience, the skills and the expertise that we need. After all, we are bringing people in from outside in an advisory capacity and in a non-executive capacity to these boards which have control of significant amounts of expenditure, and that expenditure control is very, very difficult for PCTs because most of the money is spent by other people. Having influence and control over that is extremely difficult.

Mr McIvor: I have a board which oversees the expenditure of £310 million each year; my non-execs hold me to account, they scrutinise what I do and I feel that they also bring me a view of what the local population says, but the most important role they
have is that role of governance of expenditure of that public money. I think they do it exceedingly well, and I have a very good chair and board.

Q57 Anne Milton: But there are going to be less of them in some ways.

Mr McIvor: In the bigger PCTs the board will have the same role.

Q58 Anne Milton: But there will be less of them if we are going to merge PCTs and their non-execs down to one.

Mr McIvor: But they are still going to oversee the expenditure, the governance and the way it operates and they will still have that overseeing role. There will be less of them for the local opinion which they bring in, which is one of their roles, but their overseeing of expenditure and of the use of that money will be exactly the same.

Q59 Anne Milton: There will be less of a local voice, you would concede that.

Mr McIvor: Yes.

Mr de Braux: There might be fewer non-executives, but they will still be in the majority of every board, so they will still have the authority over boards that they have today.

Q60 Anne Milton: But there will be one instead of eight.

Mr de Braux: The other point I was going to make about the quality, Gill made the point that when we expanded PCTs we did struggle to find people to fill all of the executive posts, and we recognise that there has been a lot of development. Exactly the same applies to the huge expansion in a short time to find people who can come with all the necessary skills, which is why we run the programmes we do to develop the skills of non-executives. The NHS is much better for having very good and very well-developed and trained non-executive directors.

Q61 Anne Milton: My concern is that in doing that some of them go native and actually lose their local links. That local voice is quite important.

Ms Millington: One of the things that has changed since PCTs were first set up is that there have been other developments elsewhere—scrutiny committees have been set up, for example. The accountability is not just through the broad structure of the NHS itself, it is through local government, it is through national government as well. When my non-exec colleagues and I are good we are very, very good, and when we are bad we are horrid, so there is not a simple answer that they are all good or they are all bad, of course not, they are just silly people like the rest of us. Equally, I do not think numbers necessarily make for better governance: if you doubled the number of MPs in the House of Commons I am not convinced that the country would be a better place. What is changing is the understanding that to get the local input you do not necessarily do it by those representatives on the board, there are other ways and arguably better ways of doing it. You work very closely with your local government colleagues, you work very closely with the voluntary sector, you work very closely with the patient and public organisations and voluntary organisations, and I think that is a better way of doing it. The proper use of non-executives is that you get that slight detachment which allows them to query the executive about how policy is being carried out. They can bring their particular skills to articulate and then define that policy, and they share the full accountability and responsibility. It is a remarkable thing that you get so many people who are prepared to do this badly paid and remarkably thankless job, but thank heavens we do because they are very passionate about the NHS.

Chairman: Can we move on now because we are running out of time, unfortunately. We have just two questions that we would like to finish off on; Paul is going to take the first one.

Q62 Mr Burstow: I will try and encapsulate ten questions in one breath, if possible. It really boils down to an issue of clarity, and I was very interested in what Dame Gill was saying earlier on about PCTs now retaining their provider functions, because that is a much clearer and more explicit version of the statements that have been made and have changed over the last few months. We had Nigel Crisp’s letter which was very clear about the direction of travel, which was that PCTs would be minimum providers of service, we then had the qualifications that it did not have to be until December 2008 and then we had the Secretary of State coming on and saying some soothing words in September, but still say basically that PCTs would not be in the business of providing. We then had the written statement on 18 October and then we had oral questions last week, and at each stage the clarity seems to have gone down rather than becoming clearer. I want to ask two things: one, do you feel that the officials in the Department, in terms of what they are saying from the very top of the organisation, and the political leadership of the Department are on the same hymn sheet and are saying the same things; two, do you really think that the direction of travel is still as it was in Nigel Crisp’s letter, or is it now something else? Where are we in fact in terms of service provision? Are we really just going to have commissioning organisations by December 2008 or are we going to have something that is a bit more of a hybrid, varying from one part of the country as well as varying in terms of whether or not you have commissioning functions or provider functions?

Dame Gill Morgan: That does span 16 questions in one. Do you want to start?

Mr de Braux: It is unclear where the future will be. This proposal is fundamentally about strengthening commissioning and that is what everybody has focused on. One of the realities, I think, is that if you spend 80% of your time and concerns worrying about the provision of services, then you do not have the energies to put into commissioning, and what we know in primary care trusts is that most of the staff are involved in providing services, so there is a real desire to make sure that these new organisations focus on commissioning. There are other examples
in the public sector where organisations have a focus on commissioning but still carry out some provision—local authorities are a very good example of this—and I thought the statement about “unless and until PCTs decide otherwise their provision will stay” is pretty clear actually. There will always be cases where provision rightly remains—

Q63 Mr Burstow: That is very important, that is the new phrase, “unless and/or until”—depending on who actually utters the sentence, but it is along that line. The “until” is the bit that is interesting because there is always a caveat by reference to the White Paper and what the White Paper says, therefore, is absolutely critical as to whether that “until” becomes when. I just want to understand what you think the relationship between that statement about “unless and until” and the White Paper actually is going to be.

Mr de Braux: I do think that the White Paper, which we have not seen yet, will come out with things that we have not considered. I was in Birmingham on Saturday, with the Listening event there, and it is quite clear that when you address a much wider body of people as they did, different ideas come up than perhaps people have been thinking about for many years, and that is going to be very interesting. But I stick to the point that there will always be some services for which I believe PCTs will say there is no alternative provider, much as we have tried to find an alternative provider it will not be safe to do so, or nobody is interested in providing that bit of the market or whatever, and I think it will stay with PCTs.

Q64 Mr Burstow: How long should these new organisations, once they are set up, be given to demonstrate whether they have succeeded or failed?

Mr de Braux: I think what we have to do is demonstrate that they are commissioning effectively, and where the challenge will come from strategic health authorities to them is if they are not commissioning as well as they might be and a lot of their energies are going into providing services, then we will be asking them to—

Q65 Mr Burstow: One year, two years, three years?

Dame Gill Morgan: If you were looking at a change of this scale in industry you would be saying you have to give a minimum of three years run to begin to see the benefits. The NHS is very good at dealing with change. That three years run to see the benefits, that does not mean you drop the ball in the meantime, those are two different philosophies, because this is meant to be about improving things for patients, not just doing as we are, so to be seeing the benefits systematically, you would give it three years in industry.

Q66 Mike Penning: We should be seeing the benefits of PCT restructuring about now.

Dame Gill Morgan: From the last restructuring, yes, and we have seen some of the benefits and some of the difficulties.

Mike Penning: We have not had a chance to even see the benefits yet.

Chairman: The last one then is Richard.

Q67 Dr Taylor: It really bothers me when you say it takes three years for changes to take place, because how many changes have we had in the last three years?

Dame Gill Morgan: If you were sitting in industry and you were making a change of this scale—this is such as ICI and British Airways—they look to see the real benefits coming in and clicking in after about three years.

Q68 Dr Taylor: You think you can do it quicker.

Dame Gill Morgan: If you are in industry and you produce a change, you have a graph which says performance dips and then it picks up again, and then you get the gains. What the NHS has become very good at doing is actually not having the dip. We tend to make the change, keep the thing flat rather than dipping—we cannot afford dipping in performance because that is affecting patients—and then the improvement comes in after three years again. The NHS is actually quite unique in terms of how good it is at managing the change without a dip in performance.

Q69 Dr Taylor: Contestability is the buzz-word; how does that apply to community services? John said that there sometimes would not be alternative providers.

Dame Gill Morgan: Yes.

Q70 Dr Taylor: How are you going to make sure there is contestability in community services without splitting up what already exists?

Dame Gill Morgan: It is going to be different on service for service, but let me give you an example of what I would be thinking about and doing in a PCT. I would be looking at which of services that I provide are not delivering the level and the quality of care that is being delivered in other places, so I would be benchmarking my services, I would be identifying who was best in class. For example, one set of issues at the moment, which you as a committee have actually looked at, is sexual health services. We know that in many parts of the country sexual health services are not up to scratch; in those areas I would be talking to people like the Terence Higgins Trust which we know has a fantastic sexual health integrated service, which is already running in a number of PCT areas, and I would be finding out whether, one, I could steal their best ideas; two, whether they actually would want to come and provide the service at the local level; and, three, how do I get the services in my patch up to the best in the country? That is contestability; at the end of the day it does not necessarily mean that you take the service away from a local provider, but it does mean you really know how you are doing and you aspire to be the best you possibly can, because at the end of the day you have got to be the best because you are serving the patients.
Q71 Dr Taylor: I accept that with the Terence Higgins Trust, but really coming down to the more bread-and-butter things, the general practice staff and the community nursing staff who work together—

Dame Gill Morgan: My personal view—and this is a personal view—is that a number of the issues around employment law and TUPE makes it highly unlikely in my working lifetime that you will see large numbers of these staff working for private or other independent organisations, I just do not believe that is a possibility. I think that what you are much more likely to see is the type of approach that I am talking about, which is that you will find organisations identifying where they are strong and where they are weak and looking for ways of improving the services where they are weak.

Q72 Dr Taylor: As a generalisation, where general practice staff and community nursing staff are working well together, it is unlikely we will see a change.

Dame Gill Morgan: If something is working well, why would we want to go and bust it?

Q73 Dr Taylor: This is the terrible impression that we get, that very often when things are working well this is exactly what the Government does want to do.

Dame Gill Morgan: Dr Taylor, you are talking about us now.

Ms Jeffrey: This goes back to what Mr Burstow was saying: you are absolutely right, it would have been much more helpful had we had the correct story from the beginning, and it has been very difficult to work through the changes, the reversals, the tweaks and the amendments. Take, for example, Derbyshire: would we have gone for one Derbyshire organisation had we known that that would have been a providing as well as a commissioning organisation? I cannot answer that, but you are quite right, it has made it very difficult.

Q74 Mr Burstow: This inquiry is about establishing whether the system currently is broken. I do not actually think, from the evidence we have heard today, chairman, that there really is an argument that the system is broken, there are bits of it that are defective is what you have been telling us.

Dame Gill Morgan: I think, if I may say so, it is not whether it is broken, it is whether it could be better. I do not think any of us would argue that it is broken because we all believe there have been huge benefits from the last restructure, but could we do things better, could we provide better patient services, could we provide services that actually meet public needs in an improved way? Yes, I think we could.

Q75 Dr Naysmith: Looking at the Derbyshire thing that has just been said, you said there is only one, but that is a proposal which is now going out to consultation which can be changed.

Ms Jeffrey: Absolutely.

Q76 Dr Naysmith: If, in the light of changes, you think there is something better then maybe you will have to do that.

Ms Jeffrey: Absolutely, but maybe there will be further changes to policy in the future which we have not even thought of yet. Going back to what Dr Taylor said and John de Braux’s answer, I think it would be very sad if PCTs ended up as providers of last resort; in other words, we only provided that rump of services that nobody else, that the housing associations, that the private sector, that the voluntary sector, that the community sector did not want to provide. That would not be the best outcome for patients and I for one will try hard to see that that does not happen.

Mike Penning: But that is where we are going.

Mr Campbell: That is what people fear the most.

Q77 Chairman: At the very opening of this session we had a number of examples from yourselves collectively about how this current structure has been responding to commissioning and to providing services inside the community as it were, and how you have gone across PCTs on occasions when there is need to commission at a wider level as well. Are we to assume that you thought that was happening anyway and really what we have here in terms of this reconfiguration is something that in a sense could potentially disturb that or not?

Dame Gill Morgan: Like anything which develops in an organic way, it is patchy. One of the issues is about how do you spread the learning, so although I talked about sharing there are other communities that have not shared very effectively, so this is an opportunity to make the learning from the places that have been sharing both management structures and also commissioning functions more widespread and more available. It is a different type of question really.

Chairman: Could I thank you all for coming along and I am sorry about the overrun.
Witness: Dr Helen Groom, GP, member of PEC, Oxford City PCT, examined.

Q78 Chairman: Good morning, Dr Groom, I am sorry for the overrun this morning. You have probably been more involved in this debate than we have for the last hour and a half, and really we would like the benefit of your overview on many of the things you have heard here, certainly how it has impacted in Thames Valley and what your views are on the current Thames Valley proposals.

Dr Groom: I think it is quite important that we deal with why Oxfordshire is actually different from what is happening in the rest of the country. It was interesting, listening to my colleagues before talking about the changes; I think we are turning the clock back slightly and in terms of the PCT reconfiguration we are looking back towards the size that the old health authorities used to be at, and I think there are some reasons why you might want to go to that level. Certainly in Oxfordshire we have struggled as PCTs to actually have the discussions with our secondary care and tertiary care providers in terms of the Oxford Radcliffe and the Nuffield Orthopaedic Hospital, and there is that power struggle that Dr Stoate was referring to. There are real tensions there and there are reasons why it might be better to work as one group, which increasingly, as was said, we have been doing. So although there have been a lot of discussions about losing the local focus, I think there is broad agreement in Oxfordshire that one PCT may work. We are turning the clock back because there was a lot of discussion about practice-based commissioning and over the last few years we have lost a lot of the clinical engagement—in some areas, not in all—of practitioners on the ground—the GPs, the community nurses, the pharmacists, the therapists—directly in commissioning, and I do think we need to go back to where doctors talked to doctors, the therapist talked to the therapists in primary, secondary and tertiary care, the people doing the work actually talked to each other about the services they are providing. In that way we are turning the clock back. What is very different in Oxfordshire is that we suddenly had the announcement, whilst we were having all of those debates and discussions about how we might make it work, and in the paper that went to Thames Valley Strategic Health Authority there were two lines that said that our strategic health authority wished to tender out the management and leadership services for the future single Oxfordshire PCT and that they would wish to invite bids from NHS bodies, the voluntary sector and private sector companies. It has been made very clear that whilst in Oxfordshire and certainly in Oxford City we are a three star primary care trust in terms of QOF points across Oxfordshire, we are top of the league and you would think that that would indicate we are providing good quality service across primary care, we have been told that we are very poor performers in terms of commissioning, in particular because of our £35 million deficit, and that is why it is extremely important that these changes happen and that, in particular, we have the best possible management for the future PCT. I do not disagree with that, I think it is really important that we have the best management and leadership for the PCT, but what it is very important that we question is whether we should be tendering out to a private sector company to take on the commissioning of services for Oxfordshire. We are saying that a private sector company would actually come and hold the purse strings for the £600 million of money that is spent on healthcare services in Oxfordshire, and whilst I think we can debate whether private sector involvement in the way we run our buildings might be appropriate, and private sector involvement in the provision of hip operations, cataracts, of MRI scans may be appropriate, this is a much, much bigger step that has actually been taken with no discussion and no consultation. The senior managers knew about this on the Friday before the paper went to the strategic health authority on the Wednesday, staff knew about it on the Tuesday before the paper went to the strategic health authority on the Wednesday. Our strategic health authority are very clear that they do not need to consult on this—they need to consult on the PCT mergers but in terms of the tendering-out process, this is not a service change and therefore they do not intend to consult on this. We feel that we need to be questioning whether this is an appropriate way within a national health service, is this an appropriate direction of travel? If the agreement is that it might be, we at least should be consulting on this proposal and have much, much wider discussion with patients, the public, MPs and staff about whether this is actually something that is going to really move us forward. My mouth was open when Gill was saying that she could not see it in her lifetime, in Oxfordshire the PCT senior management are going to be in the private sector. The private companies that are interested are not just interested in the commissioning—that is where they want to move into—they are providers. Until the PCT decides that we are actually going to move provision into the private sector I think there is quite a large conflict of interest there. I could go on.

Dr Naysmith: Could I ask a question here?

Chairman: Yes, go on.

Q79 Dr Naysmith: Where do you think the idea comes from?

Dr Groom: I think it is part of a direction of travel that the NHS has been set on. It is interesting, again when my previous colleagues were saying that things will not fall down: they will not because the NHS is so used to constant change that actually clinicians on the ground and the vast majority of managers who work in it are determined and committed as public servants to making sure that things continue to happen for patient benefit.

Q80 Dr Naysmith: What I am really asking is why Oxfordshire?
Dr Groom: Why Oxfordshire? I upset my colleagues sometimes when I say this, but I think it is because we have a complex secondary and tertiary care provider. We have a world-renowned teaching hospital that does lots of research, and in commissioning terms they have been the most difficult people to engage in a discussion about what we need to provide based on health needs. In Oxfordshire, though, we are quite a simple geographical area. The other major teaching hospitals are within the major metropolitan areas such as London, Manchester, for example. In Oxfordshire we are one shire so we can have one PCT, we will have a major provider and I also think we are an area where we do not have any major Labour councils, we do not have a huge number of Labour MPs and in terms of an ethos it might be an area where, in terms of public perception and certainly in terms of their ability to accept more private sector involvement and to actually use the private sector, it was felt that it might be more acceptable than in other areas.

Q81 Dr Naysmith: I am trying to get at who is feeling this, “it was felt that”—who is doing the feeling?
Dr Groom: Again, I am a member of the professional executive committee, I am here in a personal capacity but involved with a group that has been concerned about the changes and the privatisation that has been happening through the service over the last eight to nine years, and the cumulative effect of all of the changes that we have been through since this Government came to power.

Q82 Dr Naysmith: You are not really answering my question, which is where is the idea being pushed? Who is pushing the idea?
Dr Groom: Who is pushing it? Do you want my answer to that?

Q83 Dr Naysmith: Yes, that is why I am asking.
Dr Groom: I think Number 10. United Health have been very clear that they are extremely interested and feel that they would wish to bid for this tender, and the chief executive of United Health is Simon Stevens.

Q84 Mr Campbell: Do you think they want to make money?
Dr Groom: They are a private company, of course they want to make money.

Q85 Mr Campbell: Lots of money.
Dr Groom: The average return for most private sector companies is 10%. They might say to begin with that they do not want that—£600 million, that is £60 million and we are already being asked to take £35 million out of the health economy. £100 million gone, what is that going to do to services in Oxfordshire?

Q86 Anne Milton: Can I congratulate you for actually coming in a personal capacity and putting your head above the parapet. Good for you. My mouth also fell open because I have met a private healthcare provider who would say exactly the same, that the messages from the Government are very strong and this is why it will go ahead, so I may be not as surprised as many people would be that Oxfordshire are thinking of doing this.

Dr Groom: It is the strategic health authority that is thinking of doing it.

Q87 Dr Taylor: May I pick up two points from your submission. First, the purchaser/provider split was shown after its introduction in the early 1990s to have doubled administrative costs. Do you see any way that the mergers that are being considered at the moment are going to save money?
Dr Groom: When the PCTs were first set up, each one of them tried to work on commissioning and, as was made very clear earlier on, PCTs are already working together as teams to work with the major providers, and I think from that point of view there will be economies of scale. The major problem is around payment by results and the increase in plurality of providers means that there will inevitably be a big increase in the amount of transaction costs.

Q88 Dr Taylor: Secondly, a reduction in the number of PCTs from five to one in Oxfordshire will lead to a diminution in local knowledge and it also, you say, will reduce the frequency and ease of direct contact between primary care staff and the hospital staff. Can you elaborate on that, because the purchaser/provider split drove a huge wedge between primary and secondary care, and you are saying this is going to make that even worse?
Dr Groom: You need to take the sentence after that which then comes back to commissioning, because I think commissioning is actually different from purchasing. Within each of the PCTs in Oxfordshire there have been some very good examples where clinicians from primary and secondary care have managed to get together, but they have been infrequent and sporadic. The worry in terms of five into one is all the worries that were expressed earlier on in terms of there will be less non-execs and there will be less clinicians who are actually involved in the PCT. Practice-based commissioning is what we will have to make work if we are going to have larger PCTs. We need to ensure that practice-based commissioning takes off so that you can ensure that you do not have the diminution in contact between GPs, consultants and therapists across the primary and secondary care divide. I think that is very important; that is what will achieve the change.

Q89 Dr Taylor: If it was possible would you agree that professional executive committees ought to remain, even though there are more of those than the PCTs?
**Dr Groom:** I think that professional involvement in the PCT should remain, although obviously if we are run by a private sector company we have no idea what the actual structure of the PCT will be.

**Q90 Mr Burstow:** I am very interested in this issue of accountability. We asked Sir Nigel Crisp about this last week and he said, of course, that they are not outsourcing the governance arrangements, they are just creating an outsourced commissioning function. That though begs some questions about the issue of commercial confidentiality which, certainly in my experience through asking questions here, is often an obstacle to obtaining information about performance of those organisations that are now providing services under contract to the NHS. Many of the performance indicators and measures that are collected by those contracts are not available under the grounds of commercial confidentiality; has that been discussed in any way in Oxfordshire in terms of how an outsourced commissioner could be scrutinised both by the public, elected members and by those involved in the governance arrangements for commissioning?

**Dr Groom:** I know that that has been of great concern to the chairs of current PCTs and to the non-exec members on the boards, and they have been pursuing discussions with our strategic health authority over what those governance arrangements will mean. I think one of the things that has really worried them is that there will still be consultation on five to one, so in terms of the board actually being set up, that cannot happen until at least March/April next year. The advertisement for the tender goes into the European Journal this month. We do not understand how there can be public board involvement in the setting up of the contracts that people will be tendering for, we are not clear about who is involved in those discussions and, in particular, who will be the non-execs who will be involved in that. We are not clear who it is who will be writing those contracts that they will be tendering for and we are also not entirely sure who will be on the selection panel for who actually wins those tenders because it will not be the board of the future PCT because they will not be there.

**Q91 Mr Burstow:** We would have liked to have asked Nicholas Relf, the chief executive of the SHA those questions, but unfortunately he declined our invitation, and it is a great pity that we are not having the chance today to ask him those questions.

**Dr Groom:** It is interesting you say about putting my head above the parapet, I went to the strategic health authority meeting at which this was discussed and it was true they discussed the paper for 45 minutes, there was one question from their non-execs on this proposal and that was to say, as a point of clarification, was this process going to be as well as the standard NHS recruitment procedure and it was made very clear that obviously it was not. That was the only discussion that was held at the strategic health authority, there was no public involvement. I have to say that that is why people like me, and there are many others, are prepared to put their heads above the parapet.

**Q92 Chairman:** Could I just add to what you have been told, Dr Groom? I have the letter that declines his attendance here today, although we did request him to come along. It is our intention to hand this to the Minister and ask questions of this letter and its contents to the Minister when he comes to give evidence to the Committee next week. We will be pursuing many of the issues you have brought up in your short time here this morning, so if there is nothing urgently pressing from my colleagues I would like to thank you very much indeed for coming along this morning.

**Dr Groom:** Thank you.

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**Witnesses:** Dr Michael Dixon, Chair, NHS Alliance, Mr Robert Sloane, NHS Alliance, Dr Peter Reader, NHS Alliance, Yvonne Sawbridge, NHS Alliance, Dr Tony Stanton, Joint Chief Executive, Londonwide Local Medical Committees, Lucy Marks, Tower Hamlets PCT, PEC Chair, examined.

**Q93 Chairman:** Good morning—it is nearly good afternoon, I am afraid, and I do apologise for that. Most of you have been in the room for all of this morning and you will have seen the areas that were covered. I wonder if first of all I could just ask you to introduce yourselves to the Committee for the record.

**Dr Dixon:** I am Michael Dixon, I am a working GP but I am also a practice-based commissioner, a local lead commissioner and chair of NHS Alliance, and I can speak for NHS Alliance. I felt it was appropriate to bring three experts, if you like, who this morning will be speaking for three of our networks: Dr Peter Reader, who is a GP as well, who leads our PEC chair network, so he can speak for PEC chairs in PCTs; Yvonne Sawbridge who leads our nurses network, who is going to speak for nurses and also for allied and other professionals, having discussed it with other leads in that group; and Robert Sloan who is a previous chief executive, has been acting chief executive for several PCTs and leads our national leadership network, so he is speaking for chairs, chief execs and leaders in the primary care trusts. I felt it was important that they should come along—although they will not be representing official Alliance policy—so that you can find out what their various constituencies are saying.

**Dr Stanton:** Chairman, I am Tony Stanton, an ex-GP—I used to be a proper doctor, as my mother
would say—and I awarded myself the wonderful title of joint chief executive of Londonwide Local Medical Committees which represents GPs in London from the west in Mr Burstow’s constituency, to the east in Dr Stoate’s constituency.

**Ms Marks:** I am Lucy Marks, I am a clinical psychologist, PEC chair in Tower Hamlets and I am a member of the Confederation.

**Q94 Chairman:** Thank you very much. I do not think we want to try and attempt to go through the last session in as much as we got pulled in all sorts of ways with every question, but given that you all sat through it, could I ask for your views around the last session. Maybe we could start with organisational change as a strap line and ask your views about that and any interaction you may have with what was said in the last session, either by witnesses or actually by members of the Committee.

**Dr Dixon:** Shall I start off because there are issues around why the changes are necessary, the outcome in terms of current plans for reconfiguration and the process by which those plans were made. Why the change? Alliance would agree that there is a need for change because not all primary care trusts are uniformly good, and there are three particular problems: there are some which are weak commissioners, some which did not engage fully with their local professionals and some which did not have the clout to be strong commissioners of their local acute trusts. Reconfiguration would seem to be the solution for that, and in terms of the general direction Alliance is happy with the direction but we are unhappy with some of the implementation. In terms of the actual process, certainly we feel that there has not been great consultation, we have heard there was very little time, but certainly 40% of our PEC chairs said they were not consulted by the strategic health authorities at all. As far as frontline clinicians are concerned I think they felt very disempowered and not engaged at all, it has just gone on above their heads, which I think is not a good start in trying to get practice-based commissioning, patient involvement and the like occurring. In terms of outcomes, I do think this map looks a little bit depressing because it is just a map of England with the counties and the unitary authorities marked on it. I am not sure how much work has gone into producing this, but anyone could have produced it on 29 August or whenever without great effort, which means that there has not been a great deal of sensitivity towards local culture and local history. It also means that the focus has been on co-terminosity with the local authorities and not on what I consider to be the far greater and more pressing problem in the NHS at the moment, which is a proper commissioner/provider relationship between primary and secondary care. That is something that I hope will be taken seriously in considering the submissions. The other issue is about how we relate local people and clinicians; we have raised it already and it is an issue, I quite agree. The other issue, when we have these merging PCTs, some with large budgetary deficits and some which have not, is how we continue to engage our local clinicians who are trying to go into practice-based commissioning but who may find themselves suddenly with budgets that are rapidly changing. Those are the issues and I think there is a solution. As always the frontline can find a solution to any change. The solution is going to be about creating very strong localities, making sure that practice-based commissioning works from bottom up, making sure that localities bring those practice-based commissioners together and that we also make sure that the PCTs are listening to the frontline and not vice versa, which has sometimes been the case previously.

**Q95 Chairman:** Has anybody got anything to add to that?

**Mr Sloane:** There was an earlier reference to the evolution of primary care organisations in this country, and reference was made to the establishment of primary care groups in 1999. That was a process that was quite unique in the history of the NHS because it required the organisation to identify what were then termed natural communities, and natural communities were known to the people who lived there, whether that was in Bristol, Birmingham or anywhere else beginning with B. It was actually a process of identifying where people lived, where people worked, where people related and where people felt they belonged. We managed to carry some of that sense of localness through into the evolution that constituted primary care trusts and, really to follow on Dr Dixon’s line, that process of organisational change was tracked in some work that we did with Birmingham HSRC (Health Services Management Centre) in April of this year, and what was becoming very clear at that stage was that PCTs were looking at their three-fold functions of improving health, commissioning services and providing primary and community care. The range of models that was emerging was hugely diverse, it ranged from the single unitary, compliant structure like Southampon City through to the association model of Greater Manchester, but I suppose the two characteristics that distinguished that work were essentially about principles of subsidiarity, how can services best be organised locally, and only when economies of scale or other functions that could not be accommodated locally were evident did the scaling-up then take place. The other aspect that characterised that change was essentially around having a core rationale that was clear to clinicians, managers and local organisations, whether they were voluntary groups, carers groups or church groups, and I think our contention would be rather along the lines of the previous speakers: that process had already taken root, it was already well-established, there was a median size of primary care trust which hovered around 175,000 people. The escalation of that process runs the risk of losing those core ingredients or core organisation changes, so it is not so much about whether it is the right thing to do, it is about the place and the now in which this change is being taken forward.
Q96 Dr Naysmith: I was the one in the previous session who raised the question of primary care groups. I was a great fan of them at the time and thought, you know, it was a pity we moved them up too quickly. The root question that arises from what you have just said and what I was arguing is what sort of level of engagement is there now with primary care trusts before we start talking of what it will be in the future, and maybe Ms Marks would be the one to answer, if you know all about PECs. To what extent does primary care contribute to the kinds of decisions that primary care trusts make at the moment, in the current situation?

Ms Marks: One of the differences between primary care groups and primary care trusts obviously is that it was the coming together of community services and GP practices, and I think that in principle the idea of having a PEC (a professional executive committee) which is multi-professional and which is also needing to work very closely with the management team of the primary care trust, has meant that new partnerships have developed and this puts us in quite a good position for redesigning services that we need to do in terms of commissioning in a different way, because I think what good commissioning is about is getting clinicians and managers involved, but essentially new services need to be clinically led. But they need to be clinically led in a partnership, so a partnership between multi-professional groups of clinicians as well as managers. We have to make sure that the changes that are coming on board now enable us to continue doing that and enable the PECs to work very closely with the local medical committees and all our GP colleagues as well as all the therapists and nurses to do that properly. Partnerships are the key here really; we do not want people to go off and do things in isolation. We also need to work with the local authority, so on our PEC we have a local authority member and we also have somebody from patients and public involvement. Those partnerships are essential.

Q97 Dr Naysmith: I know quite a few GPs in Bristol and many of them were interested when primary care groups started off, but I get the impression now that some of them are not nearly as interested in taking part as they were then. Is that unreasonable?

Dr Reader: I would like to come in on this because the view of the PECs is that we would actually welcome anything that strengthens commissioning—PEC chairs are very much there because they are driven, they want to commission an improved patient care—and I use the term “commissioning” carefully, rather than procurement, because there is a very big difference in here and the PEC chairs feel that this process is actually being driven by two things, co-terminosity—which does bring some benefits but is not a panacea—and also making management savings. There is a very strong feeling from the PEC community that that is driving an awful lot of the shape and form that is coming out, not the function. If one turns to what really makes commissioning work, I think we have accepted that there is an element around size of that and, as we have also discussed already, a lot of PCTs have been evolving organically to deliver that, and there is a lot within there which is about local relationships, local clinical leadership, trust and partnerships, which is actually what delivers real commissioning. You need those clinicians having that clinician to clinician conversation that can actually evolve and innovate and change a service as opposed to just shifting big blocks around.

Q98 Dr Naysmith: Do you think the proposals will be an improvement on the current situation, or is there the possibility that they will be an improvement?

Dr Reader: I think they will put a huge stall on the benefits that we are now just beginning to see. The thing has been quoted variably as 18 months to three years to organisations actually beginning to be effective: I have been hearing down the network and from talking to other PEC chairs that they are finally beginning to move forward in those agendas and the advent of practice-based commissioning is actually going to be a huge help with that. But even if we look at practice-based commissioning, 50% of PCTs have got less than 50% of practices likely to be involved by December 2006 and most of that involvement has been driven by PECs taking local leadership forward, engaging with the local practices, showing them what the benefits are and translating to them what it really means. That is absolutely key and vital, and there is at least one example I know of where there has been a very large buy-in to practice-based commissioning prior to the Commissioning a Patient-Led NHS document came out and, subsequent to it, an awful lot of cold feet and back-pedalling from the local GPs because it is going to destroy their local clinical leadership that they know and trust and have actually been building up over three years; they just do not know who they are going to be working with.

Q99 Dr Naysmith: It is not just GPs because there are other professionals, that is why Yvonne Sawbridge is trying to come in.

Ms Sawbridge: Thank you very much. I just wanted to add to that really to say that any change is really hard work and it takes transformational leadership. One of my worries is that while we are getting rid of some of the organisations, transformational leaders are rare beasts, in my experience, and we do not want to lose them, we need them to be engaging all clinicians, managers and local communities in order to make sure that we are getting the changes that we are all committed to.

Q100 Dr Stoate: I want to talk about practice-based commissioning and obviously many of the plans that are currently being put forward are going to hinge very, very much—on whether practice-based commissioning actually works. We have heard from people on PECs that there is a huge enthusiasm within the PECs to try and drive local practices and trying to make this work, but actually it seems to be a bit difficult to get across. I would like to ask Dr
Stanton a couple of questions, because I know from long experience and knowing Tony very well that he meets ordinary workaday GPs on a frequent basis, possibly more than most. Do you honestly think, Dr Stanton, that GPs are enthusiastic and engaged with the whole process of practice-based commissioning? Do they actually understand what it is and what it means to them?

**Dr Stanton:** We are trying to make them enthusiastic and informed, but I have worked in and with the NHS for 41 years and the truth of the matter is that first of all none of us should be surprised at yet another round of organisational change because it happens every time, usually soon after an election. That is the first thing. Secondly, anything from the Department which comes out called *Commissioning a Patient-Led NHS* you can guarantee is nothing to do with patients leading the process, but I do think we have to see this as part of an overall process. Dr Naysmith was asking previously where this direction of travel had come from, to which Dr Groom was referring, and we are, it seems to me, with this Government—and probably with both the other major political parties—going down a road where the NHS is a brand and the provision of the services can be sub-contracted out to whoever against certain criteria. If I am correct in that analysis and if there is to be a move to practice-based commissioning, then the question has to be asked what are primary care trusts for and what are PECs for, because much of the enthusiasm with clinicians who went on PECs, it seems to me—and Peter and Lucy would speak from first hand experience—was precisely to try to inform the commissioning of care agenda for the patients of their practices or their client groups with which they worked. I think it has been extremely difficult for PECs to influence that process because the whole thing is money-driven. I relate to 12 PCTs and they vary, in my opinion, in terms of the efficiency with which they are run, but even the best-run of them have major financial problems. They are all predicting overspends in the current financial year, which is concentrating their minds. I was at Dr Stoate’s local hospital yesterday talking to the next generation of GPs and that hospital has an admitted deficit of £6 million—it may well be more. You see this all across London and it is quite impossible, I think, for individual PCTs to control that hospital expenditure, it is impossible for hospitals to cope with the limited budgets they have. Moving to a scenario of payment by results where every time a patient activity is undertaken in a hospital there is a bill, you have to find some way of controlling that demand. The only way, it seems to me, that you can attempt to control the demand is by making practice-based commissioning successful. It has been difficult, Dr Stoate, in all honesty to get practices heavily involved in this for a number of reasons: first of all, a woeful lack of information from the Department of Health, with technical guidance promised earlier this year, which when it eventually came was not worth the paper it was written on, was supposed to come again in another edition in October—we are now in November and there is no sign of it. I am sure it will not be worth having when it comes and I would hope that you, as a GP in London in part of your time, would agree that probably the only information you have had is from the local medical committee on how the process would work. This is, I think, extremely sad. Ms Millington referred to people worrying about the future of their jobs: we have had this ludicrous exercise in London where, for the last three months, every PCT person has been consumed by what is their future and then suddenly, yesterday apparently, a decision has been taken that it is the status quo. People have been terribly worried about their jobs, what is the future direction of travel, and I gather that the only possible change in London is demerging the one two-borough PCT that there is. It is madness and I think the Department really needs to be held to account on this.

**Q101 Dr Stoate:** I think I should distil from your words that enthusiasm is not unalloyed.

**Dr Stanton:** No, and why is not unallowed? If we take Bexley, where your practice is, the PCT is in deficit, the hospital is in deficit. If groups of practices take overall responsibility for the commissioning budget, who is going to be responsible for that budget? Where is the pump-priming money to help practices get involved, but where are the promises of adequate management costs, where are the promises about size of and purposes to which savings made can be put? They are totally absent.

**Q102 Dr Stoate:** You have actually anticipated my next question, because I was going to come on precisely to that. How do you think that we could try to engage GPs, because you have already said yourself that the future of the NHS, because of the power balance between primary and secondary care which I have already hinted at, will largely depend on whether practice-based commissioning can be made to work. How do you see it working?

**Dr Stanton:** The engagement is patchy across London. In some parts of London there is very widespread engagement, and Islington where Dr Reader works is a good example and Sutton and Merton Primary Care Trust is another example with heavy involvement.

**Q103 Dr Stoate:** I accept there are good bits, but as Dr Reader has already said, even by the end of next year some PCTs say that only 50% or less of their practices will be engaged. How on earth are you going to sort that out? I am not worried about the good because the people who are good and enthusiastic are already getting on with it, but what about the 50% or more who currently are either not engaged or, frankly, are uninterested? I can only speak for myself and my own organisation. We are taking the initiative and as well as producing briefings, copies of which I have sent to the Committee, we are organising a series of major events across London later this month and in the early part of December, precisely to sell the message. I think this is the only way it can be done.
Q104 Dr Stoate: I am very pleased about what LMCs are doing, but our purpose is to advise Government on what we think Government should be doing. What do you think Government should be doing, and I know that other people want to answer as well?

Dr Stanton: I think Government should be giving clear guidance as to what they mean by practice-based commissioning, they should make it compulsory for there to be adequate preparation funds, they should be very clearly defining a range of management costs and they should be very clear about the use to which savings can be put and also deal with the problem of inherited deficits.

Ms Sawbridge: I wanted to answer your question through a different route, if I may, which is where you started, which is what should PCTs be doing to engage practices in practice-based commissioning, because it is not just about GPs, as you said, it is about the whole workforce having solutions to problems. I think that is about going out and describing visions, and it takes really skilled managers and leaders who understand the art of the possible, because there is a great deal that can be gained from practice-based commissioning. They need to understand what that is, bridge the gap between the policy and the context within which people are working, and that takes time going out and talking to people, working out what their money could look like, what savings they could have, what they could spend that on, are there local problems?

The difficulty with the current system is that this organisational paralysis which is affecting us all—and I very much hope you come back and talk to the provider bit of the changes that are proposed—is getting in the way of finding time to go out and talk to people about exactly that. What the Government should do is make sure that we are supported, that there is policy support, understand the fact that change management takes time, effort, engagement and needs to be allowed to let happen in local areas.

Dr Reader: I would certainly reflect Tony’s point about greater clarity on issues such as management costs and what it all means, and I would completely agree with Yvonne, but one of my concerns is that the impact of this re-configuration by actually removing a number of PECs, by making these bigger organisations that are actually far more remote, means that these processes are just not going to happen. Even in areas where you still have the borough boundaries, such as in London, you have still got a 15% management reduction which is going to cause organisational stagnation, there are going to be restructurings to actually make that saving around commissioning and a whole load of other functions which are going to cause organisational stagnation and the eye is going to be completely off the ball of driving forward practice-based commissioning. The other thing to think about is if you look at practice-based commissioning without strategic local leadership, you have really got fund-holding; whilst fund-holding delivered some improvements, there was none of the kind of systematic innovation that we really need if we are going to make the changes that the NHS needs to move the healthcare over in the next 10 or 20 years. We need those local clinical leaders who have actually developed some of that leadership skill, some of that strategic nous to be actually there supporting those practices and helping them deliver and develop within those localities, to actually really get what you can get out of practice-based commissioning.

Q105 Dr Stoate: Are you saying that the reorganisation of PCTs is going to make things worse or better?

Dr Reader: Worse.

Dr Stoate: Worse. Okay, thank you very much.

Q106 Chairman: Did you want to add to that?

Mr Sloane: Simply to add really that the last two points illustrate quite clearly how the level at which corporate accountability is exercised is material, because if practices feel that the organisation to which they relate statutorily is remote and distant, they have a disconnect in terms of confidence, they have a disconnect in the people that they have got to know and trust. It is quite interesting to look at the way the responses in the Your Health, Your Care, Your Say exercise are panning out, and one of the predominant themes is about things that patients feel most passionately about, and that is the connectivity (or lack of it) between health and local authority services. Those are functions of course of statutory organisations, but they are also functions of the myriad of other organisations that support them.

Dr Dixon: If I may quickly come in, I think the reason stopping many GPs at the moment is because they want to make a difference and they are afraid that this time they will jump in with both feet and nothing will change. When you have this reconfiguration going on above their heads, without them being involved at all, that slightly adds to the message that they are not really part of the scene at all, and that is the bit that we need to get first. If you ask where it is working there are two elements: they have either got clinicians who are taking leadership roles and running with them, either on the PEC or sometimes individual practices gathering a few at the same time, or you have got local managers who are polarising local practices together. In terms of what the Government should do, it needs to provide people with the confidence that practice-based commissioning really will be able to run its course and there will be real emancipation at the frontline. We have to overcome that suspicion at the moment, but I think the other thing we need to do as PCTs go through this transferring stage is really invest in these local managers, making sure that the local scene is set, so that by the time the PCTs come back into office as it were, you have got your localities, you have got your practice-based commissioners and you have got your enthusiasm.

Q107 Mr Burstow: Something that puzzles me about a lot of this is really what the role of PCTs as commissioners will be, in an NHS where the tariffs are set nationally, the patients choose the hospitals...
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and you as the GPs hold the indicative budgets. What do you understand to be the role of a commissioning PCT in that sort of environment?

**Dr Dixon:** I think it will chair the process to some extent, act as local chair for the process in many ways. I hope that it will be thoroughly connected up to the localities and the practices, because if it is not in a sense their enabling voice piece then we have the problem I have just illustrated. That is practice-based commissioners will go home because they will say that they are not able to make that difference. So it will be partly making sure that practice-based commissioning can work, that local clinicians and people really do see what they want happening, and it will be partly also making sure that the thing hangs together and that you do not get things that you did not predict, like hospitals closing that people did not want to close, or you are losing out on national objectives which really are quite important but may not seem so at the frontline.

**Q108 Mr Burstow:** A chairing or facilitating role sounds rather different to the sort of role that we were hearing from the previous set of evidence-givers earlier on, and indeed from the Department itself where the talk is of powerful commissioners in the role of PCTs. How do you square that, do you see an inconsistency between what you have just said and what appears to be . . .

**Dr Dixon:** They are holding the ring and they need to be powerful commissioners because as previous speakers have said you can only commission powerfully, say with an acute trust, when you have the primary care clinicians and the secondary care clinicians talking to each other. So you go up from the bottom and you make sure that when you are having these powerful commissioning conversations they reflect what is happening down at the practice-based commissioning level and at locality level. If it is disengaged—which unfortunately sometimes it has been and commissioning has become a managerial process, not a clinical process—then you do not get any change, you just get bits of paper going back and forth. You do not see patients actually being cared for differently. They will only be powerful, therefore, in as much as they are empowering the front line that they are meant to be representing.

**Ms Sawbridge:** I would agree with that. The role of the PCT as commissioner will be about improving the health of local residents, which is its job now, and in simple terms I think it is probably what are the top ten PSA targets or public health initiatives we have to do in order to improve health at the centre. We are keeping an eye on what all the major policy objectives and local objectives are, and then what do the practices see where they sit that needs to be done, having your top ten matches and making sure that one does not skew the other. It is that sort of approach.

**Q109 Mr Burstow:** How is that sort of ring holding to be achieved in an environment where there is a greater emphasis on contestability and arguably competition and where some of the services that you historically might have provided might arguably be provided by someone else? How does that fit into this collaborative environment that you are talking about?

**Ms Sawbridge:** I guess there is something about holding the ring and managing the market too. You have got your ten things that need to be done and there are people who either are not doing that well or there is a gap, and it is a bit like the previous speaker was saying about the Terence Higgins Trust: that you have got services that you are talking to that could turn round and develop services differently, but you need to be talking to practice-based commissioners about that too. It is challenging, and as I keep saying I hope we will come back to the provider divestment bit, but I can see that that is why that sort of discussion started because it does start making it look like how do you do both because lots of people have lots of interest. Actually, that is not usually different to what we have got now, when we have got PECs with GPs talking about enhanced services and actually that is money into their business, and we manage that now.

**Mr Burstow:** Can I fulfil your request and deal with this divestment issue, which I asked about earlier on—and which we had an interesting set of answers on—sorry, is that someone else’s question? I am going to pause because I would not wish to steal someone else’s question, it was my question earlier on.

**Chairman:** Just a couple more supplementaries? Dr Taylor.

**Q110 Dr Taylor:** I was really quite bothered by Dr Reader’s assumption that there would be the removal of PECs with mergers of PCTs. That to me would be an absolute disaster; surely we have got to keep, as we said in the previous session, some sort of local professional executive input into the PCTs, however big they are. What should we recommend as the form that that should take? How do you see the equivalent of PECs feeding into the bigger organisations?

**Dr Reader:** When I said removal of PECs I am not getting any change, you just get bits of paper going back and forth. You do not see patients actually being cared for differently. They will only be powerful, therefore, in as much as they are empowering the front line that they are meant to be representing.

**Q111 Dr Taylor:** This has got to be one of our recommendations then.

**Dr Reader:** Yes, it is very important, absolutely.

**Dr Dixon:** We would hesitate to call them a PCG. We would say, however, that they need to be quite lean and fast-moving.
**Dr Reader:** One of the points about the tension between the big and powerful commissioner versus the small localist is that the small localist is not going to be able to instantly be effectively a good commissioner at any level, and for some of the higher stuff they will never be in a position to make that commissioner decision. There is a whole developmental process that needs to go on and it is going to take two to three years to get practice-based commissioning and locality up to an effective level and develop those people with those skills. Again, it is absolutely vital that the people who have been doing this and have evolved from PCGs into PCTs have an opportunity to continue that good work.

**Dr Taylor:** Thank you.

**Q113 Charlotte Atkins:** I just wanted to ask one question about practice-based commissioning before I move on to another issue. Dr Stanton said that the reason that practice-based commissioning has to work is to control demand. Would you accept that there are other ways of controlling demand, particularly with accident and emergency departments, perhaps by ensuring you have proactive arrangements locally, for instance with an ambulance service that achieves a 40% rate of not taking people to hospital? If you have an emergency service that arrives at the patient’s door or in the street or wherever it is and they have a paramedic-based community service, they can decide to save £100 a go by not taking that patient to hospital. That is another way of doing it.

**Dr Stanton:** Absolutely.

**Q114 Charlotte Atkins:** Do you think that that area of managing demand is sufficiently developed?

**Dr Stanton:** No.

**Q115 Charlotte Atkins:** You have been talking about a trade-off between a large PCT which is not locally focused and smaller PCTs which are very focused, with clinicians working very closely on a community basis, using people like community matrons, but looking very much at the group of people who are likely to be subject to emergency admissions and working with them on a proactive basis in the community rather than incurring large hospital charges for taking them in on unplanned admissions.

**Dr Stanton:** I think that is absolutely essential. That would seem to me one of the key areas that any worthwhile practiced-based commissioning group could do. We are not talking about this process being undertaken at individual practice level, we are talking about consortia of practices.

**Q116 Charlotte Atkins:** Is it possible to do that in a very large PCT possibly covering one million people?

**Dr Stanton:** With respect, this is the misunderstanding. It is not the PCT, as I see it, in this brave new world—if brave it is—which will be determining that process, it will be the enthusiasm of the clinicians of all types engaged in commissioning groups. That is where I would see the energies and talent.

**Q117 Charlotte Atkins:** So you see no conflict between having a very large PCT which is not locally focused and clinicians talking to other clinicians, it is perfectly capable of organising that on a very large PCT basis?

**Dr Stanton:** I think it would be capable because I think the enthusiasm and initiative of everyone who works in the NHS is perfectly capable of coping with any system that comes along.

**Dr Dixon:** Let me give you a concrete example. In my own practice, which is a practice-based commission with a budget of £4 million plus, the first thing we did was to employ a modern matron. As Tony says, it does not matter too much what the structure is provided you have got your budget and you have got your freedom to do that.

**Q118 Charlotte Atkins:** Can I just move on to another issue which I think Dr Stanton raised, which is basically that we were back to square one in terms of the provider function of PCTs. As I understand it, the Secretary of State has made clear in Health Questions, when speaking to us and in other statements that PCTs can now decide themselves whether they want to employ staff and continue to do so. Do you think that PCTs would also be able to continue to run community hospitals?

**Dr Stanton:** I do not think I did make any observation about the provider functions of PCTs, unless my memory fails me, not least because many of my best friends are in the RCN and I do not want to upset them! As far as I can understand it, whatever the Secretary of State has slightly pulled back on, there is clearly a direction of travel towards PCTs no longer being the direct employers of what we might loosely call community staff. We are not blessed with large numbers of community hospitals in London, they have been largely closed down over the years, although with the Better Healthcare Closer to Home proposals that Mr Burstow will be familiar with we may be.

**Q119 Charlotte Atkins:** In more rural areas would you accept that community hospitals are pretty important?

**Dr Stanton:** Terribly important. The BMA’s General Practitioners Committee has been very closely involved in the fight to strengthen their position.

**Q120 Charlotte Atkins:** Do you accept that there has been a huge amount of uncertainty and a loss of morale among staff because of this debate about the fact that the PCTs may no longer employ them? I am not just talking about nursing. I am talking about health visitors and I am not just talking about GP employees but right across the piece.

**Dr Stanton:** An outrageous effect on them and on managers employed in PCTs.
**Ms Sawbridge:** The nursing network of the NHS Alliance does include health visitors, district nurses, school nurses, practice nurses and we also have links with the AHPs, the primary care practitioners. They make up the largest community workforce employed by PCTs at the moment so they are the ones that are most affected by the divestment of provider. There has been large scale anger, dismay and concern about these changes and it is not just about pay and pensions, although I know that is what is hitting people, it is much deeper than that. It seems to be around three areas. One is the fragmentation of care that plurality of provision is likely to come to. The second is core values. In the community we deal with people not disease. We are trained in acute, we moved into community and we want the chaos and the richness that come from helping people live their lives. It does not fit neatly into “You’ve got diabetes” or “You’re having your hip replaced”. People have all sorts of things happen to them at the same time and that is a core value that makes people get out of bed and want to come to work and they are very anxious about losing that and going into organisations that do not understand that difference, which is intangible, you have to work in it to see it. The third is around training, development and the workforce. Who is going to train our future workforce? Who is going to plan across the health and social care when you have got plurality of provision? I just do not understand how that will happen. It is hard enough now. At the moment we talk to community nurses about having student nurses and “post-reg” nurses and doctors and everybody else and sometimes they moan and say, “I’m trying to get my day job done. It gets in the way,” but you can say, “This is your day job. You are part of the NHS. This is what you need to do.” How are we going to say that to other providers who will not see it like that? When we start trying to get clinical placement in general practice, who have got much more business acumen, they will say, “Yes, it’s really important but it costs.”

**Q122 Charlotte Atkins:** This is supposed to be patient focused. Do you think it will fragment the so-called patient pathway?

**Ms Sawbridge:** Yes. Seamless care is difficult enough to do at the moment and the more fragmentation the more people you are going to have knocking on the same door to deliver different aspects of care.

**Dr Dixon:** I would say yes-ish to Yvonne. I think she has illustrated very well the feeling of insecurity and lack of control. We really do need to make sure that the front-line practitioners are involved in whatever happens and they clearly did not feel that they were. I take Tony’s point, I think the direction is still quite clear, which is towards a bit more contestability in primary care. After all, we had it in secondary care and I think we must accept that it is going to happen in primary care because you do not want complacent services that offer simply what they want to offer. Hopefully we will have these PCT bottom-up commissioners who are fairly sharp, fairly tight, and who can look at proposals which sometimes may not be PCT provided services. They may sometimes be front-line provided services, perhaps not-for-profit, perhaps mutual, but the idea is that they will offer something better. At the moment in my own practice we have got healthcare assistants that come from an operation (social services) seven miles across the hill. I have got mental health services that are coming from outer space! Brining them together would be a great thing and maybe we could create some front-line ethical provider organisations that could do things better.

**Q123 Charlotte Atkins:** Might we see our community hospitals being run by private for-profit organisations?

**Ms Sawbridge:** Yes.

**Dr Reader:** Yes. If you are opening the market up to contestability then yes, absolutely, anyone can come in and bid for that. I think it was highlighted by the speaker from Oxford that these people are not going to be doing it for love.

**Dr Dixon:** That will depend upon the commissioner. I would think front-line practitioners could always put in a better bid because they will be there 20 years hence, they know the people and they have got the confidence and the track record.

**Anne Milton:** It has been very interesting having these two panels. I think it says it all. We have had the strategic approach and then this huge gap between what is happening on the ground which we are hearing from you. Just picking up on what Yvonne Sawbridge said, if practice-based commissioning will lead to less acute trusts’ time being used and will actually reduce demand, which I think the general public would find a very difficult concept in itself because, from where they sit, they go to a doctor or seek care when they need it so they do not understand reducing demand, it will be the community staff that pick up the tab. There has been no mention of social services here. Essentially this will lead to a cost-shifting exercise. We have got councils already pleading about council tax, not having enough money and making council and social service provision. The bottom line is it will be
the community staff, the district nurses and social services that are picking this up. I would be interested in your views about what is going to happen. I can see a huge number of people falling through this big hole. Yes, the demand on acute trusts will go down, people will be demanding less care, but I think there will be more misery and suffering in people’s homes as a result.

Q124 Dr Naysmith: Is Ms Sawbridge sufficiently reassured by what the Secretary of State has been saying, as Charlotte outlined, about our PCTs being able to carry on as providers if they want to?

Ms Sawbridge: The network members welcome the Secretary of State’s statement. It has been a really helpful statement. It has allayed some of the anxiety. However, I think the “until” still hangs in the air a bit. I do not think anybody is saying that it is not a good idea to look at alternatives and contestability. I think people accept that. It is that it should not be an absolute “thou shalt not provide,” that is the issue. You should be able to work out locally where you think your best staff are coming from that are going to able to meet the needs of your local population and that will include linking with the local authority and looking at the integrating of roles, all that sort of stuff, which is difficult enough at the moment but possible with good partnership and good leadership clinically and professional engagement. It will get more difficult if the services are fragmented and you are not even sure who you need to talk to to link the pathway.

Dr Reader: The original point of this paper was about strengthening commissioning. The devolution of those provider organisations actually cuts that whole section of community staff out of that loop and out of practice-based commissioning possibilities. As practice-based commissioning came in other professional staff have been champing at the bit to get involved, but it has been more complex to see where that fits in and people have been trying to work on that. As soon as the divestment to providers came along lots of PCTs’ doors—including my own—suddenly closed on thinking about them because somebody else was going to be running them. There is a whole raft of skills and knowledge and involvement that can be used there in practice-based commissioning in different ways to evolve and change services that would be lost.

Mr Sloane: There has to be a balance struck because I suggest any wholesale resistance to involvement in the private sector of the private sector in health would be a misrepresentation. Already the evidence is that the private sector can deliver efficiency gains in acute services, they can actually improve quality. As Yvonne was saying, primary and community care is a much more complex fabric of services. It needs careful thought about the design and commissioning of those services prior to planned involvement with the private sector. It is not off-limits. It can actually deliver some of that cost saving that has been held up as the reason why the organisational change is being taken forward. I think we need to keep an open mind on it in that respect.

Q125 Mr Burstow: I want to make sure we do not lose Anne’s other question, which was this issue of cost-shifting and the extent to which some of this agenda will end up shifting responsibilities onto already very hard pressed and—compared to the National Health Service—substantially less invested in services over the last three years and over the next three years as well. What is your view about that in terms of whether this will really prove to be an aid to better integration of health and social services? You have already queried the whole value of co-terminosity compared to other criteria in all of this. I think this is an issue we did not grapple with earlier. I want to make sure we have some sort of comment on this issue as to what extent there will be a shift of responsibilities on to social services to meet needs in the community that hitherto would have been treated as health needs either in the acute sector or even within the community healthcare sector.

Ms Sawbridge: I am not sure if I can answer that totally. If we look at the care trust models that we are beginning to develop, I think there were around nine that were beginning to be piloted before commissioning a patient in the NHS, I think they were looking to address exactly that because that is about going further than pooling section 31 budgets, it is about organisationally managing, employing and delivering services across health and social care. There are duplications of workers going in, healthcare assistants, social care workers doing slightly different things, ie can they give eye drops, all that sort of debate that happens locally. I guess those sort of models would be looking at that. I am really not sure how that will play out if care trusts do not take off and people are integrated and co-terminosity and plurality of provision happens around that; I think it is a risk.

Q126 Mr Burstow: I think one of the issues from the point of view of the patient is when they cease to be a patient and become treated as a client because as a client you get charged for the service and as the patient you get it free. Is that a concern that we should be looking at when we have our social services colleagues before us in the future?

Dr Reader: I think inherently once you have got services that are contracted to provide a little bit then you start to have delineations and barriers. Drawing on some of the London experience where we are worried about losing the co-terminosity with boroughs, there is an awful lot of joint working already going on with those small populations, with the boroughs, around these health and social care issues, even getting into some of the issues of housing which previously was suggested could only happen if you are working at a much bigger level. In Islington there are examples where new housing has been designed with walk-in showers so that when somebody turns 70 and a bit more infirm you do not have to go and put one in instead of the bath. It is back to this thing about how long does an
organisation need to take to get onto its feet and for these things to start to happen? All of these things are happening, it is organic, therefore it is sustainable and the partnerships and the trusts that really make the change work rather than just shifting the big boxes are there.

**Dr Stanton:** There are hopeful signs of that closer integration. The Chief Executive of the care trust is also the Director of Social Services for Bexley and there is a similar arrangement in Southwark. That is a positive sign. You are quite right that if less work is done in hospitals more work will be done in primary and social care but, equally, one of the biggest difficulties—and I am sure Michael would agree—over the years has been getting money out of the very expensive hospital sector into primary care. The overwhelming majority of our activity takes place in primary care for a tiny proportion of the budget. It is only really by finding alternative ways of providing some of the care that currently takes place in a hospital that you can get the extra investment which is needed for primary care. I think it would be very difficult to achieve but it is the only realistic way forward.

**Dr Reader:** I was very pleased to hear some of our colleagues from the NHS Confederation quote you examples of where local clinical leadership has done that despite the difficulties. We have now had the tools of practice-based commissioning which, if the balance is right around the commissioners and the providers, actually can really move that agenda forward. The restructuring change that will happen out of this will just throw all of the commissioning side into turmoil and weaken those essential clinical leadership link developments and there is a real danger of the provider side being far too powerful and taking off.

**Q127 Mr Burstow:** Dr Stanton, you were talking about the direction of travel being one in which the NHS becomes a brand that puts on services or a badge that is used.

**Dr Stanton:** Let us be clear, I was not advocating that, that was my analysis of it.

**Q128 Mr Burstow:** You were saying it was the direction of travel. Would it be fair to describe the direction of travel as you see it as one that will result in a mixed economy in the health service rather similar to the mixed economy we already have in social services?

**Dr Stanton:** Yes.

**Q129 Dr Taylor:** We talked to the Secretary of State last week a bit about contestability and level playing fields and she actually admitted that in secondary care there was not a level playing field with the independent sector treatment centres. Dr Dixon said quite clearly that the NHS can compete perfectly well if it is a level playing field. Are there any clues that there may be unleveling of the playing field in your sort of aspects when it comes to competition or contestability?

**Dr Dixon:** In primary care?

**Q130 Dr Taylor:** Yes.

**Dr Dixon:** No. One thing that the Alliance will be pushing very hard is that it is a level playing field. In a way, it is not a level playing field, if you think of it. Front-line professionals have an inbuilt advantage in that we are used to being private businessmen in general practice, we also know our population well, we know their needs and we know what they want. Nevertheless, a level playing field in a conventional sense it must be. I know the argument for not creating a level playing field in secondary care was because that was the only way to create the capacity and to encourage people to get into it and the like and that may or may not be true. I do not think those arguments apply in primary care.

**Q131 Dr Taylor:** So you would agree with the previous set of witnesses that, as far as contestability with community services is concerned, there really is not going to be a problem because there are not alternative providers?

**Dr Dixon:** I think alternative providers will come along and they will go to PCTs and say, “We can manage your community hospital better,” or they might say, “We can run a better diabetic service in your locality than those four or five practices are doing,” and the like. That is where commissioners are going to have to be very careful to avoid the sort of things that can happen, such as fragmentation and over-provision which would be very expensive. Commissioners are going to need to be extremely competent umpires in that game. Coming back to Robert’s point, there are gaps in primary care, the quality is not uniformly good, the access is sometimes not as good as it might be and all of us need a bit of a creative edge to keep our standards up. I see the sum effect of this as being something about upping the game of public providers rather than a massive invasion by private providers. Certainly if the private provision comes in, I would hope to see them as enablers rather than us all becoming services under their yoke.

**Q132 Dr Taylor:** Could you see them moving in to try and take over some of the threatened community hospitals?

**Dr Dixon:** I think there will be experiments going on all over the country and it is probably good that there should be because if we find that a private provider goes into a community hospital and suddenly it is twice as good as it was and other people have not found the solutions, then I think we must let that sort of thing happen. I would hope that we would pilot them and watch them. Ultimately the decision will be for the PCT commissioners and I hope the PCT commissioners will act wisely in that. **Ms Sawbridge:** I would not disagree with anything that Dr Dixon has said. But what has happened with some of the nursing homes in the past is they may well go bankrupt the night before, they do not give you three months’ notice and then you have got the residents there to move and to sort out. Who is going to be left sorting out the community hospital if they
cannot make it work? I think we should look at it and where it looks in the interests of the local population we should do that, but we should be mindful of some of the real risks.

Ms Marks: I would like to add something about the voluntary sector. I think the voluntary sector, certainly where I work, in Tower Hamlets, which is very mixed in terms of the cultures and ethnic groups, does have quite a key role to play. They are involved in advocacy and interpreting services, they are involved in expert patient programmes to develop self-care for different groups of people and that is positive. I think we should remember that we need to ask questions about where it is sensible to think about whether contestability is going to help us move things forward, not just have it as something that is a blanket.

Q133 Dr Naysmith: It is fairly significant that we have got to the end of a very long evidence session and we have barely touched on the public health function which lots of my friend who work in public health will tell me is always what happens, but it is a really important function. How do you think these primary care trust changes are likely to affect public health and public health programmes and the administration of public health activities?

Dr Reader: I would have concerns that it would be quite a negative effect because it is back down to that local knowledge. Within very close proximities to each other you can have huge differences in health needs of the population. The bigger PCTs get the more difficult it is to focus on those. What PCT's have increasingly been getting into over the last year or so is ways of focusing down on their communities and because of the close links that they have with the practice and the other services around that they are able to set up schemes which will address those health needs in a small localised way. I would be quite concerned that the enlarging would actually lose that focus and you would go back to the more sweeping, larger public health-type approach that we had in the health authorities.

Q134 Dr Naysmith: Is that the general view?

Dr Dixon: I think Peter is sounding an important warning, but I think there are ways of preventing that. Going back to practice-based commissioning, we produced a document recently on practice-based commissioning and health because it is the bit that could easily get left out. GPs are not awfully good on health—nurses and other professionals are far, far better.

Q135 Dr Naysmith: Do you mean they are good on illness but not so good on health?

Dr Dixon: We sometimes stick to our surgeries and we do not see our role as outside in the main street and the housing estate and elsewhere. I think this is something very exciting that we need to emancipate and see ourselves as needing to take on. In a way these changes, if managed right, could turn out better than Peter suggests. One of the problems with public health and PCTs is that sometimes it has been a bit of a dog’s dinner because you have been trying to roll up your sleeves, get into the housing estate and sorts things out there a bit while having to worry about some strategy for a disease, the commissioning of the PCT and the rest of it. It seems to me that we could make something out of this if we see these much larger PCTs having public health at a higher level, that is very strategic to do, with improved commissioning and then we devolve health down to communities, going even deeper than we have with PCTs thus far and emancipating all local professionals and the local population as well to meet all of its business and be far more practical and grounded in health initiatives. Some PCTs have done that but quite a lot have not. It would be nice to see the sort of things that have been going on in PCTs through our own “Fast-Forward” and “Can Do” happening everywhere.

Ms Sawbridge: We have got a chance, if we get the commissioning organisations right, to start doing some of that work around commissioning for health, not just ill health. I would agree, I think general practice has not been a natural ally of public health in the past because it does not tend to think big enough, although it can use local developments and get involved in debt, for example, by having debt counselling organisations in their surgery and recognising the link between poverty and ill health, etcetera, it is a chance, but in order to do that you have got to have somebody who is strategically able to focus that horizon at the commissioning level and who understands it and who is able to influence other people take that on board. So we need to watch that when the commissioning organisations are set up they have got the right level of clinical involvement, public health, GP, nurse, AHP, etcetera, at strategic enough levels to make sure the corridor discussions that happen are happening with clinicians and not managers alone.

Q136 Chairman: Could you ever see a situation where a PCT was not a provider and another organisation could take over issues like dental health and issues like prescribing? PCTs at the moment look at the prescribing lists of all the GP practices and in some areas can and do save money for the local health service. Even going along and chatting to people that are around now that maybe were not around when you first started prescribing this drug may save your practice quite a lot of money. Who does that wider role that is out there guiding the primary health care services? Do we see this being done without PCTs?

Dr Dixon: I think quite a lot of it can be done without PCTs. Practice-based commissioners will have an inbuilt advantage to make sure they are improving the local health because that will move costs upstream and they have an inbuilt advantage to rationalising their prescribing in terms of their budgets. I hope an awful lot of this will go downstream. As Yvonne says, you will need the strategy and you also need the experts who can give you the tips as to how you might be able to do it in your practice-based commissioning scheme.
Chairman: Practice-based commissioning, as I think everyone would agree, in terms of a GP practice in particular is different in all cases. I know some very strong GPs who work together collaboratively with the PCT at the moment on public health and other issues. I know others who are small business people that do not go much beyond their surgeries and everything else. I have no doubt they are committed to their patients. Are they committed to the wider issues that involve the public health of the people of Rotherham and communities like it that have some very, very difficult issues in terms of public health, through industry and through culture and lifestyle? That is the real issue, is it not? Maybe it is one for Tony Stanton to answer in terms of the local medical committees. Are they able to do this? They do not do it at the moment in any great detail.

Q137 Dr Naysmith: You have got to build some incentives in and some of the incentives have not been very good ones in the past. Dr Stanton: We have many tasks in local medical committees but organising the public health has not been one we have tackled so far. I would have thought, in answer to Dr Naysmith’s question about the role of public health in PCTs, whatever their size and configuration, as I understand it from Sir Nigel Crisp’s document, that this is their number one responsibility. The PCT should be setting the public health agenda for the area and should be identifying health need for the whole community so that commissioning groups, however they are formed, know the framework within which they are working, so they have that responsibility.

Mr Sloane: I think what you are describing could well lead us on to another set of discussions around what is the future of those organisations that we currently call primary care trusts. Even using the term tends to reinforce the idea that the primary care trust is a model that is well established. What you are actually describing is a managing agency of the sort that is existing already in Brighton, where the commissioning of services is the predominant role and what that turns on is local accountability, local governance and a local demonstration that the proper stewardship of public funds is in safe hands and the performance of contractors who are executing those services is to the very highest standard that the public would expect. I think it is a hint of something that is already turning and possibly the way forward.

Chairman: Thank you very much indeed. I think that has been a very good session. We are trying to cram this in to two sessions and I hope we make it. It might be a little bit ambitious in view of what we have picked up in this first one. Thank you very much for your attendance.
Thursday 10 November 2005

Members present:

Rt Hon Kevin Barron, in the Chair

Mr David Amess  
Charlotte Atkins  
Mr Paul Burstow  
Mr Ronnie Campbell  
Anne Milton  

Dr Doug Naysmith  
Mike Penning  
Dr Howard Stoate  
Dr Richard Taylor

Witnesses: Mr Alwyn Hollins, Chair, Basildon PCT, Mr Philip Barrett, High Peak & Dales PCT (appearing in a personal capacity), and Mrs Karen Rhodes, North Lincolnshire PCT (appearing in a personal capacity), examined.

Q138 Chairman: Good morning. May I welcome localfocusand I have serious concerns about how such an arrangement, particularly for a Shire-wide PCT, would operate. Mrs Rhodes: I think there are savings to be made by economies of scale in the commissioning function, I do not have any doubts about that, but I am very worried about the provider functions of PCTs. The organisation that I work for is coterminous at the moment with its local authority and we obviously have a lot of benefits through that which we do not want to lose, so it is about maximising that and making sure we do not lose it. I am also concerned that we do not lose any of the clinical engagement that we have got set up within the structures that are currently around because I think it would be very sad if we did. I think there is the potential with practice-based commissioning for us to develop that further with GPs, but I think there is a risk that the other healthcare professionals, if they are moved out to other providers, might get lost in that process. There has been a suggestion that PCTs have concentrated on their provision function rather than their commissioning function and that coming together process we consistently got the message from the Department of Health, obviously through the SHA, that the eventual reconfiguration of PCTs would be a smooth, planned and evolutionary process, not the revolutionary process that we appear to have been told about now.

Q139 Chairman: Could you give us your views on whether these reforms are being driven by the wishes of Primary Care Trusts, as the Government suggests, or has it been a “top down’ approach”

Mr Hollins: In Basildon Primary Care Trust we welcome the policy on the reconfiguration of PCTs. We actually think that practice-based commissioning is the “arrowhead” of the upcoming modernisation for the NHS and is the natural evolution of the modernisation of services. Within Essex we have been working towards reconfiguration for the last 18 months and our Strategic Health Authority (SHA) has actively encouraged the 13 PCTs to work in five natural clusters, each one around one of the district general hospitals. We believe that the reconfiguration proposals at the high level are definitely the right thing to do.

Mr Barrett: Let me make it clear that I am speaking in my personal capacity rather than in my position as Director of Finance. I felt that the process of consolidation of PCTs was happening at a fairly sensible pace and PCTs from the “bottom up” were coming together and deciding that they could do things better in partnership and we were seeing, where it was appropriate, that joint working was being developed often through common management teams, but then suddenly we have this new development in terms of Commissioning a patient-led NHS and the suggestion that PCTs should be coterminous and in the search for significant financial savings there is a suggestion that you move to what is arguably the largest grouping of PCTs within that coterminosity. I feel that that has significant dangers in terms of losing the benefit of local focus and I have serious concerns about how such an arrangement, particularly for a Shire-wide PCT, would operate.

Mrs Rhodes: I think the SHA has actively encouraged the 13 PCTs to work in five natural clusters, each one around one of the district general hospitals. We believe that the reconfiguration proposals at the high level are definitely the right thing to do.
Q141 Chairman: Looking at it around the hospital as it were, what were your findings about Social Services and local authority delivery?

Mr Hollins: Because Essex is a very large county, it is the second or third largest geographically in the country, Social Services themselves have to work in natural locality clusters and therefore the alignment could be around those localities, not necessarily the totality or a rough north-south split within the county.

Q142 Charlotte Atkins: PCTs have only been set up for three years and we are now talking about putting in major change. What do you think the impact will be of PCTs focusing on their work programme?

Mr Barrett: I think it is going to present a significant distraction over the next year to 18 months. Management capacity is a finite resource. When we look at the various priorities that we have to achieve, we have a very significant agenda going forward: we have practice-based commissioning, the roll out of dentistry from 1 April and the roll out of a national programme for information technology, the completion of the Agenda for Change process, obviously improved waiting list times, cancer waits, and all of these together against a background of significant financial stress. If we put that together and if we then introduce such a significant reorganisation, it is my opinion that management inevitably are going to be somewhat distracted by this extra workload. There is also the issue of significant changes of jobs in this process and inevitably people will be distracted by thoughts of self-preservation.

Q143 Charlotte Atkins: Especially in your case because you have got eight PCTs going into one PCT.

Mr Barrett: That is right. In my particular position there will be eight finance directors looking for one finance director’s position.

Q144 Charlotte Atkins: Would the others like to comment?

Mrs Rhodes: I think we are already seeing the impact of it because there are already quite major project structures being set up within PCTs and the PCTs they are going to be reorganised with to manage this process, although I recognise the final decision has not been made, but you have got to start somewhere. It has taken an enormous amount of my time to work with the staff that are affected by this, particularly in provider services. In a lot of meetings that you go to, whether it is on the agenda or not, part of the meeting is always taken up with a discussion about this. We also could see ourselves in a period of planning blight because nobody wants to make decisions for the future until the new PCT and the new board is formed. As well as slowing things down and taking our eye off the ball because we have got to focus on the reorganisation, it could potentially mean some fundamental decisions not being made because the PCTs that are in place at the moment will not want to make decisions that then have an impact for PCT boards for the future.

Q145 Charlotte Atkins: If the Government were to leave the decision at local level, would that not improve the situation in that at least you would have some control over what is happening locally rather than a “top down” approach?

Mrs Rhodes: With which decision?

Q146 Charlotte Atkins: The decision about what your configuration should be. We are supposed to be going through a consultation period over three months. I am assuming, probably wrongly, that decisions will be made after the consultation, not before it.

Mrs Rhodes: Certainly where I come from our ideal solution would have been to keep one coterminous PCT with our local authority, but because of the financial position that we are in there is no way we are going to be able to achieve the savings that we need to make without reorganisation with another PCT. I do not think it is going to make us viable, quite honestly.

Mr Hollins: Let me talk specifically about the three PCTs in the south-west of Essex, which are Basildon, Thurrock and Billericay, Brentwood and Wickford. Well before the reorganisation was announced we had been working together in a health partnership. We already share directorships of acute and mental health commissioning. We moved towards a shared organisation which was majoring on the three key areas, long-term conditions, reforming emergency care and planned care and co-sharing directorates. We were actually already positioning ourselves for a natural merger. Speaking personally, if the reorganisation had given the latitude to the PCTs to merge naturally I think that we would probably have merged no later than 1 April 2007 in a controlled and planned manner. Reconfiguring NHS organisations mid-financial year is definitely not a good idea because you have to close the books twice, which can be very expensive.

Q147 Anne Milton: Do you think that reconfiguration was necessary to deliver the improvements the Government wanted, or would it have been possible within the existing structures?

Mr Barrett: I think we have to ask ourselves what the driving force is that is driving the initiative. Clearly the issue of finances seems to be one of the key issues. I have some concerns in terms of whether the scale of savings that have been discussed can be achieved. In my own particular PCT, when I look at the costs of my own board and PEC and the two senior executives who are most at risk out of this process, which is the director of finance and the chief executive, we are probably looking at a total cost of £400,000. If you multiply that by 150 PCTs that might disappear out of this process, the most we are looking at could be £60 million. There is not yet published an HR policy for this process. In order to save that full £60 million there would have to be redundancies, which are costly and not built into those numbers.

Mrs Rhodes: I think we are going to have to set up locality structures to maintain the local focus and clinical engagement and that is not going to be done
without funding. Some of the savings that we will make by reorganising PCTs, taking out a board, taking out a Professional Executive Committee (PEC), taking out directors, will have to be reinvested at locality level in order to get the engagement and the structures that we need so we do not lose our integrated services and our engagement with our GPs.

**Mr Hollins:** I fully agree with my colleague, the big strength of the PCT has been the locality focus, really getting down to the health needs of the local population. For the first time we have been able to get genuine clinical engagement right at the coal face. If we lose that then we have potentially lost the benefit of the PCTs for the last four years.

Q148 **Anne Milton:** So you doubt whether you will be able to deliver the financial savings that are required?

**Mr Hollins:** I think we can. In the south-west of Essex we believe the three PCTs could have saved the 15% that we were required to do.

Q149 **Anne Milton:** Do you accept the fact that it would be possible to deliver improvements within the existing structures if you had stayed the same?

**Mrs Rhodes:** Not and make the savings.

Q150 **Anne Milton:** So not on the financial side?

**Mrs Rhodes:** No.

**Mr Hollins:** We would have wanted, again speaking personally, to reconfigure naturally into one PCT for our area because individually we have felt over the last three or four years we have struggled to create enough capacity to deliver the agenda and that is why we have been working together anyway.

Q151 **Chairman:** Mr Barrett, you mentioned £60 million in savings throughout the UK on this. Have you heard different figures to that?

**Mr Barrett:** That is my calculation that I have given. The target figure that has been mentioned is £250 million, but in order to achieve that you have to do more than just eliminate PEC boards and a couple of the senior executives. Equally, I would support the comment that we must put locality structures in place, partly in order to maintain as much clinical engagement as we possibly can and also to assist in the roll out of practice-based commissioning because it is going to be desperately difficult to achieve that on a very big PCT basis. It would be the result of negotiations with local practice consortia and they are best handled locally.

Q152 **Dr Naysmith:** What does clinical engagement mean in practice? I think all three of you have used that phrase. Give me some examples.

**Mr Barrett:** This is the on-going contact with clinicians who can provide clinical input into management decisions. An example might be that if we were looking to reconfigure a service we would want to seek the opinion of our local GPs in terms of whether this was the best way forward and if they could come up with some other suggestions. As a management team we need that sort of input from the clinicians.

Q153 **Dr Naysmith:** So you are saying you get that now and there is a danger you might lose it in some of these reorganisations, are you?

**Mr Barrett:** Yes, because we have a local structure in place. We have the PEC in place which includes GP representatives, representatives from allied health professions and other clinical groups and that is one of the key ways. We also have at the PCT level a whole number of subgroups, things like prescribing subgroups, primary care subgroups, which GPs particularly attend. In our PCT over half our GPs take some part in either the PEC or some of the subgroups and that is the sort of clinical engagement that is so vital.

Q154 **Dr Stoate:** The Government is looking for a saving of £250 million. Do any of you believe that that sort of figure is achievable and, if so, how? Silence! Does that mean no one wants to commit themselves or nobody believes it is possible?

**Mr Hollins:** Our SHA has calculated that the average saving for a PCT is in fact £900,000 and not the £400,000 that Philip was talking about. We have no views as to whether that is right or wrong. It could well be a little bit on the high side. We believe that within the South West three PCTs we could make our share of the savings based on the work that we have done already.

Q155 **Dr Stoate:** Does that take into account Mrs Rhodes’ point of view that you have got to put some of those savings back in to locality structures to make them work at practice level?

**Mr Hollins:** Yes.

Q156 **Dr Stoate:** So you believe it is achievable?

**Mr Hollins:** Yes.

Q157 **Dr Stoate:** Do either of the other two believe it is achievable?

**Mrs Rhodes:** Does it not depend on what your financial position is to start off with? I come from a PCT that has got a deficit, not an enormous deficit, but we are already trying to take finances out to deal with that and so another lot on top may be unachievable.

Q158 **Dr Stoate:** So you think probably not?

**Mrs Rhodes:** No.

Q159 **Dr Stoate:** What about you, Mr Barrett?

**Mr Barrett:** In terms of the direct costs that I can relate to in relation to what is going to change on day one in terms of PECs disappearing, boards disappearing and arguably a couple of the senior executives, that amounts to that amount of money that I have mentioned in my PCT. We are a relatively small PCT and arguably the larger the organisation the more potential there is for savings. I am struggling to find ways that we will reach £250 million out of this exercise. When PCTs were
established it must have been recognised at that time that there would be some financial costs in exchange for the benefits of a local focus and therefore there possibly is an argument that there is some sort of premium that is worth paying for those benefits.

**Q160 Dr Taylor:** Two of you have said that mergers are inevitable and that you are quite happy with them. How are you going to maintain the local focus when you lose the separate PCTs? Are you going to maintain PECs or the equivalent of PECs in each sort of area? How are you going to do it?

**Mrs Rhodes:** Where I come from we will have a locality structure, I do not think there is any doubt about that. It is yet to be decided what the actual function of the locality will be as opposed to the function of the central PCT.

**Q161 Dr Taylor:** But the aim will be to take clinicians on board in localities, will it?

**Mrs Rhodes:** Yes, whether we have an expert reference group or a locality board or whatever way we do it. In the everyday work of commissioning and providing care they will be engaged at that level.

**Q162 Dr Taylor:** What will you do about patient and citizen involvement?

**Mrs Rhodes:** It will probably be at all levels.

**Q163 Dr Taylor:** Will you try to keep forums where you have got them at the moment or will you go with one PCT, one patient forum?

**Mr Barrett:** I think it is fair to say that we are only at the start of the process at the moment and therefore we have not put all the jigsaw pieces in place. I think a lot depends on the geography of the area. Derbyshire is a fairly reasonable sized area. To have just one may not be the best way forward.

**Q164 Mr Amess:** The Committee has heard what you have said. No doubt you are making robust representations not only through the local authority but through the Member of Parliament who represents part of my old constituency. You are literally Basildon stand alone, the PCT?

**Mr Hollins:** In terms of?

**Q165 Mr Amess:** No, whether we have an expert equal citizensto the acute and the mental health and reference group or whatever way you are going to make the system work?

**Mrs Rhodes:** I cannot answer that at the moment.

**Mr Barrett:** I think it is fair to say that at the moment.

**Q166 Mr Amess:** It is just the town itself, the new town?

**Mr Hollins:** Yes.

**Q167 Mr Amess:** Nothing else? as you are aware, for 14 glorious years. I knew all the general practitioners, I was closely in touch with all that went on in Basildon Hospital and many of the staff remain my friends today. The written evidence you have given to the Committee is pretty devastating, frankly. You point out that already unsettled staff, particularly in provider services are voting with their feet by moving to organisations perceived as more stable and this time this will be the acute sector of the NHS or mental health trusts. You say, “This is highly counter-productive at a time when Government policy, through patient choice and good medical practice, is focusing on admission avoidance and managing long-term conditions in the community.” That is pretty devastating. Is there anything else you want to add to the impact on staff?

**Mr Hollins:** It is pretty obvious that if somebody is uncertain about their future role in life they will worry. All the PCTs are in the same position right now and so the job opportunities for people to move will be limited. The turnover at the hospitals is relatively high and therefore there are opportunities for community nurses to go into what might be seen as a ‘safer ship’. One thing I would like to say about the provider side of it is that when the policy came out in July we were very surprised that provider services were in the equation with regard to being disaggregated from PCTs. There had never been any hint whatsoever from the Department of Health that such a policy was in the pipeline. As a rule you do tend to get some advance information about what the thinking is. For this to hit the decks in a raw state actually knocked us off our seats to some extent. Since then there has been a statement about how it may or may not be in or out of the PCTs. One thing I would like to ask today is if you could get absolute clarity for us as to whether the provider services are in or out but not like “shake it all about” because our provider services have been the poor relations of the NHS for many years. I know some staff in our community that have had different employer names on their pay slips and have been tuped five times in less than ten years. I think it is time to treat them as equal citizens to the acute and the mental health and to build them up so that they can be a solid provider of services. We need to have contracts which are strong and equivalent to the other providers so they can be commissioned from.

**Q168 Mr Amess:** I am the last person to want to put words in people’s mouths. Would you say that this is a crisis that you are facing at the moment in terms of staffing levels?

**Mr Hollins:** No, I do not think so. Our turnover, fortunately, is one of the lowest in Essex in terms of the NHS Trusts. Over the last 12 months we have been blessed by the fact that when we advertise for clinical staff we do get quite a long list of applicants.

**Q169 Mr Amess:** I hope you are not pinching them all from Southend.

**Mr Hollins:** I hope not.

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1 TUPE—Transfer of Undertakings (Protection of Employment) Regulations 1981
Q170 Chairman: Have any of the others anything to add in terms of staff morale?

Mr Barrett: Just a comment in terms of some practical examples. I was talking last week with one of my matrons in a community hospital in Buxton. She has lost four qualified nurses in the last few weeks to the local foundation trusts and they have gone because of uncertainty about their future, fear about effectively being privatised. Even though clearly we try and dispel the rumours as best we can, the rumours are out there. Let me give another example. One commissioning manager with 32 years NHS experience, aged 56, has decided to take early retirement because he cannot face another NHS reorganisation.

Mrs Rhodes: I think there is a very serious risk in destabilising some essential community services. Where I come from, at the moment we have not seen a drift of staff, but they are so uncomfortable about their futures that it is only a matter of time. It will happen, I am sure.

Q171 Mr Burstow: I am rather attracted by this idea of ‘hokey-cokey’ policy making which was being described just now. I think your perspective on this is clear around this question of divestment, but it would be useful to hear all three of our witnesses give their view as to whether or not you are clear, in the light of what has been said subsequent to the letter from Sir Nigel Crisp of 28 July, that the direction of travel is to minimise service provision by PCTs in the future and if you are not clear, why are you not clear? What do you believe needs to be done by ministers to make you absolutely clear about the direction of travel?

Mrs Rhodes: I feel cautiously optimistic, but I hand on heart cannot say to the staff in the PCT that they will stay with the PCT because that decision is very clearly being given to the PCT boards. We also do not know what the White Paper is going to say. Without that it would be unwise to give staff false hopes. We are not doing that.

Q172 Mr Burstow: So for you the White Paper is a very key part of this process and what is written in that will influence it a lot?

Mrs Rhodes: Absolutely.

Mr Hollins: I agree. I think it is unclear at the moment. Our SHA has tried to get clarification of the latest statement and the view coming back is that there is no change to policy, ie PCTs will divest themselves of provider services at some point.

Mr Barrett: I would be quite happy to see PCTs divest of their provider services to another NHS organisation, we could be talking about a care trust for instance, and there would probably be some advantages in terms of economies of scale. There is an argument that some provider services within small PCTs are perhaps too small. I think we could achieve the benefits in terms of decoupling commissioning and providing. The PCT would then be commissioning that service from an NHS care trust.

Q173 Mr Burstow: That would be a reinvention of NHS community trusts, would it not?

Mr Barrett: Yes. That is probably why it is not going to happen, because it is going to create new organisations when we are trying to save money by reducing organisations.

Chairman: Thank you very much indeed for coming along this morning. It has been very useful for us for the purposes of this inquiry.

Witnesses: Lynn Young, Royal College of Nursing, Dr Tim Crayford, Faculty of Public Health and Association of Directors of Public Health, Liz Railton, Association of Directors of Social Services, Councillor David Rogers OBE, Local Government Executive, Birmingham and the Black Country SHA, examined.

Q174 Chairman: Good morning. Welcome to the Committee. This is the second evidence session we are having in relation to our current inquiry on Primary Care Trusts and related issues. Could you introduce yourselves for the record, please?

Ms Young: I am Lynn Young. I am a Primary Healthcare Adviser at the Royal College of Nursing.

Cllr Rogers: Councillor David Rogers. I chair the Community Well-being Board of the Local Government Association.

Ms Railton: Liz Railton, Honorary Secretary of the ADSS and a serving Director of Social Services.

Mr Nicholson: David Nicholson, Chief Executive of Birmingham and the Black Country Strategic Health Authority, Shropshire and Staffordshire Strategic Health Authority and West Midlands South Strategic Health Authority.

Dr Crayford: Tim Crayford. I am representing the Association of Directors of Public Health and the Faculty of Public Health and I am a serving Director of Public Health and a Medical Director at Croydon Primary Care Trust.

Q175 Dr Stoate: Could you set out, in brief, the RCN’s view on the Government’s proposed changes and whether or not you are happy with the way the process has been managed?

Ms Young: I do not want to be over-dramatic, but I think if I said we had a reaction of complete shock, horror and dismay when we read Nigel Crisp’s letter, the now infamous letter, that would not be overplaying it. Having said that, we were expecting the demand for mergers and reconfiguration and we were expecting, and indeed support, the call for stronger, more robust commissioning. The dismay was the demand to completely unpick, diminish and remove community services from the NHS potentially but Primary Care Trusts which are still very new organisations. I cannot overestimate the amount of anxiety, uncertainty and unhappiness that that has created amongst a very, very valuable, precious workforce in terms of enhancing community health.

Q176 Dr Stoate: What effect is it having on the workforce?
Ms Young: Some of the phone calls have been along the lines of, “I have been a district nurse here for 15 years. What is going to happen to me now?” These are services in the community that are hidden, they are at the edges of society and they are invisible in terms of the people who have got the budget, those who make policy, but they are very valuable to those people who are in receipt and who need them. When you think of the challenging public health agenda and the reduction of health inequalities that we all want to see, you will not do that unless you have got a very strong, robust, well-managed and well-resourced community health workforce, which is mainly nurses but it includes other people as well.

Q177 Anne Milton: I should declare that I am a member of the Royal College of Nursing. Although the staff are on the edges, they are often a crucial lifeline for an awful lot of people. They are almost like the pillars holding a lot of community services up. What about the loss of function? My concern would be that there has been a huge loss of focus and a loss of function during this process.

Ms Young: The level of distraction has been quite phenomenal and the amount of energy being put into what is being demanded from the letter is unacceptable. It has taken people’s focus away from doing the very important provision of services they do every day. I would also remind the Committee that we are expecting a flu epidemic. We do not know the severity, we do not know the level, but if we are going to manage that well it will take everybody’s full attention, full focus and full commitment to ensure that it is not as difficult as it might otherwise be and that is dependant very much on community services, mainly nurses.

Q178 Anne Milton: You are describing what could be said to be a damaged workforce. How long do you think it will take for them to repair that damage?

Ms Young: I think it depends very much on the level of reassurance given. At the moment the RCN is not impressed by the Secretary of State’s statement about Primary Care Trusts’ function in terms of provision. This does not go far enough. This is not a U-turn. Clearly the lady is not for turning! We would like to see a much stronger, more robust statement about the NHS family and the future of community services and where they are going to sit and be managed in the future.

Q179 Chairman: I want to move on now to coterminosity. This is one of the major issues that the Government holds up in front of us in terms of the central aim of this policy. What benefits do you think this will yield?

Cllr Rogers: I would say that there is very clear evidence already, where it exists, that the partnership working between PCTs and local authorities is delivering good outcomes for the people that we represent, you as elected Members to Parliament and my colleagues as elected members of local authorities. It is helpful to have that degree of coterminosity. We do not want to damage what already exists, but in the part of the country that I come from, for example, it is a relatively small county council, it currently has four PCTs, five district councils and there is a very low degree of coterminosity there, it gets in the way of joint working between the Social Services authority and the PCTs. We do not want to damage what exists already, but we want to see an increase in coterminosity where that does not currently exist.

Ms Railton: The ADSS is very close to where the LGA is on this issue of coterminosity. Where we want to focus is very much on what changes will lead to better lives. If you take the view that whilst it is important for the NHS to concentrate on dealing with ill health, it is equally important for it to concentrate on a range of other determinants of health, then I think you do need to take the view that partnerships work and dealing with the health and well-being of citizens and their communities leads you to the view that partnership work is extremely important and alignment and coterminosity is one of the pre-determinants for effective partnership work. It is extraordinarily difficult and time-consuming to undertake the partnership work when there is no alignment between the boundaries of local authorities and the boundaries of PCTs. So it is an important determinant of our ability to work in partnership. Looking at the issues coming through in terms of things that I think will impact on the health service in years to come, for example growing obesity in our young people, thinking about the fact that we may well have the first generation of children in several centuries to be facing a decrease in their life expectancy, those sorts of issues need to be looming very large for the NHS and they will not be dealt with purely by the NHS focusing on current ill health and focusing on what is actually happening at the moment in the acute sector. Our argument is the issues are much broader and they need a much broader based set of solutions and therefore partnership is key, but alignment and coterminosity need to be a part of that.

Q180 Mr Burstow: Having said that, we have had evidence which makes the point to us that by no means is coterminosity a panacea, it does not solve all of the problems of the agendas you have outlined as being ones that need to be addressed. We have heard that particularly in evidence from Basildon PCT but elsewhere as well. In respect of those areas where there are large counties and a multiplicity of district councils and maybe some unitaries as well, in that sort of context what do you think has to be the approach to try and address ensuring partnership working is made a reality, not least given the fact that housing authorities often are the district authorities and not the counties? How is it working now and what could be done differently to make it work better in the future?
Ms Railton: I think we need to understand the different levels of commissioning that need to be brought to bear in this agenda. There is a level of commissioning which is about understanding whole population needs, which is a fairly strategic level of commissioning and it needs to be there and we need to be able to align the work of local government with the work of the health service on that. Certainly in a county environment it can be extremely difficult to develop a strategic approach when you are working with anything up to 11—it is even 13 in some areas—separate PCTs. So there is a layer of commissioning that is about strategic with commissioning. There is also commissioning which needs to be quite specialist. If you are commissioning for a cancer treatment, you are commissioning for children services, you are commissioning for mental health service, you need to have sufficient critical mass to have the right expertise and you need to be able to match that expertise from within the health sector into the local government sector. We do believe that, whatever organisational structures are brought in, neighbourhood community level commissioning is very, very important. These sorts of services can only be delivered effectively at the most local level, but that is not the same as strategic level whole population commissioning.

Q181 Mr Burstow: Do you think these proposals, as they are coming forward at the moment and as they are being taken forward for consultation, will enable local authorities, for example, to better progress their community strategies and better develop the necessary alliances to produce local area agreements that the Department for the Deputy Prime Minister is now bringing forward? Are those sorts of areas of engagement by the health service with local government likely to be assisted by this change or in any way hampered?

Cllr Rogers: I think that is correct. There are these two levels that Liz has just referred to, the strategic level that can be very readily aligned with the local area agreement process at a strategic local authority level and the important neighbourhood or locality or community level, which has also been mentioned both by Liz and by earlier witnesses, that requires some degree of structure below that and reflects local communities which, as we all know, are very different. Rural communities are very different from urban communities. That is why, again in line with what an earlier witness said, we think that what is in the forthcoming White Paper will be extremely important in setting the scene for this. In the Local Government Association we are seeking to provide input into that by publishing within the next week a paper which is to be called “The Future of Health and Adult Social Care: A Partnership Approach for Well-being”. We see these as part of the whole process, not two separate processes. Social care cannot be seen as being separate from healthcare, it is part of a spectrum and it also needs to be set within that wider well-being agenda which incorporates a whole range of the other things that local authorities are also responsible for, such as leisure services, housing, we might talk also about the arts and libraries and things of that sort. These are the things that give people a sense of well-being and help to reduce the likelihood that they are going to become ill.

Q182 Charlotte Atkins: Mr Nicholson, given the whole range of titles you gave us earlier on, how can you justify, in terms of clinical engagement or clinician engagement and the empowerment of local people and the involvement of non-executive directors and so on, such a huge Primary Care Trust as the one that you are proposing for Staffordshire, the largest in the West Midlands, although it is covering one of the largest areas?

Mr Nicholson: I have been in the NHS now for nearly 30 years and this is my eighth or ninth major structural change.

Q183 Charlotte Atkins: So you have a taste for them, do you?

Mr Nicholson: I do not have a taste for them. What I know is that the pursuit of the Holy Grail or the perfect geographical organisation for health services does not exist. Whatever you do is some kind of compromise in relation to what the local circumstances are. These changes are not just a set of structural geographic changes, these are about getting the NHS organisations fit for a new world. When PCTs were set up we did not have payment by results, we did not have foundation trusts, we did not have choice and we did not have practice-based commissioning. All these new system changes have been introduced. We have got to judge what sort of arrangements we have against those sorts of criteria to make sure that whatever we do set up is fit for purpose. I think Liz is absolutely right, whichever geography you go for there are a variety of levels of function we need to operate at and it is a matter of judgment as to where you set the statutory board. We take the judgment across the West Midlands as a whole, with one exception, that coterminosity with Social Services is a key part of our big change, which is about shifting services closer to home and shifting services away from acute care to primary/community care. We have gone for coterminosity across that. If you go for coterminosity across that you end up with a Stoke PCT which has widespread support locally from MPs and the local government and Staffordshire which has support from the local government but does not have support from the local MPs.

Q184 Charlotte Atkins: Forty of your 49 respondents in a hostile way to the one Primary Care Trust idea. Do you recognise that there are at least two natural health economies within Staffordshire? Coterminosity sometimes may involve the whole of the county council Social Service areas, but where those Social Services are organised on a north-south-east-west basis then why does it make sense to have coterminosity across the wider area, hence losing the local focus which the PCTs were set up to create?
Mr Nicholson: The strength of small PCTs is their local focus. We would say that any arrangements in Staffordshire need to be focused and built around practice-based commissioning localities. The work done by PCTs with public health and with the district councils is excellent and we would not want to lose that. The issue for me is whether you need a statutory board. If we have a statutory board for the whole of North Staffordshire Stoke will not be very happy, it will have problems around Stoke and comiternity. It is never going to be absolutely perfect. If you look at North Staffordshire at the moment, apart from the mental health trust, every single health organisation is in significant financial deficit. The way in which we have managed it in North Staffordshire has simply not worked. I am looking at a deficit across North Staffordshire of probably £30 million at the moment. Every single PCT is in deficit and the acute hospital. The people in that health community have failed to work together to deliver the improvements that we need. We need an alternative way of doing it. That is the reason that we were concerned. Having said all of that, we are part of a consultation process. I know my chair and the board of Shropshire and Staffordshire are keen and interested to engage in a discussion about it.

Charlotte Atkins: That has not been clear so far.

Q185 Dr Taylor: Using Worcestershire as an example, where it is merely a merger of three into one, which does not seem to be quite as difficult, how do you envisage maintaining local involvement from clinicians and from patients and the public?

Mr Nicholson: As it happens, I spent Tuesday going round Worcestershire visiting all the community hospitals and it is an extraordinary place. It is obvious from meeting the people there that the sense of local ownership is very important and that local decision making is critical. I would say the same as I said about Staffordshire, ie we need to build on the practice-based commissioning and on the locality arrangements that are already in place for district councils to make sure that that works. In terms of local engagement, public involvement and all the rest of it, PCTs do not do it at their peril. It is absolutely clear to me that Worcestershire is one of the places where we need public and local engagement with the public.

Q186 Dr Taylor: You have been very good at keeping us informed. On 19 October you sent us a long letter. There is a phrase in that that I would like you to clarify because it strikes me that it means you do not really approve of what is going on. In subsection D you say, “There is advantage, provided a, b, and c are not compromised, in not reconfiguring for reconfiguring sake . . . stability at a time of high expectations of delivery is beneficial.” Can I unpick that and try and get your thoughts behind that?

Mr Nicholson: If you look at the West Midlands as a whole, you will see that we have probably gone for more PCTs than most other places in the country. What we have tried to do is where things work really well and the example I would give is Birmingham, where the current configuration of PCTs works pretty well, we are not going to change it just for the sake of changing it, unless there were really strong views why we needed to do that. That is why we have gone for the configuration that we have gone for.

Q187 Dr Taylor: So “if it ain’t broke, don’t fix it” and you are able to say that?

Mr Nicholson: No. We have also got to make a judgment as to whether it is fit for the new world as well, not only has it worked in the past, but are the configuration, the organisation and the people there.

Q188 Mike Penning: I am very interested to hear you say that if an acute trust or a PCT has a deficit they have failed. Who have they failed, the Government or the people that we are trying to treat and look after? I think a lot of trusts would be very disappointed to hear what you have said because they are working very, very hard. Just to say that someone who is in deficit means they have failed is an appalling statement.

Mr Nicholson: The system has failed, that is the point I was trying to make. Just because you have local determination and local organisations does not necessarily mean you will get a better outcome. As far as PCTs are concerned, they have a statutory duty to balance their books. It is not a managerial issue, it is a statutory duty. When we appoint boards and people to run those boards we expect them to deliver; that is what they are paid for. If they overspend, all that means is that other parts of the NHS have to make up their deficit. It is other parts of the system that will suffer if these organisations do not get it right.

Q189 Mike Penning: At the end of the day what we are all interested in is that constituents get the best possible care and the best possible treatment that £75 billion can produce. You are saying that if a trust or an acute hospital goes into deficit their management failure has got nothing to do with the Government’s problems, it has nothing to do with all these changes that you have described going through, it is all about the frontline managers failing, are you not? There is no blaming the Government, is there?

Mr Nicholson: I am a manager. In my health service career I have never been given as much growth as I have been given over the last few years and we have got a responsibility to make sure we maximise the amount of healthcare out of that money. It seems to me absolutely what we are there to do.

Q190 Mike Penning: You are a manager, you are an employee of the state, you are there to make sure we get the best possible treatment for the patients and our constituents as possible and yet you seem to be saying that if there is not enough money coming through to the frontline—and in my part of Hertfordshire there certainly is not—then it is the managers that have failed because the system has
failed. I find that a difficult thing to accept. It is more like a comment I would expect to hear from the Minister later on.

**Mr Nicholson:** I am sorry, but that is what I am paid to do. When I am paid to deliver a set of improvements in healthcare and to deliver balance—

**Q191 Mike Penning:** And to defend the Government’s position.

**Mr Nicholson:** I am not defending the Government’s position. That is actually my responsibility and that is what I am accountable for.

**Q192 Anne Milton:** Because there is no statutory obligation on quality of care, would you say that this service, therefore, is driven first and foremost by financial balance?

**Mr Nicholson:** Well, clearly not because for whole sets of the population we are not in financial balance. People have to make judgments and it is absolutely—

**Q193 Anne Milton:** So you would sacrifice some financial balance for, say, quality of care or quantity of care?

**Mr Nicholson:** I think in any kind of environment you are always making trade-offs and it may be that in one year you have to spend slightly more money than you have got in order to deliver a service or develop something, but you have to make it up the year after.

**Q194 Mike Penning:** But this is people’s lives we are talking about. We are talking about trade-offs with people’s lives. I find this terminology just appalling.

**Mr Nicholson:** But the NHS is cash-limited and the reality is that if one part of the system loses discipline, another part of the system has to make it up and that is equally unacceptable. I would have thought.

**Q195 Mike Penning:** We could look at how the financial distribution of the £75 billion is done rather than just blaming people in the front-line.

**Mr Nicholson:** Absolutely, and in my part of the world, Birmingham and the Black Country in particular, we are £40 million under target in terms of the amount of money that we have and we have one of the sickest and poorly healthest populations in the country, absolutely right.

**Q196 Mr Burstow:** You gave us a sort of critique of the performance of PCTs which is one of the reasons why you argue there is a need to look at reconfiguration. Does that not also beg some questions about the role of the SHA in terms of performance-managing that health economy in that if there are deficits, is the problem not just in the system below the SHA, but also in the SHA’s capacity to performance-manage effectively?

**Mr Nicholson:** Yes, I am sure that accountability falls in various parts of the system, in the acute sector, in the PCTs and in the SHAs.

**Q197 Mr Burstow:** I just wanted to make sure that was on the record.

**Mr Nicholson:** Absolutely.

**Q198 Mr Burstow:** Can I just pick up on this issue of clinical engagement which Doug asked questions about in the earlier session in terms of clarifying what it is. I want to pick it up in the context of local government because a lot of emphasis has been placed on practice-led commissioning and in a way an evolution of the role of the GP and other practitioners holding commissioning responsibilities at that very local level. Do our local government colleagues here have any thoughts and views about how effective clinical engagement with local government will prove to be on the basis of experience in the past and will that be a good model for really getting engagement with those who will be making commissioning decisions in the future?

**Cllr Rogers:** My answer to that is I hope so. GPs, I think, are very important figures in their local communities and some of them are more willing than others to engage in these processes. I hope that any new structures would help rather than hinder that and, as I was trying to indicate earlier, I think that is very clearly linked with the community or neighbourhood or locality parts of this agenda.

**Q199 Mr Burstow:** Are there any clear incentives, as far as you can see, which will actually make that a reality or are there any incentives that should be recommended which could make it a reality?

**Cllr Rogers:** I think it is possible for those to be in the system and maybe Liz, as a Director, would have a greater knowledge of that particular point.

**Ms Railton:** Yes, there are a couple of things here. I think. One of the great regrets about this debate is that we are focusing on PCT structures and organisation and not on how practice-based commissioning will actually work. We have not had that debate properly. We, as directors, do not quite understand how it will work. We think it is, in principle, a good idea because we think that at the end of the day it is about delivery being led by those at the front-line. We certainly think it is a good idea for staff working within councils, particularly in social care, housing and so on, to work alongside their partners at the front-line of the Health Service, but we do not quite understand at the moment exactly how practice-based commissioning will work, we do not quite understand what the role of GPs will be in it and we do not quite understand how well aligned that will be. Will GPs, for example, group in ways that actually work with the grain of their localities? For example, we are grouping schools at the moment so that they work together to serve their localities, so will those groupings map at all on to the groupings of GPs and, as I say, will they work with the grain of their local communities? There are a lot of issues about that which seem to me to be being ignored in the present debate because of all the noise that is being created over PCT boundaries. You asked about incentives. Well, the underlying incentive about people’s lives is that we are seeing increasing numbers of older people in our
communities and we do not want to see those older people having to go into hospital for their treatment. We see increasing numbers of people living in our communities with long-term conditions and again we do not want to see them constantly going in and out of hospital and relying on the acute sector for their treatment. There are huge incentives on the NHS actually to deal with that because I believe, though I am not an expert on this, that a significant percentage of those who come through the hospital door and get into hospital beds are actually the older members of our community. The incentives to actually work with those people in their own homes in the community and in the places where they want to be, and it is not just healthcare, it is also their housing needs, their leisure needs, their stimulation, their friendships, their community support, their social care—who gets them up in the mornings and makes sure they have got meals, et cetera, et cetera, there are huge incentives for us to work together on this particular issue.

Cllr Rogers: I think this is happening to some extent with Surestart programmes and the evolution of those into children’s centres and with the extended schools and a whole range of things in relation to children, but many of the staff we are talking about who are currently PCT employees, and we do not know where they are going to be employed in the future, are not only based in GP practices or in surgeries, but they are based increasingly at least for some of their time in these other locations within the community. There is no reason why that should not be extended further into housing offices, leisure centres and so on and again that comes back to my point earlier about the wider wellbeing agenda. If I could also return very briefly to Dr Taylor’s point about patient and public involvement, the issue there I think is a link with the health scrutiny role of local government. My view is that the changes to both of those processes, the initiation of health scrutiny and the setting up of PPI forums a few years ago was perhaps not the best answer at the time and there is considerable scope for some rationalisation there and for using the expertise that local authorities have in public engagement to engage with the public in relation to this set of issues.

Q200 Chairman: Could I ask you about this issue about practice-based commissioning. I am maybe stating the obvious here, but when you said you do not know how it works, would this whole area of commissioning and providing have been better dealt with outside of the issue of reconfiguration of SHAs and PCTs?

Ms Railton: Absolutely. One of our real concerns about this debate at this time is that it precedes a White Paper that aims to actually draw the picture of what we are trying to do for the future both in the NHS and in local government with social care.

Q201 Dr Taylor: Going back to Mr Nicholson and rather following up Mike’s point, you have made it very clear that you are paid to manage within cash limits, which I absolutely understand, but is it not also part of your job to tell the Government that with Agenda for Change, GP contracts, consultant contracts, out-of-hours care and all these further reconfigurations, that even though they put extra money in, you do not have enough?

Mr Nicholson: We never have enough. We are ambitious and we want to do more for our people, for our communities, that is absolutely right, and you are absolutely right that if you look at those examples you gave, whether it is Agenda for Change, the consultant contracts, the GP contracts, all of those cost more money than we originally identified in the arrangements to do it, and we make that very clear to Sir Nigel Crisp and his team when we meet them.

Q202 Dr Taylor: So we can take it that you are on our side in that and you are making that point?

Mr Nicholson: I am on the patients’ side!

Q203 Mr Campbell: Can I ask you about the privatisation side of this debate. Basically we have had witnesses in before who said that there would be a lot of creaming off, in other words, cherry-picking of these private companies who may get their hands on something, so what do you think of that? Will that happen? Will the private companies come in and rip you off and make plenty of money because that has been suggested?

Ms Young: I want to respond to that very seriously. That is a danger and I think also we are looking at the potential fragmentation of community services which will not serve local communities well. The beauty of the best of community services is when there is strong integration between the different agencies and there is very, very robust partnership working between health and care and all the different disciplines within the community. Now, if you open the marketplace and say that you can have a number of different providers doing discrete parts of the service, it does beg the question: how on earth are we going to get the seamless service provided often to very, very needy, vulnerable people who actually, because of their problems, have a wide range of needs which go across all agencies? There are very, very complex needs in the community which actually require a robust service rather than lots and lots of little ones all doing bits and parts of the service.

Q204 Mr Campbell: Does anybody else want to come in?

Cllr Rogers: I do not want to go too far down the road you are asking us about, but all I would say—

Q205 Mr Campbell: It is very important.

Cllr Rogers: I know it is, but all I would say is that there is a good deal of expertise in local government in relation to a very similar approach because the social care market has been transformed over the last 15 or 20 years since the Care in the Community changes. There is a great diversity of providers, some of them private, some of them public and some of them from the voluntary sector and from a range of social enterprises, so, without answering your
question directly, there is a good deal of evidence that could be looked at as to what has happened over the last decade or two.

**Chairman:** We now want to move on to the last section which is about public health and where all that fits.

**Q206 Dr Naysmith:** Just before I go on to public health and bring Dr Crayford in because he is sitting there very patiently, and it is very interesting that we get public health at the end of the agenda with about four minutes left for questioning, but I was going to say one or two things to David Nicholson really and tell him that I agree with him absolutely, that his job is to manage a budget properly, and there have been huge increases in money in the last few years into the National Health Service, and I would want him to do his job properly, as he has just been outlining, and make sure that the money is spent sensibly and wisely and right on. Now I want to speak to Dr Crayford and ask him a little bit about what these changes mean to the public health function. Do you think there are advantages of these reforms and disadvantages, if you can fairly quickly outline for us these two areas?

**Dr Crayford:** Yes, our view on the changes resulting from Sir Nigel Crisp’s letter is not entirely negative and in fact, as I think we have heard from other speakers today, some of these changes about PCT merger were in the wind and appeared to be a natural direction of travel for many parts of the NHS. What seems to have accelerated those changes has been the £250 million cost saving and we think that is possibly driving these changes a little too quickly and that that now is the main driver for reconfiguration rather than the natural evolution of structures which I think every NHS evolution has experienced. Some of the good things which will likely come out of this are larger commissioning arrangements. Many of our members, directors of public health and other people working in public health, support the NHS through providing expert advice to commissioning and we feel it is sensible that those commissioning decisions should be taken at a larger level, so larger PCTs we think are good things. What is uncertain and what we think the Department of Health rapidly needs to clarify is how public health will relate to local area agreements and local strategic partnerships, and some of the things we have heard today from Liz Railton and other members about retaining that local engagement, which is the other half of public health; it is about joined-up working at the local level between LSPs and other partners, so people working in housing, in education and so forth. If the Health Service is going to function effectively in public health terms, that joining up has to occur, and at the moment with the state of progress of this reorganisation, we are uncertain as to how public health is going to be placed. Our view would be that we need to have strong representation probably through the equivalent of directors of public health to local strategic partnerships in the country.

**Q207 Dr Naysmith:** It is my impression that it has taken quite a long time for public health to get reorganised given the PCTs were only set up about two or three years ago over the country as a whole and everything is in flux now and this is not going to help the public health function, but particularly how do you think it will help in achieving the objectives of Choosing Health?

**Dr Crayford:** Well, Choosing Health, we fear, is a potential vulnerability through this change. We have heard from a number of witnesses this morning that the NHS is under severe financial strain at the moment, particularly at PCT level. Now, the Department of Health, we think very positively, has made a number of financial commitments, one being through this reorganisation that public health departments will be excluded from the £250 million cost saving, and we think that is a very positive contribution and we welcome that. However, we think possibly almost a more necessary commitment is one to preserve funding which has been allocated for Choosing Health. In this year for the spearhead PCTs, these are the ones particularly in the deprived areas of the country, and looking forward to 2006/07 and 2007–08, there are earmarked funds there which currently are not ring-fenced and we are very concerned in the context of financial pressure, that money will necessarily be used to support PCT deficits. As we have heard from David Nicholson earlier, it is a statutory duty of PCTs to break even and if money is not ring-fenced, particularly where public health initiatives are things that take years and decades to bring about, they are a very easy opportunity for cost savings where targets have to be met within a single financial year and financial balance has to be produced within a single financial year. That is a very difficult decision that NHS managers, who are colleagues, have to make in prioritising these funds and we feel that some form of ring-fencing is a very necessary requirement of the Department of Health going forward.

**Q208 Dr Naysmith:** I was not quite sure, but did you say that the public health function is going to be excepted from the savings which are going to have to be made or not?

**Dr Crayford:** There has been a commitment from—

**Q209 Dr Naysmith:** That has been made clearly, has it?

**Dr Crayford:** Yes, there are two things here. There is the existing public health resource represented by the departments of public health which are found in most PCTs and those departments of public health have been excepted from the £250 million management cost savings. We think that that has been a very sensible decision in terms of delivery of Choosing Health, but funds which have been earmarked in future financial allocations to the NHS have not been ring-fenced and that money, we think, is vulnerable.

**Cllr Rogers:** The Local Government Association and the Department of Health have a shared priority on public health and health inequalities and 12 pathfinder authorities have been working on ways...
and developing learning to help other local authorities and PCTs work more closely together on these issues. That was recently covered in a supplement to The Municipal Journal and I have got copies of that supplement with me today which I could leave with the Committee to make that point. Dr Naysmith: That would be very helpful.

Q210 Dr Taylor: I have just a very quick comment because I was very relieved to meet the newly appointed Director of Public Health to my own PCT which is about to be merged and he had applied even knowing that the job apparently was going to disappear, but he had very clear ideas how the county of Worcestershire was going to work with maintaining directors of public health or their equivalent who would be involved with local strategic partnerships and relieved also, as you said, that the funding for actual public health doctors would not be withdrawn, so I think it is a little encouraging on the public health side.

Dr Crayford: It is, but the point about the fact that there will be potentially fewer directors of public health, I think, is well made and the Department of Health, I think, could provide reassurance to local strategic partnerships about having senior public health leadership probably through the continuation of the director of public health function. This, we suspect, will need to be through two levels of director of public health support: one to PCTs which will be more focused on NHS commissioning; and the second to local strategic partnerships which will be more focused on public health delivery and working closely with local authorities.

Q211 Dr Taylor: So if there was a replacement for the professional executive committee, the public health chap should be on that?

Dr Crayford: Exactly.

Q212 Dr Naysmith: So you are reasonably optimistic then about the public health function in all of these changes?

Dr Crayford: In terms of the existing resource, yes. The exclusion from the management cost savings is good. Choosing Health though is a significant challenge and if we are to deliver the vision for the NHS on public health outlined by Wanless and then in the Choosing Health White Paper, that will require significant levels of investment, not just that which we have seen through sums coming in the future years’ NHS allocations, but through investment across local authorities and the NHS.

Q213 Dr Naysmith: Well, we have got the Minister coming next, so we can ask him about this.

Ms Young: Can I just add to that because I think the letter, the Mr Orford letter, confirming that there should be no reduction in public health funding through all these changes, was obviously very welcome, but it takes more than directors of public health to actually deliver good public health function and delivery is much, much more significant to people on the ground than the commissioning decisions. We have great concerns at the RCN in terms of the school nurses, health visitors and community midwives who do such a lot in terms of public health function along with other parts of their role, and these proposals severely, I think, bring great concerns in terms of future workforce planning, clinical placements, the training of the future workforce and how we are going to do that in a very, very fragmented, multi-organisational community, and actually we need to consider that very, very seriously indeed.

Dr Crayford: I would support that point entirely. Lynn is absolutely right. The director of public health is just a focus for something which has to be everybody’s business across the NHS and other organisations and many of Lynn’s members are absolutely the key staff to the delivery of the future public health agenda.

Q214 Chairman: Was there any consultation with your Association or with public health experts, as it were, on the ground about these changes?

Dr Crayford: Prior to the letter?

Q215 Chairman: Prior to the 28 July letter.

Dr Crayford: No, there was not, no.

Ms Young: Not a word, not even a telephone call.

Chairman: Could I thank all of you for coming along this morning. It has been a very interesting and informative session. Thank you very much.
Witnesses: Lord Warner, a Member of the House of Lords, Minister of State for NHS Delivery, Mr John Bacon, Group Director of Health and Social Care Services Delivery, Department of Health, and Mr Michael O’Higgins, Chair, External Review Panel (Commissioning a Patient-Led NHS), examined.

Q216 Chairman: Good morning, Minister. I wonder if I could ask you if you would introduce yourself and your colleagues.

Lord Warner: Thank you very much, Chairman. On my right is Michael O’Higgins who is the managing partner and member of the international board of the PO Consulting Group who has been chairing the External Panel, which you know about and which may come up this morning, and I thought it was helpful to bring him along, as I think you did. On my left is John Bacon, who may be known to some members of this Committee from previous appearances, who is the Group Director of Health and Social Care Services Delivery in the Department of Health. I am Norman Warner and I am the Minister of State for Delivery in the Department of Health.

Q217 Chairman: Perhaps I could just open up the questioning this morning on the issue of PCT reorganisation. We had witnesses here last week who described it, some of it in great detail, and said they were already making excellent progress in improving commissioning, developing good local alternatives to the acute sector and working collaboratively with other PCTs as well where they needed to do so in terms of that. They were effectively describing the organic growth which was taking place inside the primary care trust sector and it really begs the question: why are they being reorganised again after three years under this current system?

Lord Warner: Well, Chairman, I think it would be fair to say that we did try to set out some of the justifications both in the written evidence we gave the Committee and in the written ministerial statement that Patricia Hewitt put before Parliament as well in the document that was issued on 27 July. However, if I can just summarise the justifications, I think they would be along the lines that we are very concerned that we do need to shift more towards prevention and moving services closer to patients with a much stronger emphasis on primary and community services. We have done a great deal as a government in responding to people’s concerns about hospital services, but the focus does need to change, and, in our judgment, that needs a stronger set of primary care trusts to design, plan and shape those service areas and to be able to play a more effective role in commissioning services around from hospitals and to hold those hospitals and GP services more firmly to account. That is why we are moving into a mode of strengthening the commissioning function through stronger PCTs in the way that we propose. The other change which is taking place alongside this which does push you towards strengthening the PCT role is the rolling out of practice-based commissioning, which we can touch upon in more detail, does put GPs much more centre-stage in commissioning services for their patients. I thought that you had had some rather revealing evidence from Dame Gill Morgan and her colleagues when they came to speak to you last week about the fact that there were already in many parts of the country PCTs talking about mergers, talking about, and not just talking but working together in some ways and Gill, in the evidence as I recall, mentioned 43 actually doing it and others moving in that direction. We have a very clear sense of uncertainty around that direction of travel within the NHS because what it is worth just bearing in mind is that we did talk about organisational change in the Creating a Patient-Led NHS document which was published before the election in March and that did herald and foretell that there would need to be some organisational change, so the document of 28 July needs to be seen in the context of that advance. In a nutshell, this is about strengthening the commissioning function in a context of practice-based commissioning being much more centre-stage than it has in the past.

Q218 Chairman: I think my colleagues will want to pursue many of those issues there, but the one specific one that Dame Gill did bring to us last week was that it normally takes in the region of about three years before the reorganisation begins to bear the fruit that you would want it to and yet here we are, three years on from the initial reorganisation and the bringing in of PCTs, and we have got this rather strange situation where we have now been reorganised already and the assessment has not been made. So three years in and you get the benefits and the fruits of reorganisation, yet in three years we get a reorganisation, so could you explain what your feelings are about that?

Lord Warner: What I would say is that I did read Dame Gill’s evidence very carefully and she was citing companies like British Airways and the private sector, as I understood it, for why it took them three years to make changes. I think this is a little different. What we have seen, I think, and this did also, I think, come out in our evidence and other evidence that has been put to you, is that there has been a certain patchiness about the effectiveness of the changes which have been introduced around the country. It has not been consistent. What we have seen is some PCTs doing very good jobs, but the current PCTs themselves are quite variable in size and there is quite a considerable variety. In the proposals that have come forward, which I think also Dame Gill mentioned, in not all parts of the country are there proposals for reorganisation, but there are some parts of the country where there are proposals not to change particular PCTs, so it is not all change and the variety of change is variable in the proposals that have come from the strategic health authorities. We believe that we have to actually say that we want to make a move in this area both because of the patchiness of the progress which has been made and the clear evidence in some places that people are struggling. I think one of the issues that came up in your earlier session was the issue of management capacity and we do know, and I think Dr Doug Naysmith raised some of these issues previously,
that there are some issues about some parts of the country struggling, particularly in finance and human resources with their capacity, and we think we need to address those issues, but through a process of change being orchestrated by people at the local level discussing their concerns and considerations. I think it is worth bearing in mind that this is not a top-down imposed set of changes. The processes that are being adopted are asking people locally through the agency of the strategic health authority to come forward with proposals which we have passed to an external panel first and there will then be a further three-month consultative process. People will then emerge from that process. Therefore, we are tackling the issues that need to be tackled, but we are not forcing change in areas where there may not be a need for change.

Q219 Anne Milton: I do not think that entirely paints the picture that we have heard of. First of all, in terms of this being bottom-up, the suggestions are bottom-up, but if nobody likes them at the top, then they say no, so it becomes a top-down process. We heard this morning about the distraction that these mergers are causing, we heard about the uncertainty, and one gentleman talked about the staff being cheated five times already in his lifetime, and we got a fairly strident description from the Royal College of Nursing about the effect it was having, particularly on community nurses. I am left in no doubt of the fact that this is going to cause a huge distraction, a huge loss of focus, a decrease of service delivery and some extraordinarily unhappy staff. You might be very clear about where all of this is going, but clearly NHS staff do not feel the same.

Lord Warner: Well, I do just have to repeat what I said that change was heralded organisationally in the document that was published and was widely distributed around the NHS, called Creating a Patient-Led NHS in March. It was clearly indicated. The new kid on the block, if I may put it that way, since the changes of three years ago is practice-based commissioning. Now, in many of these very small PCTs, you could be having some rather crowded territory with practice-based commissioning and GP-commissioning having, particularly on community nurses. I am left in no doubt of the fact that this is going to cause a huge distraction, a huge loss of focus, a decrease of service delivery and some extraordinarily unhappy staff. You might be very clear about where all of this is going, but clearly NHS staff do not feel the same.

Q220 Anne Milton: No, but, with all due respect, what it feels like to you is not quite the point; it is what it feels like to the NHS staff which is what matters. In fact what is my concern is the loss of function. Payment by Results is going to put a huge driver for acute hospitals to be sucking money in and unless practice-based commissioning is really off the ground, then there is not going to be that balance in it. What we have heard is that this reorganisation is going to be a distraction, therefore, practice-based commissioning will have less of an opportunity to get off the ground and my fear actually is that there is just going to be money pouring back into the trusts and being diverted away from community services and the opposite is going to be achieved.

Lord Warner: But, as I understand the evidence that was put to you by people closer to the ground than myself from the Confederation and others, they were using the information that you are giving me to draw exactly the opposite conclusion. They were actually saying that Payment by Results without strong commissioning could lead to the outcome that you are suggesting and that is why we do actually need to strengthen the commissioning function both at the PCT level and at the practice-based commissioning level. Without that strengthening, the very concerns that you are expressing could take place.

Q221 Anne Milton: But we will have an 18-month time-lag and while the reorganisation is going on, the PCTs are not going to feel strong, there is going to be a loss of staff and there is going to be a loss of focus. I think that is what we have all heard.

Lord Warner: Well, clearly that is your view. What I am saying is that Payment by Results itself is not going to be rolled out overnight; it is being rolled out over a four-year period. We are trying to take action here to strengthen the commissioning side. The kind of timetable, which I think is available to the Committee, does mean that it will be possible by the middle of 2006 to have the new PCTs up and running and, as I have said earlier, some PCTs will not change their organisational patterns. There is already a move in many of these PCTs to work together and I think John de Braux gave you some good evidence from his own area of how you would maintain the continuity of services that are required which was set out as a requirement in the letter to the SHA on 28 July.

Q222 Mike Penning: Minister, if I can then you draw you a little bit more on the letter from Sir Nigel Crisp on the 28th, the timing of which I think you can describe in many different ways, but probably balancing the profession and Members of Parliament by its timing, it has been described to us that the consultation process has been flawed or is flawed based around the length of time that has been given to consult with the relevant bodies and with
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MPs as a whole, and this is having a major effect on morale within the PCT staff. I wonder if you would like to comment on that for me.

**Lord Warner:** I have already to some extent pointed out that this process in a way did not start in July, but the process in some ways started in March 2005 with the document which heralded some degree of organisational change. There was inevitably to some extent some degree of slowing down because of the election and the aftermath of the election and what was becoming clear to us in June and July was that there was growing uncertainty in the NHS about what was coming down the track. The NHS is pretty good at speculating about change, and not always accurately, and there was uncertainty which is itself just as corrosive as actual change itself. If people are speculating about possible changes, even if they are incorrect speculations, that does itself damage morale and it does damage organisational functionality. What I think Patricia Hewitt and I wanted to ensure was that we did try to give some clear pictures of the direction of travel through the document on 28 July. I would be the first to acknowledge that the timing was not impeccable, but we were where we were. If we had just let things drift another three months until Parliament came back, we would have had more speculation and more unease about where the direction of travel was. We believe that there was a genuine attempt, and I think this is the evidence from the proposals that I have seen, and it was not consistent across the country, there was a genuine attempt to engage people at the local level, but the fall-back position in all of this is, as I have said before and will say again, that there is a three-month formal consultation before any decisions are taken, so we have had a preliminary consultation and there is still a three-month consultation to take place locally with every conceivable stakeholder before any decisions are taken about organisational change.

**Q223 Mike Penning:** So you are assuring the Committee that the earliest possible opportunity that Sir Nigel Crisp's letter could have landed on our doorsteps was the day after Parliament rose?

**Lord Warner:** Absolutely. I am assuring the Committee that we could not have got that letter out earlier. If we could have got that letter out earlier, we would have got that letter out earlier. We must be a slightly odd set of characters if we deliberately set out to provoke you all by doing what you seem to be implying we were trying to do. Our concern was the uncertainty in the NHS and that is an important consideration. We made it clear in the document that was published that MPs were part of that consultative process and we have made that absolutely clear.

**Q224 Mike Penning:** My final point on the consultation process, which you have freely admitted this morning in some areas was not perfect and has been described by other people giving evidence to this Committee as being flawed, are you confident that the legal processes that the consultation has gone through are there and you are not going to be in any way legally challenged?

**Lord Warner:** Well, the formal legal processes are the three-month requirement which will take place on the proposals which come out for consultation probably in early December so that people can have their say. Now, we could be said to have actually gone much further than the normal formal legal processes on consultation and indeed, whatever else we have achieved, we seem to have achieved a good deal of understanding that there are changes taking place and people are certainly fairly well warmed up to start considering the proposals in their local area, so we have actually in a sense extended the consultation process in many ways by starting it back in the summer rather than waiting for proposals to be too firm on the horizon before they can come out. It is highly likely, though I do not want to speculate because I have not heard what has come out of Mr O’Higgins’ Panel’s observations on these proposals, but we certainly knew, going into the Panel, that there were different options in different parts of the country, so there will be different proposals, different options which will be part of the formal consultation.

**Q225 Mike Penning:** With respect, Minister, I asked a question and I have not had an answer to it. Do you expect, or do you have knowledge of, legal challenges to the consultation?

**Lord Warner:** Well, we know that the Royal College of Nursing, and it is in the public arena, are proposing to take judicial review action. I am not aware of any other legal challenges and I do not anticipate that we will be legally challenged over the consultation process because, as I have said, we will be conducting the normal three-month consultation process which we are required to do.

**Q226 Chairman:** Just staying on that, Minister, you describe a picture here which clearly happened in July because of the 90-day consultation process and everything else and that has to get in train at some stage, but what were the inadequacies of this message that everybody got in March that they clearly did not concentrate their minds on? Is that not what we are seeing here, that people should have known in March, but nobody concentrated their minds on it until the letter of 28 July?

**Lord Warner:** Well, I think in the situation we are in, we are to some extent, if I may put it this way, damned if we do, damned if we do not. We are facing a situation where the messages coming to us are a great deal of uncertainty, and I can let Mr Bacon elaborate on that because he is closer to this in his role, about what is going on in terms of the prospects of organisational change and we feel there is a need to begin a process to enable people locally to engage with that issue of organisational change which is why we have constructed that document of 28 July. Now, in an ideal world, I am absolutely acknowledging, it would have been nice if that could have been got out earlier, but, as I have also said, there was a degree of slowing down because of the
election and the aftermath of the election and we had a new set of ministers picking up the reins in this area, but we did have to listen to that noise coming out of the system and we have done nothing here to offset in any way or to disrupt the prospect of a final three-month consultation period.

Q227 Chairman: I accept that, but what you describe is actually that the people you contacted in the Health Service in March did not pick this up. It is no good saying that ministers were not put in place until well after 5 May because there is this wider issue about why the response was not earlier in the year.

Mr Bacon: Perhaps I can add to what Lord Warner has said. The background to this is that during the course of the year or more before March 2005, we had quite a lot of pressure on us to allow organisational change and indeed, as Dame Gill Morgan commented, something over 40 PCTs had already, with our agreement, forged joint management teams because they could see locally that their current organisations were not of the right critical mass or of the right shape to do the commissioning function properly, so we had some pressure in the system to do this. We felt over the winter of 2004–05 that we wanted to take a structural look at this, about what organisational change we wanted to see, and the outcome of that was signalled in Sir Nigel’s document in March, but what it actually said was not, “Go off and create change”, but it said, “We will give you further guidance as to how we want this done shortly”. Of course the election intervened and we had, first of all, to wait for the electoral process to take place and, secondly, then to take our new ministerial team through our thinking and to get their thinking to produce a document which would then give formal guidance to the Service as to how we wanted this to proceed. We had promised in Sir Nigel’s letter and I think rather more in conference speeches, et cetera, that we would get this advice out before the summer, so there was a lot of pressure there and a lot of expectation in the Service that we would do that, and, since we had committed to doing that, we felt that we ought to honour that commitment to produce that document. That is the sort of sequence and background and I think it is worth repeating the point, and I think it has come through in your evidence already, that there was a lot of pressure in the system to get on with some of this, so it was not just us imposing the timetable, but we already had a build-up of pressure to do this.

Q228 Mr Burstow: Just on the process, before the election, who at the ministerial level was leading on this work?

Mr Bacon: That was a whole ministerial team, but specifically John Hutton, as the then Minister of State for Health, was the Minister who revealed it.

Q229 Dr Taylor: It appears to us that this was happening naturally and, if it was happening naturally, why did you not let it go on happening naturally where it was felt to be needed and not force a big-bang approach on everybody?

Lord Warner: We have not forced a big-bang approach on everybody; we have asked people to look at their circumstances locally against a set of criteria. What was taking place was some change in some areas, it was not taking place in all areas and it was not necessarily taking place in the areas where one might have expected some changes to take place. We do know that some PCTs were increasingly struggling in terms of financial management and in terms of their budget management, which we had to look at, so what we had was a rather mixed picture of organic change, if I may describe what I think you are suggesting in those terms, where there were definitely some changes. There were some people saying, “Why don’t you hurry up and let us move faster in this area?”, there were some being rather sluggish and not moving forward and there were problems in particular areas, and there were some areas where very little change was actually required, so, because of this rather mixed picture, those were the very grounds for not having a top-down set of changes. You are quite right, I would agree with that, we did not want a lot of top-down changes. What we did want people to do was address the issues locally and come forward with their proposals for actually changing the configuration of PCTs in a context of expanded practice-based commissioning and against a set of criteria, one of which was the very powerful criterion of coterminosity between health and social care which is a key issue for the Health Service in the future.

Q230 Dr Taylor: Are you not in fact being driven by financial considerations because is it not a coincidence that you expect to save £250 million which is in fact the deficit of the NHS?

Lord Warner: We would be quite a remarkable political party if, in framing our manifesto for a May election, we could have foreseen what the deficit for 2004–05 would have been; we would be vested with the gift of foresight.

Q231 Dr Taylor: Minister, it was predicted in the Health Service Journal before the election, well clear of it.

Lord Warner: I have to say that we prefer to use our own financial monitoring systems!

Q232 Mr Burstow: Is that more accurate?

Lord Warner: Chairman, I do have to defend Mr Bacon and his colleagues in terms of their financial monitoring services. I must repudiate the idea that we should get rid of the Civil Service in this area and replace it with the Health Service Journal editorial team!

Q233 Dr Stoate: Minister, I entirely accept your assertion that there was pressure in the system to change over the last year, I entirely agree with that. I also remember the document in March, which I think was called Commissioning a Patient-Led NHS, which did indeed talk about organisational change, but one thing that we have got this morning, particularly from the RCN which they were very concerned about, I do not recall anywhere in that
document the idea that the PCTs would lose the provider function and have the commissioning function only. Now, that is what is causing huge amounts of anxiety and anger, particularly amongst the many hundreds of thousands of nurses in this country who do genuinely now feel quite threatened in terms of their future employer status. As I say, that was not, as I recall, heralded in your March document at all and it did appear to be a bombshell in the 28 July letter which the organisations we have spoken to were very keen to focus on, so I would really like your comment on where that came from and why that was dropped into the mix when it did not appear to have been present in any previous statements.

Lord Warner: I think it would be fair to say that the contentious paragraphs, as I understand it, in the document of 28 July are paragraphs 6 and 7 and, in particular, the sentence that we would expect all changes to be completed by the end of 2008. That seems to me to be at the nub of the concerns that you are expressing. Patricia Hewitt has, I think, acknowledged that that was pretty unfelicitous, the way that was actually expressed, but I think we would go further and say that we believe, and she will be saying this this morning at a nursing conference, that that statement was too prescriptive and we have resiled from that timetable. We have tried to make that clear, or Patricia has tried to make that clear on a number of occasions, with a statement on 18 October, and she has tried to get across the point that it was not intended to be as prescriptive as that. We cannot airbrush out of history the fact that those words were said, and we acknowledge that, they were too prescriptive and we have said they were too prescriptive. What we have not said and what we need to continue to say is that some of the ideas in those paragraphs were correct. We are in a situation, and some of the evidence that was given to you, I think, suggested, that some PCTs do want to change the relationship and the balance between their commissioning activity and their provider activity. There are PCTs, and Brighton is one, which have no provider services, and Brighton does not run any services at all. There is a very mixed pattern around the NHS in terms of the balance between commissioning and providers. We know that there are areas where particularly, for example, specialist voluntary organisations feel that they could do more for particular people, especially with long-term conditions, in providing services. We have already got people like the voluntary sector, Marie Curie nurses, MacMillan nurses, actually providing a lot of direct services themselves under the banner of the NHS. What we are now saying and have tried to make clear is that there is going to be a variety of service models, and we have made it absolutely clear, including PCTs, with none or few directly provided services and what we want to see is that this is left to the judgment of people locally, the PCTs locally, to get the configuration that best meets the needs of their patients in their locality.

Lord Warner: I just would like to quote from the statement that Patricia Hewitt issued, which has been given, and repeated, to the Royal College of Nursing many times. This statement says, “District nurses, health visitors and other staff delivering clinical services will continue to be employed by their PCT unless, and until, the PCT decides otherwise. The terms and conditions of staff will of course be protected. The decision will be driven locally following our White Paper deliberations and would only be implemented following full local public consultation”. Now, I do not think we can be much clearer than that and that has been repeated to the Royal College of Nursing several times. The Secretary of State has written only this week to the Royal College of Nursing to clarify, I would think beyond peradventure, what our position is on this. We cannot say that never at any point in time in the future will a PCT not decide to change its configuration of community services and, if that is what is being asked, it is an assurance which none of us can give because if the needs of patients in particular areas require changes in those services, and, Dr Stoate, you are a GP, it would be surprising if we had practice-based commissioning and there were no recommendations coming out of practice-based commissioning for changes in the configuration and delivery of community services, so we cannot give that guarantee that for all time there will be no changes. What we are saying is that they will be changes driven by the needs of local areas with the PCT in the driving seat and going through the normal processes of statutory consultation on changes in service configuration and guaranteeing that the terms and conditions of staff would be safeguarded in the normal way, and the public sector and the Health Service in particular have a pretty good track record, I would say, in safeguarding the terms and conditions of service when there is organisational change.

Q235 Mr Burstow: It is helpful to have this restatement of the clarification which was in Sir Nigel’s letter in August about the timetabling of divestment not being December 2008, or indeed
October 2006, which was the uncertainty that the original letter from 28 July caused. If, as you say, you are resiling from the December 2008 time line for divestment, what that still does not leave absolutely clear is whether or not the policy intention of the Government, as set out in the letter of 28 July, which was that the direction of travel was clear, is that the PCTs’ role in provision would be reduced to a minimum. Is it still the Government’s long-term intention that the role of PCTs, as providers of services, in time, not 2008 but maybe some point in the future, will have a divestment of service so that they are minimum providers? Is that where the Government want to go?

**Lord Warner:** What I would like to repeat is what I said right at the beginning of this evidence session. The purpose of the change in the PCT reconfigurations is to strengthen the commissioning function. I think one of the people who gave evidence to you last week said, “Of course there is a tension for us if we are both giving a lot of our time to managing the provision of services. How can we find enough time to give the attention we need to give to commissioning”?

**Q236 Mr Burstow:** We heard the evidence last week but the question is very simple, it is about what the Government’s policy intention is.

**Lord Warner:** We did try to act on an evidence basis. The evidence basis is that it is difficult to get that strengthening of commissioning if you are continuing to run over time a growing volume. This is the context where we want to see expansion of community services. The message which is coming out of the public consultation—which will lead into the White Paper—is all about how you can expand community services. It is about rebalancing the Health Service between hospital and services outside hospital. If that is what the public want, it is what the professionals want, we think it is the Government’s job to facilitate that change. The logic of that change is that you rebalance the system between commissioning and providing.

**Q237 Mr Burstow:** The letter from Sir Nigel Crisp was somewhat more explicit about what that rebalancing would mean, whether it is by December 2008 or not, and you say that is now the timeframe, but it was explicit that the provision would be reduced to a minimum. A minimum is rather different. What I am trying to establish is whether or not that still holds good as the policy intention behind all this?

**Lord Warner:** The policy intention of the Government is in the context of expanding community and social care services to meet the needs of an ageing population with many more long-term conditions. It is to enable PCTs to strengthen their commissioning function and get a better balance between that commissioning function and the provider function, and at the same time not be prescriptive about the timescales and the basis upon which that is done. That is the policy of the Government.

**Q238 Mr Burstow:** The reason I am asking this is because the former minister responsible for this policy, John Hutton—Mr Bacon confirmed it was him just now—was asked very similar questions at the Public Administration Committee just a week ago on 1 November. He was asked, “Is it the case that you would like to see primary care trusts divest themselves of their provider responsibilities?” John Hutton’s answer was very clear and unequivocal, it was “Yes, that is the policy of the Government”. Is John Hutton right, is that the policy of the Government?

**Lord Warner:** I am not saying anything different from John Hutton, only I am probably saying it in a rather lengthier fashion.

**Q239 Mr Burstow:** I am trying to remove a lot of the verbiage.

**Lord Warner:** I know you are. I know what you are trying to do.

**Q240 Mr Burstow:** It is either yes or no.

**Lord Warner:** I am not going to put in that yes or no. I am making it clear.

**Q241 Mr Burstow:** John Hutton did and he was very happy to give the answer yes.

**Lord Warner:** He is a Cabinet Minister, I am rather slower of thought and movement. What I would say is that the direction of travel is in the direction that John is saying. We are saying it is down to people at the local level to get the timing of that right. It follows arithmetically that if you want to strengthen commissioning and you have got expanding community services, you are not going to go on enlarging the direct provider side of PCTs. The pace at which that is done is down for local decision.

**Q242 Dr Naysmith:** I would like to be clear as well because this, as you know, has caused lots of problems in lots of places. Are you saying it is the Government’s policy not just to facilitate divestment but to encourage it?

**Lord Warner:** If we expand services we must allow new providers to come in, and some of the worst parts of this country with the greatest health inequalities are some of the poorest areas in this country in terms of primary and community services. In some of those places we have to ask why the traditional methods have not given those people a fair level of services, and we must enable new providers to come in to provide those services, and we must enable new configurations of services to be provided in many of those hard-to-reach communities in terms of health and social care.

**Q243 Mr Burstow:** That is not the same as PCTs giving up their existing services and divesting themselves.

**Lord Warner:** It could mean the inadequacies of the present pattern of service provision have to be changed. That is why I cannot give you a straight yes or no because it turns on the needs of particular areas. I would say as a general statement it is some of the worst-served areas with the greatest health
inequalities which most need new entrants to provide new services in their particular communities.

Q244 Chairman: I think we accept that but is not the real question here, if it is about PCTs not being providers any more, and that is the general direction of travel—and at least you and John Hutton agree on that—could we foresee a situation where because a PCT would not be encouraged to keep providing services, that those services provided by another organisation may not be as good? I do take the point about what you believe to be the poorer services out there in primary care should be improved, and maybe this is a method of doing it, but could you envisage a situation where a PCT could be effectively stopped from providing the service and that could go to somebody else but it could be a lesser service that they provide?

Lord Warner: That is certainly not our intention and it would be a contradiction of what I have been saying about strengthening the commissioning function. The purpose of strengthening the PCT commissioning function is to improve the quality of services. If they were substituting an inferior service for a current directly-provided service by the PCT, they would actually be failing in their commissioning duties.

Q245 Chairman: It is an extreme example I give but I think it is important for people outside who work in and people who receive services from the primary care sector. You could have suggested on 28 July that this was going to happen within a very tight timetable, it was going to be removed from them as providers, and that is what has caused quite a lot of concern within the primary care sector, but we are not saying that has been withdrawn altogether, are we?

Lord Warner: What I am saying is the direction of travel with PCTs providing fewer direct services is in our view an inevitable consequence of strengthening the commissioning function. What I am also saying is that both Patricia and I regard the wording which was used in the 28 July document on this territory as far too prescriptive and that is unfortunate. I am acknowledging it is unfortunate that the confusion and concern that has been caused has actually happened. I cannot be plainer about what I am saying about that.

Q246 Charlotte Atkins: Can I ask you to be plain about the future running of community hospitals? Will it be the case that if PCTs continue to want to run community hospitals they will be allowed to do so?

Lord Warner: In the future what we are trying to do is ensure you have strong commissioners. That is the starting point for PCTs, that they actually look at what the needs of their community are, and that could include a community hospital with a certain range of services. The thing about community hospitals is that they are not uniform, they have a variety of services in them and they are likely, if I may speculate a little, to have an even wider variety of services in the future and I will come back to that remark in a moment. What it is down to the PCTs to do is look at what is the best way of providing those services.

Q247 Charlotte Atkins: But it will be a decision of the PCT? Yes?

Lord Warner: Can I put this in context. If the community hospitals expand following the public consultation we are going through and the White Paper which comes out, it is not really consistent with strengthening the commissioning function of PCTs that they should take on a bigger role in managing an expanded version of community hospitals. That is not consistent with policy direction or our wish to get commissioning at the centre of their functionality. What I am saying is, it seems to me the logic of what is coming out of the current public consultation is to try to get more services closer to patients and more accessible than in a big acute hospital. The logic of that is, and we have committed ourselves to providing more community hospitals in our manifesto, that we will be making some policy statements about the future direction of community hospitals in the White Paper, that is an area in all likelihood of expansion rather than contraction, but there needs to be a local dialogue about precisely what services you put into those community hospitals, which are likely to be different in a suburban area from a very rural area, and there is going to be a mix of arrangements so they will be very varied I would suggest in their future pattern.

Q248 Charlotte Atkins: You rightly say, and I accept this, in certain circumstances PCTs have to merge to strengthen commissioning, but you do not seem to have any problem with strengthening GP commissioning while they are still providers of services.

Lord Warner: We are not going to stop GPs being providers of services, they are at the centre stage. 90% of people’s contacts with the NHS are through primary care and community services, that is where we are at. So the GPs are clearly providers but they are already, if I may say so, providers and commissioners. The group of people who come in on the average morning surgery, some of them they will provide the service for, others they will refer to somebody else, so they are commissioning and providing at the moment. What we are saying is that the evidence suggests to us that actually giving GPs a stronger role in that commissioning, what they can commission, what they can access more directly for their patients instead of sending them off to an acute hospital in a more traditional way, both takes advantage of the skills of GPs and actually is more beneficial for many of their patients. We do not want to artificially disrupt the relationship between GPs and their patients.

Q249 Charlotte Atkins: But what you are saying is that GPs are able to ride both horses in terms of providing and commissioning, but PCTs somehow find the two tasks impossible to parallel.
Lord Warner: I am not saying it is impossible, what we are saying is we think the evidence so far is that many of them have struggled, and some of the evidence which was given to you suggests they have struggled. What we are saying is what is critical for the future of the NHS is very strong commissioning, if you want to get the right balance between services which are provided in an acute and general hospital and the services which are provided in primary and community care services.

Q250 Charlotte Atkins: We certainly found that some PCTs have struggled but from the evidence we have had, and I am glad you have read it very carefully, we also heard that joint arrangements were beginning to work effectively. Lord Warner said, is that variable, but there are certainly cases where the act of trying to do this jointly is of itself consuming management effort to the distraction of the actual process of commissioning. We have heard from a number of PCTs that they would prefer to be in a single statutory organisation so they do not have the issues of having to negotiate between themselves before they can negotiate with their providers. So I think there is quite a strong driver to get the best fit we can for the act of commissioning, but you cannot impose a single solution to that because it is very dependent on geography and population density, so what you would find in London I am sure would be very different from what you would find in some of the shire counties. We want to ensure that the management effort goes into commissioning and not trying to make an imperfect set of statutory bodies work better together.

Q251 Charlotte Atkins: So it is okay for shire counties to come up with a PCT which is even larger than the old health authority we got rid of some years ago?

Lord Warner: If they are able to demonstrate against the criteria we have set that they will come out with a good commissioning model, and if the external panel believe those criteria have been properly addressed and then if the public consultation process is considered to be supportive, then there is no reason why they should not. But the acid test is whether it will be fit for the purpose we want in commissioning.

Q252 Charlotte Atkins: Presumably local opinion will be taken on board even though it has not been in the pre-consultation period?

Lord Warner: I have said that before any decisions are taken, round about early December, I would expect us to put in the public arena a set of proposals which take account of the views expressed by the external panel for public consultation where there is a change of configuration across England for a three month period. Some of those proposals will be more than one option because that is what has come up from the different areas. There is not a single option, they have actually proposed several options with pros and cons, we are not going to distort that and we are not going to arbitrarily remove those options, they will go forward for public consultation on a three month period and those views will come in before ministers take any decisions.

Q253 Charlotte Atkins: Mr O’Higgins was nodding his head at that point and, as he is sitting there for a reason, perhaps I could bring him in. How many times has the external panel met? I know you met on Tuesday but will you be meeting again? When is the external panel likely to come up with its recommendations as to the consultation period?

Mr O’Higgins: The external panel met yesterday for the first time, an all-day meeting, and we are quite clear our brief at this stage is to determine whether the proposals which have come from authorities meet the criteria sufficiently to go for public consultation. It was not our goal yesterday to make substantive comments on proposals in one direction or another, because that would pre-empt the consultation process. What we did yesterday was to go through each of the submissions, examining the extent to which we believed they met the criteria. We have not yet had the chance to report to the Minister on those deliberations. However we will be setting out some general observations including, if I may, the fact that in certain areas the pre-consultation process was not fully adequate, because we have had representations which make that clear, but we will be setting out area by area our view on whether the proposals as they stand at present are appropriate to go for public consultation, and in some instances recommending modifications or raising questions about the extent to which perhaps other options should also go for public consultation.

Q254 Charlotte Atkins: So you consider submissions not only from the SHA but also from other organisations within the process?

Mr O’Higgins: We did not do a comprehensive consideration of everything anybody submitted in the timescale possible, what we did have was a sense from other intelligence that the Department provided us with, and which individual members of the panel had, of where there was satisfaction or less satisfaction about particular proposals and about the extent of consultation on those proposals.

Lord Warner: We did actually make sure all the comments from MPs and other local authorities, et cetera, which have been made to us and that we were aware of were fed into the panel. So they had them alongside the SHA proposals.

Mr O’Higgins: As you can imagine, panel members have been receiving individual comments from different authorities as well.

Q255 Chairman: Can you tell us when we are going to see signs of that, not just as a Committee but people who have written in as well? Is there likely to be some publication?

Lord Warner: We will do our best to put this in the public arena. Some of these are phone calls so there is a slight problem; they are not all quite as formal and well-documented as the SHA proposals. We will
try to put in the public arena, providing they are not actionable, the comments which have come in on this, so that MPs and the public can see what has gone to the panel.

Q256 Chairman: That would become part of the consultation process?

Lord Warner: That would be available for people to access as we move into the three month consultation period. We have no interest in not being as transparent as possible about this and we want to be as transparent as possible. The next step is for ministers to receive and consider these proposals and we will then have to take a decision whether they are in a fit state to go out for the three month formal consultation or whether the remarks and observations by the panel suggest we should not start that process, we should refer matters back to the SHA for some further discussions locally with people including with MPs.

Q257 Mr Burstow: Can I ask Mr O'Higgins a question about the criteria, whether or not any of the criteria you are evaluating, and which have been set out in Nigel Crisp's letter, are considered to be hurdle-criteria which have to be got over before any of the other criteria are taken into account?

Mr O'Higgins: In the way we conducted our deliberations yesterday, no, but I emphasise the deliberations yesterday were about the extent to which the proposals were adequate to go out to public consultation. At the end of the public consultation process when we are considering what has emerged from that, we may then examine certain issues more substantively.

Q258 Mr Burstow: So, for example, finance would not be an overriding criterion, the 15% savings?

Mr O'Higgins: No, finance is not an overriding criterion. Public health is an issue which is quite important and we need to be examining substantive documents. Nor indeed is size an overriding criterion. The proposals we have reviewed reflect quite a wide range of sizes of proposed PCTs in the new structures and the panel has not assumed there should be specific limits, upper or lower, for the population size of new PCTs and in many cases of existing PCTs which will not change. However, what we do assume is that particularly small PCTs can expect to be challenged on the extent to which they can achieve economy of scale savings and about their ability to ensure contestability. Rather large PCTs will be challenged and be expected to have quite clear proposals to ensure local patient and stakeholder needs are met.

Q259 Dr Naysmith: What is a rather small PCT? I know you are not setting limits but what are we talking about when you say a rather small PCT?

Mr O'Higgins: The proposals as they have come in at present have PCTs varying from 140,000 in size through to an upper limit of 1.2 million.

Q260 Dr Naysmith: So 140 is the lower end?

Mr O'Higgins: 140,000 I think is about the lowest of those in the existing health authority proposals. John?

Mr Bacon: Yes.

Mr O'Higgins: Give or take a few thousand.

Mr Bacon: We have a small number of proposals which are less than 150,000, largely based around small unitary authorities, and we have a handful of very large, 1 million or 1 million-plus.

Q261 Dr Naysmith: The reason for them is because you have this question of the boundaries with social services and you will get that with small unitary authorities?

Mr O'Higgins: One criterion which might justify a particularly small area is the importance of co-terminosity. Then you have an area like the Isle of Wight which has particular features which may make that appropriate. So in that sense one of the reasons I said there are no absolute hurdles is that it is a combination of factors like that which would need to be reviewed.

Q262 Mr Burstow: Back to the divestment issue and just to be clear, will staff transferring outside the NHS, including into private sector organisations, be able to retain membership of the NHS pension fund?

Lord Warner: Where this has happened in the past, my recollection is—and I will check when I get back and correct if what I am saying is misleading—that staff have a choice. They can actually enter new arrangements for their future pension on terms which are meant to be equivalent in kind to the present arrangements and in effect freeze their current NHS pension where it is. So they have a choice. In some cases they can transfer pensions, as I understand it.

Mr Bacon: As Lord Warner, I would need to go back and check this. First of all, of course, under any circumstance employees are entitled to TUPE transfer. We neither can nor would want to do anything to disturb that. There are occasions when pension issues are difficult. It would be wrong for me to deny that. What we are looking at, and always look at, is how we can make the best possible arrangement for individual members of staff in these circumstances, so it will vary, but we are very focused on it. It is one of the things we know staff have greatest concerns about and we will do whatever we can possibly do.

Q263 Mr Burstow: You would not see this being a particular impediment to divestment to non-NHS providers of services?

Mr Bacon: As I say, we are currently working through to ensure we give the best possible position to staff in these processes, as we have done in the past.

Q264 Mr Campbell: Given the timescale is tight, these organisations are being set up but they clearly appear as though they do not know what their
functions are. I will give Derbyshire as an example, they do not know what their functions are. Are we not running ahead of ourselves here?

Lord Warner: Can I make sure I understand the question. Are we talking about PCTs?

Q265 Mr Campbell: Yes.

Lord Warner: The PCTs’ functions do not change. What we are talking about here is changing the boundaries not the functions. What we are giving an emphasis to is that they will strengthen their commissioning functions. They already have a commissioning function, the point of the change is about ensuring they actually give more attention to that particular function against other functions they have.

Q266 Mr Campbell: As these new organisations develop, they still are not quite aware of all their functions. Will there be more functions to come?

Lord Warner: What we are trying to do is get them to focus on particular functions in their present domain. There are two I would really refer to. One we have talked a lot about, which is strengthening the commissioning function. The other area which we need to ensure that the new boards discharge as well as they can, is this local public accountability for the expenditure of the budgets that they have been given because the line of money from the centre, from Parliament and the Department of Health, is down to the PCT. The PCT is the local accountable body. In many ways they have not been as centre-stage as they might be in discharging that public accountability locally and explaining the pattern of services which are being used and developed in their particular areas. We would like to come out of these changes with a strengthening, it is not changing the function but it is strengthening the way they have discharged that function.

Q267 Chairman: Do you think if this divestment had not been in the 28 July letter, that PCTs were potentially going to divest their roles as providers in a few years’ time, then actually they would have looked at this whole situation of PCT reconfiguration differently? Some of them may have looked at these changes on the basis they were going to potentially lose the provider status which they currently have. Would that not have moulded their thinking in terms of what they should be doing because they are going to be divesting themselves of this particular function, which is a major part in terms of talking to them from our perspective?

Lord Warner: It would be foolish for me to deny, given the letters I have had from you and many colleagues about some of these issues, that 28 July has not shaped some people’s approach to this particular set of issues. So I totally acknowledge that. What I would also say though is that I think there would have been some concerns expressed at some point in some form of consultation about some of the other changes as well—the changes of boundaries for example. I agree entirely that probably this issue has taken a lot of the attention away from some of the other issues which were in the 28 July document.

Q268 Chairman: When you look at the criteria which Mr O’Higgins is looking at, his particular role in this, has that changed anything because of the decisions later by the Secretary of State that they may not lose their provider status, that they would be effectively a party to them losing their provider status in these areas? Has it changed anything in terms of what they are looking at?

Mr O’Higgins: I do not think so in that the criteria were not specifically about providing per se but were about issues such as public health, co-terminosity, business continuity and so on. It is something I guess, when we get the substantive proposals at the end of the consultation period, we would need to examine, but as of our review of yesterday, no.

Q269 Mr Amess: Can I ask about the size of PCTs and local engagement. Lord Warner, I know you obviously were not a minister at the time, perhaps you were not even a peer, but I served on the Committee Stage of the Bill which brought into being primary care trusts and John Denham was the minister at the time. Looking back on it all it is certainly reading I would recommend to the Committee because, whilst they got rather fed up with me, many of the things which the Department of Health now is considering introducing were all raised at the time when we tried to scrutinise the Bill; as ever not one amendment was accepted. I think you were listening in the room next door to our proceedings before you came in and one of your employees told us in 30 years this was the eighth time there had been changes. I think you get the drift that people are not terribly keen on these changes. The other thing, before I get to the question, is that I am very amused by this business of consultation because it is marvellous all this consultation you will be conducting but my gut feeling is you will not take a blind bit of notice of it because you have already made up your mind on all these issues. However, I am very relaxed about it because, in view of the votes last night, I think you will have a bit of trouble getting your original intentions through Parliament. But, as you know, clinicians are not terribly keen on these proposals. I think the Committee is quite keen to know what is your rationale for returning to more remote management structures when clinical engagement, so we are told, is more important than ever to deliver practice-based commissioning?

Lord Warner: I would have thought that practice-based commissioning is getting decision-making much closer to patients than almost anything else. Many GPs have at the moment indicative budgets and what we are trying to do is give them better information about their referral patterns, the cost of those referral patterns, a wider range of services accessible to them, we would hope, and they would help develop them in the community. That would enable people like Dr Howard Stoate to get closer to meeting the needs of his patients faster than what we have at the moment. That is what practice-based
commissioning is all about. One of the big messages coming out of the public consultation at the Birmingham event ten days ago was that people do not see—and in some areas of your constituency travel is quite difficult—the point of going great long distances unnecessarily to get access to specialist care and other services. At the heart of this is bringing both practice-based commissioning and strengthening the commissioning function closer and getting services more accessible and closer to the patients. This is what this is all about.

Q270 Mr Amess: You may win the argument but I still think you have got a bit of a way to go to convince the clinicians. Going back to the Committee Stage of the primary care trust legislation, I remember the then minister, John Denham, saying how terribly important these non-executive directors were in the organisations, how this was absolutely fundamental to democracy, because we still just about have a democracy in this country. How will you address the democratic deficit which will arise from the loss of significant numbers of non-executive directors?

Lord Warner: Non-executive directors in the new PCTs will be in exactly the same position in discharging their non-executive functions as the non-executive directors in the current PCTs. They will be in the majority, they will discharge the same functions, they will hold the chief executive and other members of the executive board to account. I thought this was rather elegantly explained by Mr McIvor to you last week.

Q271 Charlotte Atkins: The only difference will be that they may be serving a population of nearly 1 million. How does a non-executive director engage with a community which is so large? It does not make any sense.

Lord Warner: I would fully agree, if we went down that path, the non-executive directors in particular areas would be more distant from their localities, but I think the question I was asked was about their functionality and their functions do not change. They need to hold people to account and I answered I think Mr Campbell a little while ago on this. What we are wanting to see is these non-executives and their chairs actually carrying out strong public accountability for the spending of taxpayers' money that is allocated to that particular PCT for the design and shaping of the services in their area.

Q272 Charlotte Atkins: But surely the role of a non-executive director is not just about accountability in terms of the management of the PCT, it is also engaging the community, ensuring the community is actually getting the services for the first time ever that they need, rather than having remote health authorities which service, say, a consultation and forget about the needs of the rural population on the edges of that conurbation?

Lord Warner: What I would say is that the evidence from one or two areas where there have been very small PCTs, where they have come together, they have not been as effective as you might suppose in being able to deliver to their communities the range of services they need. The commissioning function is an important element in this. There are many and varied ways of actually understanding the needs of particular communities. I come back to my earlier statement about health inequalities. There are some serious problems around health inequalities, as you will know, in some of our cities, our urban areas, but also in some of our rural areas. What we need is a stronger commissioning function based on evidence and information of what is going on in there. It simply is not true that just having small PCTs close to those communities have, if I may put it this way, delivered the bacon in terms of services for many of those areas.

Q273 Dr Taylor: Minister. I completely fail to see how practice-based commissioning is bringing things closer to patients when you are reducing the numbers of non-executive directors and the plan I believe is to reduce the number of patient forums to just one per PCT. How the dickens are you bringing it closer to patients when you are removing the number of patient representatives so drastically? Or do I just not understand the difference between PBC and the old PCT commissioning?

Lord Warner: As I recall, there are something like 300 million patient contacts each year with GPs, or getting on for that.

Q274 Dr Taylor: Excuse me for interrupting but the patient does not go to the GP to say, “I want NHS reorganised in this way”, he goes to say, “I have got a sore big toe”. That is not the sort of contact we need in a patient-led NHS; patients leading the way the NHS is going.

Lord Warner: Am I allowed to answer the first question before going on to your second set of observations?

Q275 Dr Taylor: Of course you are. Go on. Lord Warner: I will get back into my flow again. The 300 million contacts which there are between patients and GPs are indicative, if you try to sum those and work out what they mean, of what the patients’ needs in any locality are. What we have at the moment is a varied pattern of behaviour by GPs up and down the country. Some have easier access to a wider range of services than others, but the evidence we would suggest is that if you give those GPs the budgets, the information, about referral patterns, access to services which might not necessarily be provided directly in a hospital, the GP can, using that budget, using his contact with patients in a collective GP effort, bring a different pattern of services to meet the clinical needs of patients and provide swifter service access than at the moment. That is not just me saying that, that is what the GPs who are working on practice-based commissioning are saying at the moment. You have to bear in mind, and some of this will come out in the White Paper, for a country of our kind we have an unusually high rate of referrals for out-patient consultations to specialists in something called a hospital compared to many other countries. That is
not to say you do not need specialist referrals, but many of those specialist referrals take place outside in something called a hospital in greater numbers. What we want to do, through practice-based commissioning, is put GPs, the primary care teams, much more in the driving seat, armed with the budget, armed with the data, to get a better range of services with faster access for their patients. That we think is bringing the NHS closer to patients.

Q276 Dr Taylor: In the King’s Fund response to our request for information, they talk about improving commissioner skills to manage patient demand effectively. Effective demand management—what do you understand by that?

Lord Warner: The King’s Fund will have to answer for themselves but what I would say is even with this Government and the extra money we have put into the NHS, you are still at a point where there is a cash limit, it is a much higher cash limit but there is a cash limit in any country on the amount of money you are prepared to spend on health care. What we are saying is ensuring there is good value for money, ensuring there is the most cost effective clinical response to patients’ needs, is likely to make the best value use of the money that is available and get the most appropriate treatment. Sometimes referring people to hospital for specialist services, where you do not always hit the right spot for the right specialist so there are further referrals, sometimes not dealing with long-term conditions early enough and then having emergency admissions—and I think somebody gave you evidence that it cost in his territory £2,000 for an emergency admission—all those things mean, I would not say wasting money, you are certainly not producing the most clinically cost effective response to a health care demand. What we are trying to do, working with all the professionals, is create a model where you get a more cost effective meeting of demand. If you can do that, you are able to provide a wider range of services for people.

Q277 Dr Taylor: I think we would all agree that anything you can provide out of hospital is far better than providing it in hospital. I do not think there is any argument there. I am still bothered though. Okay, the patient goes to the GP with an illness, that creates a demand, but how do they get across, without all the patients’ forums, without all the non-executive directors, major decisions about reconfigurations, about the way the Health Service is going?

Lord Warner: How do who?

Q278 Dr Taylor: The patients, the people for whom the NHS exists.

Lord Warner: One of the interesting things coming out of the consultation and certainly talking to patients on some of my own visits, is that they are themselves often bewildered by the range of services they have to engage with to get a response, whether it is primary, secondary, social care, whatever. So we are not starting from a position where the patients are absolutely clear in their minds about how to get the best service response for themselves. They rely very heavily, I would suggest, on the GP and the primary care team for a lot of the navigation of that system and they rely on family and friends. What we need to try and do is ensure we get better configuration of local services which people can access faster and remove some of the confusion. That is a big message coming out of the public consultation.

Q279 Dr Stoate: Philosophically you will be pleased to know I entirely agree with you but I do have a problem with some of the detail and that is what I want to pick you up on. What we set out when we came in in 1997 was to generate a primary care-led NHS which was much more responsive to patients’ needs and there would be far more care in the community and community-based services and that is philosophically entirely right. What I have concerns about is the differential power structure which we have created in the NHS. We have already let hospitals get on with foundation status, we have already given hospitals payment by results, but that has put a huge amount of power and control of budgets and services into the hospital centre. What we now seem to be doing is playing catch-up and saying that the hospitals have run away with all sorts of new powers and new things they can do, the PCTs cannot keep up with anything like that so we have to reconfigure the PCTs behind that to get the commissioning power back again. At the moment, every time a hospital admits a patient it is £2,000, if it is the wrong thing for that patient it is nevertheless the PCT which has to pay for it, so PCT budgets are being severely strained by hospital activity which they have no control over whatsoever. So we now see, belatedly, a restructuring of PCTs to give them that control back but that is going to take a considerable length of time when payment by results is already up and running and will be virtually complete by April next year.

Lord Warner: I understand the point you are making but what I was trying to say earlier about payment by results is it is not being introduced overnight and anything you can provide out of hospital is far better than providing it in hospital. The rules around payment by results, and John can talk in more detail about them, do actually limit the amount of loss of income for any hospital or specialty in any particular year to a certain amount, so it is not a dramatic change. However you are right, and I do not think we should apologise for this, as a Government we have tried to respond to what the public’s concerns were which were expressed before the 2000 NHS Plan, and what was on their minds very seriously, which we have had to respond to, is their concerns about A&E departments, the long wait, the unsatisfactory features of those which we inherited, the very long waits for out-patient referrals to be taken up, the shortage of diagnostic equipment, the long waits for in-patient treatment particularly for elective surgery, those were the things which were very much on the public’s mind in the consultation which led up to the 2000 NHS Plan. We had to address those concerns because they were very serious concerns.
So it is true that we have done a lot to strengthen and improve those hospital services. What we are trying to do, and I do not think it is fair to call it catch-up, is make sure the balance is better fitted in a period of still considerable investment in the NHS, so we can rebalance that system within what the public are asking us to do in terms of the balance between access to a hospital and access to services outside a hospital.

**Q280 Dr Stoate:** I appreciate that, but I have had PCTs coming to see me saying they are extremely concerned that every time a hospital does something the cash register pings in the PCT headquarters and there is nothing they can do about it because they have effectively a book of signed blank cheques, and it makes the PCTs’ job to commission community services far more restrained because they are always having to play games with the hospitals which they have no control over. When you expand that policy to emergency care as well, every time a patient turns up at A&E, whether the PCT likes it or not, the cash register pings, and there is nothing the PCT can do. Had we gone the other way and given the PCTs a far, far stronger commissioning structure, they could have put right the A&E departments’ problems and the waiting list target problems and the hospital problems in general by commissioning and targeting services from the primary care end and got the quality they wanted. We seem to have put the cart before the horse in some instances and that is why PCTs at the moment are struggling and having to reorganise.

**Lord Warner:** I will again ask John to comment but, before he does, I would say at the end of the day we are where we are, and we did have to improve the hospital services and we did fight a number of elections, if I can put it this way, on making those improvements and that is what the public required.

**Mr Bacon:** I will make one personal comment, if I may, and then come on the PBR point. My personal view is that we have not taken sufficient action since 1990 to strengthen the commissioning side, and you can debate why that is but what we are now saying is that the way in which we want the system to work absolutely demands that the commissioning function is as equally strong as the provider function. You could criticise us over many years for being tardy in that, what we are now doing is addressing it in a meaningful way. In the PBR context, what you have to look at here is that we are introducing a financial system which incentivises the provision of good services for patients. PBR is the expression we use for the current tariff-based system for essentially elective care and, with the exception of foundation trusts where we have taken it a little further, the current PBR system only applies to elective services—

**Q281 Dr Stoate:** Not from next April.

**Mr Bacon:** I am coming on to that. What we will be announcing over the next little while is that the next stage of PBR will be for 2006–07 and the precise details of how the non-elective part of the system will work. So we have been very carefully, with the service, working through the issues of how we extend PBR firstly to the non-elective services in hospitals and then progressively to a number of other services. The model of PBR may not be the same for each of the services we are looking at, so I would expect a very different model for PBR as we get into community-based services from the one we have for elective services. You can argue that we should have got all this in place first, and in an ideal world we would have, but we are trying to be very careful to ensure that we incentivise the right things and we have the right control mechanisms as we move the system into other areas.

**Q282 Dr Stoate:** Given that we are in the direction of travel we are going and given that 2006–07 is looming, we have to get practice-based commissioning up and running pretty smartly, otherwise it will cause big imbalances. I think you probably agree with that. What do you think is the proportion of practices, first of all, which are currently taking part in any practice-based commissioning of any sort and, secondly, what are you going to do about those practices which really do not want to know about it?

**Lord Warner:** I cannot give you a figure, Howard, on where they are. They are in varying states. Certainly you can go to places like Bradford where there has been a very good effort made and there is some very energetic practice-based commissioning going on, fully supported by the PCTs. We do know there is a degree of variability in PCT support for practice-based commissioning in some cases. It is not a question in some cases of GPs not wanting to do it, it is more to do with whether they have been given encouragement and support and information and the indicative budgets to do it. What we are proposing to do, and people are working very energetically on this at the moment with other stakeholders and the professional interests, is to get out before Christmas a document which sets out in a very structured way where practice-based commissioning fits into the wider commissioning agenda and starts to identify some of, what one of my colleagues has called, the rules of engagement for GPs especially for 2006–07. So by the turn of the year we will be able to give them a clear picture of what the expectations are, so the PCTs and GPs have a clear idea of what the expectations are of what could be achieved and delivered by practice-based commissioning in 2006–07. One of the things we are also working on, to give as full a picture as I can to the Committee, is trying not to do, as we sometimes do, the most difficult things first but trying to do the easiest things first. Where are the specialties? Dermatology is one which comes to mind where we could actually make good progress here. There are a lot of GPs with specialisms in dermatology; it is a very big chunk, as you know, of the caseload of GPs. We want to take some of these areas where we can make progress very quickly and use some of the good practice examples which have been used in some parts of the country and encourage others, GPs and PCTs, to follow those good practice examples. So we are going to
concentrate on practical advice and information and try to encourage them. It is not to stop people doing other things but to illustrate what are the things you could really do to make progress across the country in 2006–07.

Q283 Dr Stoate: I accept that. You have focused on the best, and you are absolutely right, there are many practices out there which do a fantastic job with their PCTs and that is best practice and it is working well in some areas, but the NHS Alliance told us last week that, in their words, “there was a woeful lack of information” for GPs about practice-based commissioning so far, and they estimated that by the end of next year, when it ought to be up and running, 50% of PCTs will have less than 50% of practices involved. We all know the direction of travel, we are where we are, we know where we need to go, but what we are told by the people out there doing it is that the information is woefully inadequate and that 50% of the PCTs feel that less than half their practices will be anything like ready in the time frame we have given them by the end of next year. How do we even begin to tackle that?

Lord Warner: The best way to tackle it is for us to work very closely with people like the Alliance, with Michael Dixon and his colleagues, and other colleagues, and not be too precious about standing back from that. I now have a huge amount of my diary time given over to working with GPs and their various interests and the other people in primary care teams to make this work. For example, I had a meeting with a lot of practice managers earlier this week to try to work with them and get a feel for where things are. You are absolutely right, there is a huge variability, I am not disagreeing in any way with what you are saying. What we have to do is energise people a bit more, but part of the energising is explaining very clearly to PCTs what the obligations are on them to facilitate practice-based commissioning and also give more of the GPs the tools. Part of the reasoning is not that they are philosophically opposed to practice-based commissioning, they simply do not have the toolkit to make it work in their particular area. All we can do is work as hard as we can to move them along that path.

Q284 Dr Stoate: With the reconfiguration of PCTs going ahead as of early next year and with the targets for practice-based commissioning at the end of next year, do you honestly believe we are going to get anywhere close to that target?

Lord Warner: I think we will get very close. I will really stick my neck out. We will achieve everybody being engaged and involved in some way but it is true to say we will have variations in different parts of the country. I am confident that we will have a pretty credible system of practice-based commissioning up and running, and not because we have brow-beaten GPs into doing it—but because we have worked with them, encouraged them, incentivised them. We do have things like negotiations which are going on at the present. GPs, it seems to me on recent evidence, tend to be rather good at responding to incentives. We do actually have contract negotiations which enable this to be incentivised.

Q285 Dr Naysmith: Following on from that, it is possible that under practice-based commissioning some practices will be better than others at using the resources, and therefore you will end up with some patients getting a much better service than others. Is that a possibility?

Lord Warner: It is a possibility but it is probably no different from where we are now.

Q286 Dr Naysmith: But we are trying to improve things.

Lord Warner: We are trying to improve things but we will not make the changes dramatically overnight. I am tempted to say that you will find that not all GPs are as well motivated and dynamic as Dr Stoate in their practices. There will be varying experiences for patients but there are a lot of varying experiences for patients at the moment. As I was saying earlier, we have to move as many along the path as quickly as possible and give them the knowledge base, the toolkit, the understanding, the support from the PCTs, to make those interventions on behalf of their patients.

Q287 Dr Naysmith: One of the things which could happen as a result of that is that patients could decide that there is a practice down the road which has a much better service than the one in their road and decide to switch, so that what you are doing will encourage patients to switch.

Lord Warner: We are not seeking to get patients—

Q288 Dr Naysmith: That is choice, is it not?

Lord Warner: We are not seeking to get patients to switch. I think the evidence at the moment from survey after survey and the current consultation which is going on is that the overwhelming majority of patients actually have a high regard for their GP. GPs are as near as anybody in the NHS to achieving sainthood with their patients. It is true. It is a very consistent message. However, they are not all as pleased as they might be about some of the access arrangements to their GPs, they would like the GPs to improve their telephone systems. They are not uncritical friends of the GPs. They expect changes in many of these areas and they expect us to remove some of these artificial barriers between primary and second care which they do not understand, but they look to the primary care team to help them through some of those boundaries. Some of them will leave. If the GPs themselves do not respond to some of those needs, some of them may vote with their feet.
Q289 Dr Naysmith: That is what I am getting at. I understand what you are trying to do, and I am all in favour of it, but you could end up with the situation, because we have some GPs nowadays who are not as good as Dr Stoate over there, who operate out of premises which are not of a high standard. We are all talking about choice all the time in the NHS now so you might see this as something which patients might want to do if one doctor can get you a social worker much quicker than another. What I am looking at is the kind of perverse things which might end up happening because of this change and you have to be aware of that.

Lord Warner: I think that is absolutely right but that is another reason why we need to strengthen the commissioning function of PCTs, because, let’s remember, they are not just commissioning services other than primary care, they are really meant to be in the lead for making sure they have the primary care in their area which is needed, that they are commissioning primary care. That is where they have to be more alert than some of them have been in the past about some of the opportunities for doing things a little differently to bring more primary care services into particular areas, whether that means liberating some of the existing GPs and their services to expand their capacity in particular areas or whatever. It is often down to things like being able to expand the premises. Sometimes the premises themselves are a limitation on GPs developing their services.

Q290 Dr Naysmith: Looking at the other side of the coin and still looking at possible perverse outcomes of your changes, have you considered the possibility that practice-based commissioning in itself might compromise patient choice? That patients who have choice at the moment, once practice-based commissioning is in place, particularly if it is a big group practice or two or three big practices getting together on commissioning, will have limited patient choice?

Lord Warner: Patients will certainly not have their choices limited in areas like elective surgery, they will make their own judgments with their GPs about where they go. As we take the choice agenda further forward, and we are working on some of this now, the information which is available to patients to exercise that choice will improve and grow. That is an inevitable consequence. What I think it will mean is that if they do not find the expectations they have of primary care, they will start looking around. That is undoubtedly true. Once you have put the choice agenda forward for the public, they will learn to exercise those choices in a variety of different ways.

Q291 Mr Amess: Saint Dr Howard Stoate, what a marvellous image! Occasional in-house prescriber of Viagra, fantastic! We are nearly at the end now, we have come to community services and you have made your position very clear on the Government’s intention to improve primary and community health services. Last week, Yvonne Sawbridge argued that fragmenting the joined-up services which community health professionals currently strive to deliver is a real risk associated with introducing a plurality of providers. You would have heard this morning the robust evidence given by the Royal College of Nurses who flagged up how are we going to cope with the flu epidemic, who believe we need strong, robust community services, who believe that the reorganisation is taking the focus away from that which they are best at doing, it is a phenomenal distraction, unacceptable and all the rest, but who believe these community health services are very important. You may argue against it but who exactly would be responsible for safeguarding seamless care in your plan?

Lord Warner: There are two elements I think. There is the element about whether you have a sufficient volume and diversity of community services and primary care in any given area. That is I think largely the responsibility of the PCT, fed from the experiences of practice-based commissioning, but ensuring that a particular area has the range and organisation of services it needs is down to a strongly commissioning PCT. At the same time, when you get down to the individual patient, one of the things we are trying to ensure is that the primary care team itself, and it is not just the GP, is effectively joined up at the point of the individual patient needing services. One of the things coming out very consistently from this current public consultation is the boundary between health and social care and how you make that work better. That is not much to do with community nursing, it is actually much more to do with the relationship between social care services and primary care services. The public is looking on an individual level much more for that to be integrated. So there are two strands here. How do you get it joined up at the geographical, territory level, and how do you get it joined up better and more seamless for the individual patient.

Q292 Mr Amess: Your comments are welcome but again I think you have a bit of convincing to do with the professionals involved. My final point is about additional providers of community services in deprived areas, just as it has proved more difficult to attract general practitioners. If this happens, will not deprived populations be more likely to miss out on the perceived benefits of competition and therefore, given that the Government is always saying they are doing everything they can to reduce inequalities, will not health inequalities actually widen as a result of these policies?

Lord Warner: I do not think so. Ten or twelve years ago I chaired a family health service authority in East London and the only way in some parts of that territory, and it is still true today, you could go forward was by attracting more providers of primary care in those territories. The truth of the matter is that in many of these areas of high health inequalities, the present volume of services—GPs, nurses, everybody else—is simply not great enough to actually cope with the demand and needs of those services. We have to find better ways, through strong commissioning, to bring a larger volume of services in there. It is not just about more diversity but simply that there are not enough health professionals
providing care in some of those communities. The response you will be able to get will be different in different areas. In some of these areas they need to be service responses which are more ethnically attuned to the needs of some of those particular service areas. That is why we need strong commissioning to meet some of those concerns. I do not think anything we are doing will make any of these situations worse, they are designed to make them better.

**Mr Amess:** I hope you are right.

**Q293 Chairman:** I think we are very impressed, Minister, that you are quoting our witnesses of last week. I have no doubt you will have read what the witness, Dr Groom from Oxford, said about the potential situation in Oxfordshire in that the SHA are currently considering whether or not the management of the future Oxfordshire PCT should be put out to tender. Could you explain to the Committee what you believe will be the benefits of this type of approach?

**Lord Warner:** I am not sure I want to be an advocate for what Oxford are proposing. I think I will try to explain the Government’s position on this and our understanding of how Oxford have got to the situation they have got to. My very clear understanding is that in Oxford we have historically had five primary care trusts and for many years few of them have actually been performing particularly well. The SHA, who are the performance monitors, so to speak, in the Health Service have rightly I think been focusing, since well before 28 July, on how they deal with that particular problem. That has been the nub of the problem which has been confronting them. One of the options they have been considering is finding a new management for PCT functions by way of an open tender. That is the path they have chosen to go on. Our position is as follows. We want to ensure that once we have had the consultation we have been discussing this morning at considerable length and a model has been decided of configuration of PCTs for all the different parts of the country, including Oxford, and once that has settled, it is then down to that new PCT to decide the organisation that it actually needs to discharge its statutory responsibilities. It is up to them to make that decision. If they choose to continue along the path that the new PCT, whoever they may be, and the Oxford SHA responsible—the Thames Valley SHA in this case—have decided they want to go along, that is a matter for them. But going along that path does not in any way remove their statutory obligations, their accountabilities, their responsibilities for the appropriate expenditure of public money in that territory. It does not mean they will have an additional budget to actually provide that type of system. They will have exactly the same budget as any other PCT of an equivalent size. So what I am saying is that it will be down to the new PCT to actually decide on the way of discharging their accountabilities in the most appropriate way, and they will be held to account for those. They will need to consider whether this model which the SHA has constructed is an appropriate model or whether they would choose to go down a more appropriate path. Our position is that we need to wait and see and leave that to the judgment and decision-making of the new PCT.

**Q294 Chairman:** The witness we had works within the Oxford City PCT, which I understand is a three-star PCT, and she may have some comment to make in relation to that. You say there are no additional budgets but what was said by the witness last week was that the Oxfordshire budget in this area is about £600 million, and if a private company took over—private company profits are normally about 10%—on that basis that is £60 million less for health care expenditure in Oxfordshire. That is a very crude analysis, as I often give, but what do you think about that type of comment?

**Lord Warner:** I suppose the short answer is, not a lot. The more serious answer is what I said earlier, that the PCT which is responsible is responsible for discharging their responsibilities to commission the services which are appropriate within the budget available for the community that they are serving. They will have exactly the same administrative budget as an equivalent PCT of that size, no more, no less. They will have to decide what is the best way of doing that. As I understand it her remarks do not relate to the issue of out-sourcing. The PCT budget would not produce a £60 million profit for the particular organisation, if it was a private organisation, that was responsible for the commissioning function of the PCT, they would be paying some kind of management fee with no doubt some degree of profit element in it but they would be paid a management fee for discharging those commissioning functions on behalf of the accountable body. It does not follow that the services they would commission within their territory would be private services, they may well commission a wider range of public services, they may well commission a range of voluntary services, mixed voluntary and public services. It does not follow that if you out-source your commissioning function on some agreed fee basis that you would actually be favouring the private sector in the direct service delivery which comes out of that commissioning.

**Q295 Mr Campbell:** Dr Dixon of the Health Service Alliance last week said he was greatly concerned that the private providers coming in would bring in new practices basically just to cream off, or cherry-pick, the services where they can make money. Would that happen? Would we see a firm coming into the Health Service and getting its hands on something and making a profit?

**Lord Warner:** If you take another territory, what you will be getting in elective surgery is independent sector treatment centres operating within an NHS tariff. That is what you would be getting. What sometimes they bring is a more efficient way of actually operating. However, what I would say in response to Dr Dixon is that if new providers come in and they take on a list of patients, they will have the same obligations to that list of patients as any
other GP or set of GPs taking on that list of patients; they will not have a different set of obligations. Dare I say it, GPs on the general medical service contracts are themselves private contractors, they are private providers and they do operate on a profit basis in their practices.

**Mr Campbell:** I am not sure of that. You had better tell me, Howard. Is that the case?

**Dr Stoate:** He is right, we are actually independent contractors and we contract services wholly to the NHS and it is on a profit or loss account basis.

**Mr Campbell:** When this comes before the House the privatisation issue will be the big issue because it is not acceptable in the Health Service, even though I am now told you make a profit.

**Dr Stoate:** It is called wages.

**Q296 Mr Campbell:** When a company comes in, what is to say that it will skim, that it will skim other patients, skim other providers as long as it makes a profit? That is what a company is for, to make a profit. The Health Service is not there to make a profit unless you make it private all the way through of course, but we are not going to do that, are we?

**Lord Warner:** Well, 12½% of our NHS budget goes on drugs, all of which are bought from the private sector at a profit. Another, getting on for, 5% goes on medical devices, all bought from the private sector at a profit. I do not see too many people actually building hospitals themselves, they are all built by the private sector at a profit. I have already mentioned GPs. We have quite a long and strong tradition in the NHS, from the outset, where the private sector has been a partner in the provision of NHS services.

**Q297 Mr Campbell:** But even Dr Dixon said that he did not want to see a full-blooded market situation, half perhaps but not a full one. What we are suggesting here, with the introduction of private providers coming in, means we are going down the road of privatisation.

**Lord Warner:** I do not think we are saying that there are going to be lots of private providers coming in. What we are saying is that in many areas, including some of the areas with the greatest health inequalities where there are shortages of primary care services, we need some new providers. Those new providers could be existing GPs and primary care teams expanding their range of services. Somewhere along the line, if we are not to fail many of these poorer communities, we have to do a better job collectively of actually providing community and primary care services for them, and that means that the commissioners, whether it is Oxford or anybody else, have to actually get the best deal they can, whether it is public providers, whether it is voluntary sector providers, whether it is private providers and sometimes it might be joint ventures, to deliver the services those communities need. That is the philosophy we are expounding, it is not hell-bent privatisation.

**Q298 Dr Naysmith:** One of the other rather troubling aspects of this affair, Lord Warner, is that in Oxfordshire the Board of the reconfigured PCT will not be appointed before next March, assuming all goes well with Mr O’Higgins and his committee, but the proposal is to put the tender out this month and that has been agreed, as we understand. So how can non-executives, who have not yet been appointed, have any input in this tendering process?

**Lord Warner:** I would have to look into what those processes are. My position is still, on behalf of the Government, that this is a decision for the newly reconfigured PCT. I will certainly ensure that is communicated very clearly to the Thames Valley Strategic Health Authority.

**Q299 Chairman:** I hear what you say about the decision of the PCT and quite right too but as we understand the changes, even the 28 July changes, it was that effectively PCTs may divest themselves of all providing and if they want to do that in the future we assume they can do that. Are we not talking about something a little bit different here because PCTs will still have the responsibility for commissioning, and by and large I would have thought that is outside the acute sector, that is your local National Health Service. If that particular contract goes to a private company which will then commission for and on behalf of, would you as a minister be totally happy that, instead of having what most people would perceive to be the local primary care National Health Service being the PCT making sure we get the provision we need in the private sector, it is a private company that is doing that? Would you be happy with that?

**Lord Warner:** I am neither happy nor unhappy. I have some experience with contracting and the issue with contracting is that you specify exactly what you want and clearly to whoever you are asking to contract for you, and that you are clear in your mind what is the price you are prepared to pay for that service you are contracting for. For this to be successful in the form as I understand the SHA proposal, the PCT itself would have to be able to discharge those responsibilities. It would have to be able to explain, it would still have an accountable officer for the public money it is spending. It would have to have some very convincing arguments that it could discharge its public accountabilities in the way it was proposing through that contract. I think I would like to pass the rest of this answer to John Bacon because he has a lot of experience in discharging public accountabilities.

**Mr Bacon:** I would just like to reinforce the points, the Minister has made. The first point to make unequivocally is that we want the new PCT, when it is created, to make decisions on this issue. Let’s be clear about that and Thames Valley Health Authority will be reminded of that. Secondly, the PCT—if it emerges as a single PCT for Oxfordshire and that would be the subject of both Mr O’Higgins’ comments and then a public consultation—would be a statutorily constituted PCT in the same way as any other PCT and would be accountable in the same way as any other PCT through the SHA to Sir
Nigel through me. Let’s be absolutely clear, we are not—and cannot—putting out to the private sector that statutory responsibility. What functions of commissioning that PCT decides it wants to contract to somebody else is a matter for the PCT, and we already have examples where elements of the process of that have been contracted to somebody else for services, usually the public sector but not exclusively. So we need to be really clear here that if that were to happen, it does not alter the statutory base of the PCT or its accountability to the NHS.

Lord Warner: Not without statutory change. Chairman. Just to emphasise again, there is this very strong line of accountability for finance from the PAC and Parliament to the Department, through the accounting officer of the Department, Sir Nigel Crisp, down the line to the PCT. There is no escape from that slightly indirect but nevertheless connected parliamentary accountability for the money that Parliament has voted effectively to that particular body. You cannot sub-contract that out under any circumstances.

Chairman: In view of what we heard last week and what we have seen in written form, these areas need to be cleared up as far as we are concerned.

Q300 Chairman: I do not know what the average size of a board of a PCT is at the moment, I know it has non-executives on it and people from the community and everything else, but if they were just laid there as being the overseers of commissioning on behalf of my primary care trust, taking my area, could you envisage it would be them and only them and everybody else who falls below them could be contracted out and could be employed by a different organisation?

Mr Bacon: There is a very important point here which is for a statutory body to function through our accountability system, Sir Nigel Crisp has to delegate to an individual his powers, his accounting officer status. He will not do that unless we are satisfied that statutory body is competent to perform its functions and he has the right to withdraw that if he feels at any time that statutory body is not discharging its functions to his standard. So whether all or some of the commissioning functions were to be put with some other body, that power exists, and that gives us the ability to ensure that statutory body is performing at the level we expect.

Q301 Chairman: You cannot see that the public interface which PCTs have, in terms of not just the annual meeting but people who sit on them from the community, would ever go, even if Oxfordshire had its way?

Mr Bacon: There is a statutory requirement for these bodies to conduct their meetings in public and that would not change.

Q302 Chairman: But the wider interface in terms of the make-up of my primary care trust and the people who sit on it? You could never envisage that changing if one person who is given the responsibility decides they can commission management services for that area, for that PCT?

Mr Bacon: The decision would be one for the board of the primary care trust and it would have on it the same balance of executives and non-executives. So unless and until the statutory basis of PCTs is changed, that will be the case. Non-executive directors will continue to be appointed by the Appointments Commission on behalf of ministers and that would still be in place.

Q303 Chairman: And no level of contracting could get rid of that situation without the Department deciding there would have to be a statutory change?

Q304 Mr Burstow: What we have heard on that is very clear and that is useful. I want to take this one step further and it comes out of this potential for out-sourcing the commissioning function but not the statutory functions, and it also applies to other out-sourcing decisions PCTs might make about their services as well, and this is the whole issue around transparency and accountability for the way in which the service is being delivered and the way in which the service delivery is being monitored, the use of key performance indicators and the extent to which these are or are not in the public domain due to commercial confidentiality. This has been an issue before in regard to some of the nationally-let contracts around scanning and I wanted to get some clarity about what will and will not be in the public domain for out-sourced contracts and what guidance and advice the Department will be giving to PCTs and indeed what guidance it gives to itself about this.

Mr Bacon: There will be no difference in the requirements for these as for any other contracts. That is the straightforward answer. The same rules would apply. I do not know them absolutely chapter and verse sitting here but—

Q305 Mr Burstow: Let us tease that out one step further. In terms of certain questions I have been asking around Alliance Medical contracts, around KPIs, trying to get information about volumes of activity, issues about repeat scans, the answers I have had back have been that that information is commercially confidential, yet the Secretary of State when she was before us a few weeks ago said that all that should be commercially confidential are issues which go to the issue of price and matters pertaining to that side of things. Yet so far, as far as I can see, the questions I have asked and other members have asked, other material which is relevant to the performance of the service is still being cloaked by commercial confidentiality.

Mr Bacon: What I would have to do is to make the point that, firstly, there are clear rules as to what is and what is not discloseable. I am quite happy to go and look at the Alliance Medical contracts against what you have requested and applying the rules as they stand and will answer accordingly.
Q306 **Mr Burstow**: Perhaps we could have a note on the issue of how commercial confidentiality is applied to the monitoring of performance, not just by the organisation itself but by elected representatives and the public more generally?

**Mr Bacon**: I am happy to do that.

Q307 **Mr Burstow**: We are going through this change process, it would be very useful to get some sense of how far into the future we will need to look and be able to make a judgment about whether these changes have been effective.

**Lord Warner**: On the commissioning side?

Q308 **Mr Burstow**: Yes, how many years forward will we be able to say, “This is the time when the fruits of this change will be identified”?  

**Lord Warner**: I think you should start seeing significant changes in 18 months to two years. I am an optimistic. I do not think we are starting totally from scratch, we are building on a lot of work which has already been done. You will see coming out of this process the successful managers, the successful executives, being able to spread their expertise over some wider territory. I have had a number of meetings with big groups of GPs only in the last few days and I think they are up for practice-based commissioning. We do have some work to do to get the mechanisms in place but there is a lot of energy and enthusiasm out there and you can go a long way on energy and I think it is there.

Q309 **Chairman**: Could I say that, even without my vain attempts at a two-minute break halfway through, it has been a rather long session. Thank you, Minister, Mr O’Higgins and Mr Bacon for coming along. We have one or two supplementary questions we would like to submit to you in writing. This is, we think, the last evidence session we are taking here but we would like to supplement this with a few more questions before we attempt to draw up our inquiry report. Thank you for coming along.  

**Lord Warner**: Chairman, we would be delighted to respond.
Written evidence

Memorandum submitted by the Department of Health (PCT 1)

Context and Background

1. The Government welcomes the opportunity provided by the Select Committee to set out the policy on the reconfiguration of PCTs.

2. Since PCTs were first established in 2000 there have been a number of changes to improve services for patients. The NHS Plan, launched in July 2000, set out a programme of sustained investment and reform to turn the NHS around, make it more responsive to patients and more in tune with the times.

3. Reforms under the NHS plan largely focussed upon the development of capacity and capability within hospitals. With investment, levels rising from £37 billion in 1997 to a projected £90 billion in 2008, both waiting lists and waiting times for hospital treatment have fallen steadily. Accident & Emergency services have improved significantly, and we have replaced large quantities of buildings and equipment.

4. With the reforms set out above well underway, Creating a Patient-Led NHS set out what is envisaged as the next phase of reform—to reshape the health service around the needs and aspirations of patients. In order to deliver this the whole system and organisations working within it need to change and to behave differently.

5. To date, many of these reforms have focused on improving secondary care services in line with patient’s top priorities such as waiting times and where considerable progress has been made. However, we know that 90 per cent of people’s contact with the NHS is within primary care services, and we now have the opportunity to shift the focus of our reforms into improving community and primary care services. We are hearing through the “Your Health, Your Care, Your Say” listening exercise that whilst the public have a great deal of affection for local primary and social care services, they often feel let down by them. Services can be unresponsive to individual needs, people have difficulties with access, and they do not understand the multiplicity of services and NHS and social care providers. The White Paper will be publishing at the turn of the year will deal with these important issues, and it will be supported by the reform of Strategic Health Authorities and Primary Care Trusts to deliver the type of health and social care that the public wants.

6. Wherever possible, people with long-term conditions—diabetes and heart disease are just two examples—should be cared for within their community, rather than in hospitals. In other areas such as dermatology and orthopaedics more could be done in the community. Patients should also be offered a greater choice of when and where they would like their treatment, and the types of treatment they will receive. The idea of having more services in the community rather than hospitals has consistently emerged as one of the public’s top priorities in the Your Health, Your Care, Your Say consultation.

7. The achievements that have been made in secondary care, including the creation of Foundation Trusts and the planned introduction of Payment by Results, have meant that the hospital sector has become stronger in relation to primary and community services. This new higher performing hospital sector may have a tendency to suck resources towards it, unless it is counter-balanced by an equally strong commissioning function that can represent patients best interests in the way services are designed and located. We recognise that local people are best placed to design local services, and want to make sure that the NHS can respond to the needs and demands of local patient populations.

8. Another key area for improvement is the development of effective and sustainable partnerships between healthcare organisations, local authorities and other local partner organisations such as voluntary and community organisations for the delivery of integrated health and social care functions, and a stronger health protection and health improvement function. Recent evidence has demonstrated that co-terminosity between these health organisations and local authorities is a key factor in developing these relationships.

Reconfiguration of PCTs

9. In order to deliver the goals outlined above, we are seeking to streamline SHAs, and make them largely co-terminous with Regional Government Offices in order to facilitate better integration between these two sets of organisations. Ambulance Trusts will also be reorganised along very similar lines and geared to improving efficiency and better frontline services to patients. Above all we need to reshape PCTs to address weaknesses and to strengthen their commissioning capability and ensure they have the influence necessary to secure the right services for their patient populations from provider organisations. They must become the focal point for planning, designing and shaping the local health services that best meet the needs of their communities and deliver value for money from the resources allocated to them.

10. We recognise that different areas will have different health and social care needs, and that relationships between healthcare organisations and local authorities will be of different natures and at different levels in various parts of the country. In order to make sure local contexts are fully addressed in any reconfigurations, we have asked the 28 SHAs to develop a range of proposals for PCT reconfigurations locally.

11. The design of new, stronger PCTs is not a top-down exercise. We have not dictated the size or structure of the new PCTs, and have instead supported SHAs in creating local solutions to the reconfiguration of PCTs. On 28 July the NHS Chief Executive (Sir Nigel Crisp) set out that proposals will be assessed against the following criteria of the PCTs ability to:
- secure high quality, safe services;
- improve health and reduce inequalities;
- improve the engagement of GPs and rollout of Practice Based Commissioning with demonstrable practice support;
- improve public involvement;
- improve commissioning and effective use of resources;
- manage financial balance and risk;
- improve coordination with social services through greater congruence of PCT and Local Government boundaries;
- deliver at least 15% reduction in management and administrative costs.

12. On 26 August, the Department sent a letter to all SHA chief executives stressing that proposals should consider the context of local health needs, and that different solutions from different SHAs would be encouraged, as long as they were justifiable against the above criteria. For those SHAs who propose fewer, larger PCTs, we have asked for evidence to demonstrate how existing successful partnerships with local partners can be maintained and improved. We have asked SHAs who opt to keep smaller PCTs to demonstrate how the necessary improvements in commissioning services can be delivered within existing structures. The letter also stressed the need to engage local stakeholders and partner organisations from the outset.

13. The changes set out in Creating a Patient-led NHS are a key priority. So any organisational changes to the system need to happen quickly and avoid a prolonged period of change and uncertainty. However, we are not imposing change from the centre. We want what is best for patients locally. This means that whilst some PCTs are likely to merge, others may not. We would expect shadow SHAs to be created from April 2006. We would want these shadow SHAs to operate alongside and then subsume existing SHAs, and their role would be to manage the transition towards new PCT configurations. We currently expect the new PCTs to be operational by October 2006. A full timetable for Commissioning a Patient-led NHS is attached at Annex A.

14. Changes to SHAs will precede changes to PCTs and any changes to the PCTs' role in providing services will take place over a longer timescale and will be subject to consultation in the usual way. Any such changes will build on the results of the forthcoming White Paper on community health and social care services, based on the current listening exercise, “Your Health, Your Care, Your Say”. PCTs already vary in the extent and nature of their provider services. A variety of service models are in operation around the NHS, such as out of hours services, voluntary sector services and walk-in centres. Staff will be fully involved in deciding new arrangements and identifying which services will be best for patients. Any staff transferring to a new employer will, of course, be entitled to appropriate legal protection of their terms and conditions of employment. The social partnership forum have decided to set up a working group led by NHS employers to fully engage all trade unions in all workforce issues arising from the commissioning a patient-led NHS change programme.

**Practice-Based Commissioning**

15. One of the best ways to give patients more of a say about local services is to empower the healthcare professionals who are closest to the patients. GPs and other primary care professionals should play a more effective role in developing better services for patients and be more accountable to their local communities for spending taxpayers’ money. That is why the Government is rolling out “practice-based commissioning”, which will ensure that GPs and other practice staff help deliver better local services for patients.

16. Practice based commissioning as a concept is not new. The implementation of this policy follows up on a historical commitment—Para 5.19 of 1998 The New NHS White Paper 1998 states that “over time, the Government expects that Groups [PCGs & PCTs] will extend indicative budgets to individual practices for the full range of services .” The NHS Improvement Plan signalled a move towards practice level commissioning. This was followed up with DH guidance in February 2005 “Practice Based Commissioning: Promoting Clinical Engagement”. Creating a Patient-Led NHS and Commissioning a Patient-Led NHS further restated the importance of PBC to deliver a truly patient-focused NHS. The NHS has known that practice-based commissioning is coming for some time.
17. Practice based commissioning will deliver better value for money as GPs and others help patients avoid going into hospital unnecessarily, and spend the money they save on improving community services, including preventative measures. PBC will also align clinical prioritisation with financial responsibility, ensuring that clinical effectiveness, value for money, public health and health inequalities are accounted for in commissioning decisions.

18. Our aspiration for practice based commissioning was, until recently, that all practices be engaged in PBC by 2008. However, Commissioning a Patient-Led NHS accelerates the timescales so that all practices will become involved in practice based commissioning in some way, and we expect the majority of practices to have engaged with Practice Based Commissioners by the end of 2006. They will not negotiate any contracts with hospitals, but will draw down on the local PCT contract. This will give them an incentive to bring more services closer to patients, avoid unnecessary hospitalisation, to cut out waste and inefficiency in the way services are provided to their patients, to help manage demand and to provide innovative alternatives in the community.

19. PCTs will support and manage the operation of practice based commissioning in their areas, providing information to GPs; will, on behalf of GPs and patients, negotiate the local component of contracts; and will conduct the “market analysis” to identify opportunities for new entrants locally, and to give current and potential providers views on strategic context for service development and reconfigurations. (eg demographic trends and population needs assessment). Overall they will ensure practice-based commissioning is conducted efficiently and effectively because they will be accountable for the taxpayers’ money allocated to their area.

20. Our approach so far has been permissive and light touch however we do have a four-point plan to support the delivery of PBC. The plan is currently under review to take account of the forthcoming White Paper and system reforms such as choice and payment by results. The plan includes:

- Policy Refresh: ongoing review and refreshing of the policy on PBC to culminate in a policy update.
- Support Programme: we have engaged a number of our external stakeholders and partners to support PCTs and Practices with the roll out of PBC.
- Performance Monitoring: although there has been no formal monitoring of uptake, SHAs are required to produce an annual report on progress for PBC which will cover the period to end of March 2006.
- Communications and Stakeholder Management: PBC continues to be of huge interest to a wide range of stakeholders. We have established a number of reference groups to manage and communicate with stakeholders.

21. Mike Dixon, Chairman of the NHS Alliance has said:

“Practice based commissioning should re-ignite the enthusiasm of frontline GPs and practices who want to have a greater say in improving the range and quality of services available to their patients”

22. Dr James Kingland, Chairman of the National Association of Primary Care said in a press release to coincide with the publication of Commissioning a Patient-Led NHS:

“I am delighted to see that the Department is pushing for a much faster roll-out of Practice Based Commissioning, with earlier universal engagement of practices. It is only through such an approach will service delivery and design improve equitably across the country and health and care services outside hospitals develop at a speed which is responsive to patient needs locally.

“Today’s document provides tremendous opportunities for primary care clinicians and others to both commission high quality services locally for their patients, as well as to provide services outside hospitals, out with their own PCTs and localities. These are exciting times; we are entering a period when real innovation can flourish up and down the country, waste can be eliminated and patient needs met timeously in line with their preferred care pathways.”

PCTs and Service Provision

23. PCTs may feel that in order to focus on stimulating innovation and choice in community services to meet local patients needs, they should consider a wide range of delivery models. This is an issue that new PCTs will wish to look at in the light of the forthcoming white paper on services outside hospitals and the public consultation Your Health, Your Care, Your Say, that is currently being undertaken on what the public expect from these services. We would expect PCTs to consider and to consult on how best to meet these demands and expectations in conjunction with their vital role in commissioning. In keeping with the principles of a patient-led NHS, no decisions regarding future arrangements for PCTs’ service provision functions will take place until these have been fully considered locally and a full consultation has been completed. The Your Health, Your Care, Your Say consultation will be used to inform the forthcoming White Paper on out of hospital care and is due to finish shortly.
24. We understand that many people feel unsettled by the prospect of another round of change and that there is anxiety amongst the staff that they will be affected directly. However, district nurses, health visitors and other staff who deliver services in the community will continue to be employed by their PCT unless and until it decides otherwise. Any such decision would be made locally in light of the forthcoming White Paper on community health and care services and with the full consultation of patients, users and staff. The terms and conditions of any staff affected will, of course, be protected.

STAKEHOLDER CONSULTATION

25. Creating a Patient-Led NHS, which was published in March 2005, made it clear that organisational change would be required to ensure that the whole system and organisations within it were able to deliver a truly patient-led NHS. The uncertainty that this created, as well as an increasing number of SHA Chief Executive vacancies across the county, meant that there was a need to fast track the reconfiguration of SHAs and PCTs. In response to this, Commissioning a Patient-Led NHS was published on 28 July.

26. From the publishing of Commissioning a Patient-Led NHS onwards, we have emphasised the need to consult the full range of local stakeholders on any proposed changes to the reconfiguration of primary care organisations. On 26 August 2005, the Department sent out a letter to all SHA chief executives, reiterating the need to consider the context of local health needs, and the need to involve local stakeholders at each stage in the development of the proposals, even before they go out to full formal consultation in December 2005.

27. All proposals have been submitted to the Department of Health. These proposals will initially be screened by a Review Team of senior officials within the Department to ensure the clarity and comprehensiveness of the proposals. Once this process has been completed, the proposals will be passed to an independent External Panel, who will assess the proposals in terms of the criteria originally identified in the Commissioning a Patient-Led NHS document, published on 28 July 2005.

28. The External Panel is chaired by Michael O'Higgins, managing partner and member of the international board of PA Consulting Group. Members include:

- Jane Barrie, Chair of the SHA Chairs;
- Peter Mount, Chair, NHS Confederation;
- Joan Saddler, Chair, Waltham Forest PCT;
- Harry Cayton, National Director for Patients and the Public, Department of Health;
- David Colin-Thome, National Director for Primary Care, Department of Health;
- Jennifer Dixon, Director of Policy, King’s Fund;
- Liz Fradd, Chief Executive, Nurse Directors’ Association;
- Ara Darzi, Imperial College;
- David Henshaw, Chief Executive, Liverpool City Council;
- Professor Rod Griffiths, President of the Faculty of Public Health, Royal College of Physicians.  

29. Once the External Panel have satisfied themselves that the proposals address each of the specified criteria satisfactorily, each set of proposals will be subject to a full, statutory public consultation. The consultation will begin in December 2005 and will last three months, in line with Cabinet Office best practice. All stakeholder groups will be actively encouraged to become involved in discussing the proposals.

30. Under the relevant regulations, each SHA is required to consult widely (NHS organisations, Local Authorities (LAs), Overview and Scrutiny Committees (OSCs), Patient Forums (PFs), Commission for Patient and Public Involvement in Health (CPPPIH) and anyone else it considers appropriate) on its proposed dissolution or changes to its name or boundaries.

31. Consultation on PCT changes is also the duty of each respective SHA. The consultation list for PCTs also includes Local Medical Committees (LMCs) and other representatives of health care professionals. The PCT list does not include OSCs or patient involvement bodies, although the SHA might be expected to include them as other persons considered appropriate.

32. Statutory staff consultation is also required in respect of all the bodies before the changes can go ahead.

33. No decisions on future local configurations will be taken until after this full statutory local consultation has been completed.

2 Professor Rod Griffiths accepted his invitation to sit on the External Panel on 18 October, which is why he was not listed in the 18 October Written Ministerial Statement and Press Notice.
Financial Benefits

34. We anticipate that boundary changes and a new focus on commissioning for PCTs will enable local organisations to make substantial savings, made by reducing management and administration costs. SHAs and PCTs are charged with demonstrating a minimum of 15% saving on management and administration costs. We expect savings of at least £250 million to be realised in this way, and these will be invested back into local frontline services, in line with the Labour Party’s manifesto promises. The SHAs have indicated that they think the savings targets are realistic and obtainable in their recent submissions to the Department of Health.

Annex A

CPLNHS Timetable

— SHAs submit proposals to the Department of Health by October 15 2005.
— All proposals will be judged according to a number of criteria including:
  — securing high quality, safe services for patients;
  — improving health and reducing inequalities;
  — improving the engagement of GPs;
  — improving public involvement;
  — improving co-ordination with social services through greater “co-terminosity” of PCT and local government boundaries;
  — effective use of resources.
— An external panel representing key interests has been established to advise Ministers on whether the proposals meet the criteria.
— Any proposals for changes to PCT boundaries will then go out for a three month statutory consultation to all local stakeholders and staff interests. This consultation will begin in early December 2005. No decisions on future local configurations will be taken until after this full statutory local consultation has been completed.
— Changes to SHAs will precede changes to PCTs and any changes to the latter will not commence before April 2006. Any changes to PCTs’ role in providing services will take place over a longer timescale and will be subject to consultation in the usual way.
— The Department expects that PCTs will make arrangements for universal coverage of Practice Based Commissioning to be in place by December 2006.

10 November 2005

Further questions for the Department of Health

Payment by Results

1. During the evidence session on 10 November, Mr Bacon suggested that Payment by Results was being implemented in different ways for different services. Could you please supply some more detailed information on how implementation will differ by service type?

At this stage, the Department of Health has no firm proposals as to how Payment by Results will operate outside of acute hospital services. The possibility therefore remains open that Payment by Results may be implemented in different ways for different services.

Starting with Mental Health services, the Health and Social Care Information Centre (“The Information Centre”) is leading development of new casemix classification tools (ie “currencies”) that, in time, could underpin an extension of Payment by Results into “out of hospital” care. Further information on the casemix classification programme is available on the Information Centre’s website (www.ic.nhs.uk).

At this stage, 14 Mental Health Trusts are participating in the work by providing data based on local activity definitions. The Information Centre will then analyse this data for its suitability to form a contracting currency that could underpin a National Tariff. Any firm proposals will be tested further across the NHS during 2006–07.

As we are testing more than one approach, we are very open-minded about the outcome, and with close NHS engagement and ownership throughout the whole project, any proposals will fit their needs as well as the Department’s.

If the testing proves successful, our aspiration is to have some elements of mental health included within the scope of Payment by Results by April 2008.
In the longer term, the Department would be keen to explore how clinically appropriate, standard currencies could be developed for other services in order to facilitate further extension of Payment by Results into “out of hospital” care.

**Practice-based Commissioning**

2. *Could you please supply the Committee with an estimate of the current total number and proportion of GP practices which are currently involved in Practice-based Commissioning? Could you please specify the level of involvement—eg how many are currently fully controlling their own indicative budgets, and how many are at an earlier stage in the process?*

The Department does not currently collect data on take-up of practice based commissioning. A survey conducted in 30 PCTs in June 2005 indicated that at the time 85% of practices felt engaged in practice based commissioning, with around 20% participating. The same survey estimated that in June 2006, over 95% of practices expected to be engaged in practice based commissioning, with around 70% participating. The level of involvement was not explored further that this.

In view of the accelerated timescale for delivering universal coverage of practice based commissioning—by December 2006—we are considering whether a central data collection is required.

3. *Could you confirm that practice based commissioning is a voluntary initiative for general practitioners? If this is the case, how can you ensure that all practices will take part?*

Practice based commissioning remains voluntary for Practices. However, PCTs should be providing the same level of management information to non-participating practices. This would include making practices aware of their indicative budget and providing regular updates on referral rates, spend against budget, etc.

Commissioning a Patient-led NHS requires all primary care trusts to have arrangements in place by December 2006 for universal coverage of practice based commissioning. PCTs will therefore be keen to encourage their Practices to participate. Furthermore, we are currently considering other incentives to encourage participation from Practices.

4. *Are you considering offering additional financial incentives to general practitioners to take part in this initiative? If so, could you please give us details?*

Yes, however, these form part of current GMS Contract negotiations. To reveal details at this point may jeopardise the success of these negotiations.

5. *Could you give some detail about the level of management costs will practices be able to claim?*

The Department has so far not been prescriptive about the amount of management allowance that PCTs should pay Practices to support PBC. However, the management allowance should cover the costs of clinical time needed to review management information and consider service and care pathway redesign. We are aware of a range of payments by PCTs from 50p–£2 for each patient on their list.

Practice based commissioning is not intended to introduce a new level of bureaucracy at practice level. We therefore expect PCTs to review their commissioning teams to consider how best to support Practices and minimise the administrative burden of the scheme.

6. *To what uses will practices be able to put any “savings”?*

Resources freed up from effective commissioning may only be used for patient services (with the exception of covering management allowance). This does not preclude the use of resources for developments where such a development would enable a wider range of services to be provided than is currently the case, and to a wider than practice population.

The proposed use of savings will be agreed with the Professional Executive Committee at the start of each financial period and this is ratified by the PCT Board.

7. *How much will practice based commissioning cost to implement (including management costs, PCT monitoring and any financial incentives for GPs) and can you estimate the expected efficiency savings that you expect to reap?*

Any implementation costs of practice based commissioning should be covered through savings made through more effective commissioning. However, the Department expects that the payment of a management allowance through an incentive scheme would require some investment upfront.

PCT support and monitoring will be cost neutral as we expect PCTs to reorganise existing commissioning resources to support the implementation of practice based commissioning.
8. How will PCTs deal with practices that fail to keep expenditure within their allocated budgets?

PCTs and practices will work together to ensure that practices manage their expenditure responsibly. Where a practice is deemed to be irresponsible whilst holding an indicative budget, for example by allowing avoidable overspends to persist in-year, the right to hold an indicative budget will be removed by the PCT.

9. Could you confirm whether or not any provider of primary medical services from the private sector would also be able to take part in practice based commissioning? If so, would it be acceptable for such commissioners to request a real, rather than an indicative, budget if they were prepared to accept the financial risks associated with any overspend?

Indicative budgets are currently available to all providers of primary care services who have a patient list. There is currently not the legal framework in place to allow primary care providers to be responsible for “real” budgets.

10. It has been argued that there is a risk that practice based commissioning will give rise to a multi-tiered service, as some practices will be better than others at using their limited commissioning resources and their patients will experience a better service as a result. How will this risk be managed? Will patients be able to choose to register with a better practice? What will happen if there is effectively no choice of GP practice in an area?

PCTs have an important role to play in ensuring that all patients within their local population have equal access to high quality primary care services. Where a practice or practices in an area are working well as effective commissioners, we would expect a PCT to ensure this good practice is spread to other practices within the area. PCTs also have a role to performance manage poorly performing practices.

We are already seeing practices working well together as locality commissioning groups in a number of areas. This is another development that will ensure a better, and more equitable, service for patients.

Patients may choose to register with an alternative Practice, but the aim of practice based commissioning to drive up the quality of all locally commissioned services.

11. Has the Government considered the risk that GPs who commission as well as provide services may have perverse incentives that may encourage them not to offer a full range of provider options to patients under the patient choice initiative? How will this risk be managed by PCTs?

Making Practice Based Commissioning a Reality—Technical Guidance (February 2005) stated if a practice is both a provider and commissioner of services, it is very important that there are no actual or perceived conflicts of interest. They should involve patients and local communities in planning commissioning and ensure that patients should be given a choice of other providers and not feel pressured to choose the practice as provider.

PCTs retain overall accountability for commissioning decisions taken within their area and need to ensure that patients are receiving a high quality local services. Through holding the responsibility for agreeing and managing contracts with providers, PCTs should make clear that choice should be offered to patients where appropriate.

12. Is it the Government’s intention that PCTs will set health improvement targets on the basis of a single practice population? If so, how feasible will it be for practices to meet such targets?

PCTs will remain accountable for the delivery of local health targets. However, PCTs should expect practices to deliver their share of any local health improvement target.

13. How do you intend to hold practice based commissioners to account for their performance as commissioners beyond looking at their expenditure against their budget allocation? Could you give us some examples of the sort of performance indicators with which you would measure whether performance is acceptable or not?

“Commissioning” is a very broad term covering a range of activities, from analysing the needs of patients through to contracting for the provision of services. PCTs will continue to be responsible for the commissioning framework for responding to the needs of their local population. Part of this will involve putting in place appropriate indicators of performance to ensure that practices fulfil their role in the overall commissioning framework.
14. Are you concerned that practice based commissioners will seek to select healthier patients onto their lists, a process known as “cream skimming”? If so, how could this be prevented?

Under their primary care contracts, practices are not allowed to refuse patients access to their lists on the grounds of race, gender, social class, age, religion, sexual orientation, appearance, disability or medical condition. We therefore do not consider this to be an issue.

DIVESTMENT OF PROVIDER SERVICES—QUESTIONS 15–18 ANSWERED TOGETHER

15. How likely do you think it is that a range of alternative providers will enter the market place to provide community services? Do you have any evidence to date that there are many potential providers waiting in the wings?

16. Can you outline what sort of organisations you would welcome into the market for community services and what sort you would resist?

17. Do you think that it may be more difficult to attract additional providers of community services in deprived areas, just as it has proved more difficult to attract GPs?

18. How will you ensure that professional training and development are not compromised if PCT community services are delivered in future by a wider range of providers?

We will address these issues in a White Paper on improving community health and care services, which we will publish around the turn of the year.

The public have told us through the Your Health, Your Care, Your Say consultation that they are not concerned who provides community health services—whether it’s the NHS, or the voluntary or independent sector. They want services that work, delivered quickly and effectively, and in the right place. We are considering all the responses to the consultation and we will bring forward proposals that give strategic direction for improving community health services, including the plurality of providers, in the White Paper. The fundamental principle will remain the same—community health care will continue to be free at the point of use, no matter who provides that care.

RECONFIGURATION OF PCTs

19. Could you provide us with an estimate of projected redundancy costs arising from the reconfiguration of PCTs?

An initial costing exercise has been undertaken. There are a number of factors which could influence this estimate and there is little influence over many of these factors, for example the ultimate cost depends on which staff are made redundant and their severance terms. We have therefore already instigated a more detailed pilot financial modelling exercise with one SHA. We will then ask each SHA to complete the same modelling. The modelling will demonstrate the timescale within which the redundancy payments can be recouped and the level of savings possible in 2007–08. We would be content to share this work once it is at an appropriate stage.

20. Could you provide us with an estimate of the costs of setting up local structures below PCT level to ensure good clinical engagement?

Practice based commissioning will ensure good clinical engagement at below-PCT level. Question 7 deals with how much we expect practice based commissioning will cost to implement.

21. Could you point to the evidence that large PCTs will be more successful at commissioning than the ones they replace?

There have been a number of separate pieces of research work undertaken on commissioning; these are as follows:

— McKinsey’s—Best Practice in Commissioning (this was commissioned by the NHSFT team).
— Norwich Union/NERA—Commissioning in the NHS (this was NOT commissioned by DH).
— Matrix—Using Practice Based Commissioning to implement new clinical pathways (again not commissioned by DH).
— McKinsey—System Architecture and Drivers for Quality (this was commissioned by DH).
— PA Consulting—Strategic Assessment of NHS Contracting and Commissioning (done for DH).
— PWC—preliminary thoughts on commissioning (internal piece of work PWC shared with us).
Health Committee: Evidence

— Health Foundation—A review of the effectiveness of primary-care led commissioning and its place in the NHS (NOT commissioned by DH).

Each touches (directly or indirectly) on population sizes for commissioning organisations. While there are many common themes within these reports about commissioning functions there is no clear consensus about ideal population size.

In addition, the DH recently commissioned a study (undertaken by PA Consulting) to look at optimum population size of PCTs. Evidence from this work suggested that post-PBC, commissioning can work effectively scaled to populations of at least one million and possibly more. On balance the department concluded that whilst the general theme of larger more strategic commissioning organisations was sound, there was not a strong enough case for a single national blueprint. Ultimately this should be a matter for local determination, and be dependent upon the needs of the population and nature of he commissioning organisation. The department has however been clear that where SHAs propose fewer, larger PCTs, they demonstrate how they will retain a locality presence, and where smaller PCTs are proposed they demonstrate how the economies of scale and improvements in commissioning services can be delivered.

14 December 2005

Memorandum submitted by Nicholas Relph, Chief Executive, Thames Valley SHA (PCT 18)

Thank you for the invitation to attend the Health Select Committee where members are particularly interested to find out more about the proposals to procure the commissioning function in Oxfordshire.

I have taken advice from the procurement experts who are working with us. At this stage I would not be able to give any more detail than that which is already in the public domain in our submission to the Department of Health of 15 October

“Commissioning a Patient-led NHS will reduce the number of Primary Care Trusts and this offers the opportunity to retain and attract the very best talent to Thames Valley. However, the scale and complexity of the new roles in managing change in a challenging environment means that the skills and capabilities need to be enhanced and widened from that required for current leadership roles.

On this basis the SHA is determined to seek the best possible candidates for all leadership posts. Following informal discussion with key local stakeholders the SHA wishes to seize the opportunity presented by Commissioning a Patient Led NHS and the increasing culture of developing choice and plurality in the NHS by exploring the opportunity of extending plurality to the management and delivery of the commissioning function. The SHA proposes to procure the provision of management services to the Oxfordshire PCT(s).

This will enable the rapid appointment of a strong new leadership team who have demonstrable experience in commissioning in a complex environment (given the ongoing challenges the need to hit the ground running is critical).

Successful bidders will be expected to bring high quality commissioning and business process skills as well as demonstrating how they will enhance clinical involvement linked to an early implementation of Practice Based Commissioning. The quality of care provided by primary care in Oxfordshire is amongst the best in England.

A Board of non-executives will be appointed via the NHS Appointments Commission to the Oxfordshire PCT(s) to oversee these arrangements. The procurement will focus on the commissioning component of the PCT(s). The successful bidder will work within current NHS rules on consultation and patient and public involvement and will, following appointment, be expected to implement their plan for current PCT hosted services in line with Commissioning a Patient-led NHS.

Bids would be welcome from NHS teams, the voluntary and private sector. Various best practice models will be considered, drawing on approaches that have been successfully adopted in the NHS and elsewhere such as franchising.

The SHA will work within any national guidelines with respect to HR and other business processes.”

This is due to the fact that we are still awaiting a response from the Department on whether they wish us to develop this proposal. If we get a positive response I would be happy to share with committee members our plans before placing an advert in the Official Journal of European Union, if this could be arranged.

I therefore decline the committee’s invitation but hope that I can meet with members at a later date if our proposals are developed.

Nicholas Relph, Chief Executive
Thames Valley SHA

2 November 2005
Memorandum submitted by Basildon PCT (PCT 11)

1. INTRODUCTION

1.1 We note that the Health Select Committee has decided to undertake an inquiry into potential changes to primary care trusts’ functions and numbers arising from the Department of Health’s recent paper, Commissioning a Patient-Led NHS. We note that the Committee will be examining:

(i) The rationale behind the changes.
(ii) The likely impact on commissioning of services.
(iii) The likely impact on provision of local services.
(iv) The likely impact on other PCT functions, including public health.
(v) The consultation process on the proposed changes.
(vi) The likely costs of change and subsequent possible cost savings.

1.2 As a PCT we welcome the decision of the Select Committee to look into these matters and submit the following evidence for your consideration. This evidence is submitted to you on behalf of Basildon Primary Care Trust in Essex, by the non-executive directors of the Trust and signed by the Chairman.

1.3 Basildon Primary Care Trust serves one of the most deprived communities in Essex, as measured by most indices of social deprivation. In particular we would draw the Committee’s attention to the low education attainment, which is one of the lowest in the country. The population served by the PCT is 109,000 and is contained within the “New Town” part of the Basildon District Council area, and within the large shire County of Essex (1.6 million people). Basildon PCT is one of the most underfunded PCTs in the country. We will gain in real terms through the NHS financial allocations announced for the next two years, having suffered the disadvantages of being more than 9% distance from target allocation at the establishment of the organisation on 2001. This year’s budget of £122 million budget will, we have been told, increase to circa £135 million in 2006–07 and circa £151 million in 2007–08. For the first time since establishment this will give Basildon PCT the money to make major investment in improving primary care services and tackling the real local health inequalities.

1.4 We set out our evidence the Select Committee below under the Select Committees terms of reference.

2. RATIONALE BEHIND THE CHANGES

2.1 Strengthening commissioning

We positively welcome and support the policy direction which strengthens commissioning and empowers local clinicians to procure locally appropriate services through practice-based commissioning (PbC). But we are puzzled at the suddenness of the announcement and publication by the DoH of the paper Commissioning a Patient Led NHS in July, during the holiday period, and the compressed timetable within which the informal consultation on reconfiguration of PCTs, Ambulance Trusts, and SHAs took place. Although we have no argument with the overall policy direction we do not believe this required the wholesale reconfiguration of PCTs. In our case, which is not uncommon in the NHS, we have already set up strong partnerships with neighbouring PCTs for commissioning, modernisation of services, risk sharing, and the implementation of PbC and capability is being strengthened daily. Our partnership is called the South West Essex Health Management Partnership and we have identified a top five shared commissioning priorities for the area: Emergency Care, Management of Long Term Conditions, Planned Care, Children’s Services and Mental Health. As a group the PCTs in this area have almost two years experience of being a commissioner of a first wave Foundation Trust (Basildon and Thurrock University Hospitals NHS Foundation Trust) within the enhanced Payment by Results (PbR) financial regimen.

We believe we would have achieved fitness for purpose ourselves over a relatively short period of time, bringing local stakeholders with us, rather than being “victim” of what is now perceived as a top down process.

2.2 Saving money

With regards to the saving £250 million, the NHS has had to find considerable savings over the years and we believe that if we had been asked to find our share of this we would have done so, reconfiguring locally to meet the challenge.

Like other PCTs in Essex we are not only expected to make the necessary savings to break even ourselves, but also to help balance the books Essex-wide by finding an additional £750,000 surplus.
2.3 Co-terminosity

Achieving co-terminosity with social services authorities in a large shire County like Essex sacrifices District Council or Borough co-terminosity where most of the partnership work actually happens, and where true public sector integration around community strategy/LSP priorities is possible. In addition the factor of two smaller unitary councils in the south of Essex needs to be considered.

3. Likely Impact on the Commissioning of Services

3.1 The reconfiguration debate will inevitably take people’s “eye off the ball” of what we all believe is the most important factor, the successful implementation of PbC. Our commissioning processes, essential for getting Local Delivery Plans (LDPs) in place for April 2006–07 onwards will be seriously compromised if Chief Executives and Directors, the key leaders in this process, are insecure about their futures. Of course as professionals they are hard at work constructing business continuity plans to make sure all the essential work is co-ordinated and delivered during this critical time, but this in itself takes energy away from the true and complex commissioning task, especially in the context of PbR and PbC.

3.2 PbC implementation is, we believe, the “arrowhead” of the commissioning reforms and is likewise in danger of being undermined or delayed. Local clinical engagement, the key to the success of this process, has already been compromised by the speculation about what the new organisations will look like, and who will be the new key players.

4. Likely Impact on Provision of Local Services

4.1 Staff in provider services, particularly, community nursing (Health Visiting, District Nursing), therapy services (Physiotherapy, Occupational Therapy, Speech and Language, Dietetics and Nutrition, Chiropody and Podiatry), community paediatric medicine and nursing etc, have been deeply unsettled by the July statement that provider services will separate from PCTs by 2008, with no clarity about where they will go or who will manage them. Some new light has been given in the recent announcement by the Secretary of State, which appears to say this is now a matter for the new PCTs to decide and not a directive, but there is still lack of complete clarity. This is causing unsettled staff to lose focus and sometimes vote with their feet by moving to organisations perceived as being more stable. In this time this will be the acute sector of the NHS or mental Health Trusts, ie those perceived to be unaffected by reconfiguration. This is highly counter productive at a time when Government policy, through patient choice and good medical practice is focusing on admission avoidance and managing long term conditions in the community. At any time PCTs can ill afford to lose the skills of their primary care and community workforce.

5. Likely Impact on other PCT Functions including Public Health

5.1 It is unclear what has happened to the “Choosing Health” White Paper and delivery plan in this debate about the size and shape of PCTs. There is a risk that unless mechanisms to implement this vital part of policy are explicit, the very thing that can have the most impact on health, especially in a deprived community like Basildon Town, is lost in an organisation that is too large to relate to local communities and too involved in strategic commissioning to really put in the investment that is needed to promote healthy living.

5.2 Impact on PCTs ability to deliver PbC has been addressed above.

6. Consultation on Proposed Changes

6.1 The Essex SHA adopted a rapid informal consultation process as requested in DoH document in July. This necessitated a very short time scale for consultation as draft submissions had to be in to DoH by 15 October, and most key players were away in August and could not respond. Consequently insufficient time was available to collect vital data to inform a complete option appraisal of the various possible configurations. The SHA submission, by their own admission is lacking in essential information, especially financial data, and they are only now commissioning work to carry out these essential investigations. Yet they have made a recommendation to the DoH that they consult on a preferred option of two PCTs, one North, one South for Essex which many according to their own public consultation report feel is not sensitive enough to address vital local issues of health inequalities and service integration.

6.2 Basildon PCT’s preferred option is to be merged as part of one South West Essex PCT, as part of a configuration that would give five PCTs across Essex. Our rationale being that collaboration already exists amongst PCTs that share a main acute provider. In our own case this is particularly strong with the jointly appointed Director Commissioning and joint programmes addressing many common needs. Our clinicians are already fully engaged with this process that is designed to achieve stronger, clinically led commissioning. In particular our clinicians and our patient representatives are concerned that our new resources next year and the year after are safeguarded for the most deprived communities they serve. The rationale for five PCTs
in Essex seems at least as strong as the rationale for two until costs are considered. We understand that
detailed costings are being undertaken and note that costs may need to be completely reconsidered if the
management costs of provider services are not necessarily to be channelled into other organisations.

6.3 In the formal consultation stage we would like assurance that real weight is given to local views
including those of the PPI forum and District Council.

6.4 In our original submission to the SHA, we made the following additional points in support of a SW
Essex PCT option.

6.4.1 The combination of the impact of the population increases in the South West of Essex associated
with Thames Gateway (additional 32,100 households by 2021) and the enhanced financial allocations over the next few years (eg an estimated budget of over £450 million by 2007–08) a SW Essex PCT is clearly a viable unit.

6.4.2 A SW Essex PCT reflects a natural health economy around a first wave Foundation Trust. A
similar natural health economy has developed in the South East of Essex. A South Essex single
PCT configuration would artificially pull together two separate, functioning, natural health
economies.

6.4.3 Children are a high priority in Basildon and neighbouring areas. There are a high number of
children on the child protection register, and children suffer significantly poorer educational
achievement compared with most parts of the country. A SW PCT will be more effective in
protecting and developing the work of our very active District Council level local Children’s and
Young People’s Strategic Partnerships (CPSVPs).

6.4.4 Bringing these two natural health economies, SW Essex and SE Essex together gives absolutely
no guarantee that in a South Essex budget, the interest of the deprived Basildon communities
would continue to be served and that Basildon people would continue to benefit from the
increased allocations per capita they have waited so long to receive.

7. LIKELY COSTS AND COSTS SAVINGS

7.1 We would refer you to our comments in paragraphs 2.2 and 6.2.

8. CONCLUSION

8.1 We would respectfully ask the Select Committee to consider the evidence we have presented. Our aim
is not to oppose change but to make the case for form to follow function. The current proposals risk
widespread system instability at the very time, when the “arrowhead” of reform, PBC, requiring close local
clinical engagement and considerable local management capacity, is being implemented.

Ahwyn Hollins, Chairman
Basildon Primary Care Trust
31 October 2005

Memorandum submitted by Colchester PCT (PCT 10)

BACKGROUND

Essex SHA has submitted a number of options as a result of informal consultation and stated its preferred
option as a North South two PCT solution. There are currently 13 PCTs. Colchester supports the five
PCT option.

1. RATIONALE BEHIND THE CHANGES

There are currently 13 PCTs in Essex. Reducing them from 13 to two is considered to be more severe than
anywhere else in the Country. We accept wholeheartedly the need to strengthen commissioning capacity and
believe that five PCTs for Essex would bring a sensible balance between size, commissioning capacity and
savings. In the majority of other SHA areas the reduction in PCT numbers has been far less draconian,
reducing on average from two–three PCTs to one strong commissioning area. If a similar approach was
applied to Essex this would lead to four–five strong commissioning PCTs.
Drive for Savings

The proportion of management costs that would be delivered by reducing from 13 PCTs in Essex to two would be disproportionate to the national average. We are concerned that this might mean a disproportionate contribution towards national savings targets from Essex with corresponding devastation to our staff. Or this might be applied to the new SHAs and PCTs to give them extra capacity. A more even spread and contribution can be achieved whilst still creating strong commissioning PCTs and a fair contribution towards savings and SHA costs. This approach would also ensure any future divestment of provider functions has sufficient management resources.

Divestment of Provider Function

Like many PCTs who manage provider functions, our PCT already separates commissioning and provider functions. We provide learning disability services for eight PCTs in North Essex and community services for the 170,000 population of Colchester. In the latter area we support a merger with Tendring PCT at both commissioning and provider levels. In both provider functions in our PCT there are separate management lines to commissioning. However these two functions, along with commissioning have the benefit of shared support functions such as finance, communications, Research and Development, Human Resources etc (within finance the support for commissioning is separate from the provider functions).

A massive reduction in PCTs in Essex will also create a significant loss of focus in the primary care agenda and the success we have had in moving away from traditional hospital locations for many out patient services. The process of divestment will distract from this drive and many benefits for patients will be lost or put in jeopardy—having the exact opposite of the intended affect of divestment for those PCTs such as ours where commissioning and provision are already separate. It is however accepted by merger with our neighboring PCT we will achieve benefits of economies of scale and be able to strengthen the respective functions.

Practice Based Commissioning (PBC)

Larger mergers and divestment of provider functions do not enhance the challenge to ensure 100% Practice Based Commissioning is achieved. A merger between two or three PCTs will create more capacity to focus on Practice Based Commissioning but with larger mergers comes the need to create localities so as to be locally sensitive to the high risks associated with PBC. It is imperative to be effective in clinical engagement and enhance PCT to “know your patch” this is less likely in a very large PCT which is geographically remote.

If a PCT has, as we have, separate commissioning and provider functions then there is no reason why this would be a distraction from PBC, on the contrary we consider this to be an advantage.

Contestability

We are not opposed to contestability as a means of achieving change but believe the timing of this should be left to PCTs to determine. There needs to be a level playing field so that PCTs can demonstrate that it does not distract from their commissioning role or indeed on the contrary that there are benefits (economies of scale etc and support functions).

2. Likely Impact on Commissioning of Services

We see the benefits of creating more capacity in commissioning to be able to match on an equal footing the capacity in provider services as enjoyed by larger Trusts and in particular Foundation Trusts. We also believe that the same rigor should be applied to our own provider services and see this as perfectly achievable whilst having a separate provide function and from the capacity created from merging with Tendring PCT and without the need to merge with seven other PCTs as preferred in the SHAs submission.

The other benefits of a localised service where there is engagement of clinicians where relationships have built up both in Primary and Secondary Care could be seriously jeopardised with a very large remote PCT even with a locality function.

The best economies of scale and capacity can be achieved by having a matrix of commissioning where for different aspects of commissioning there are different population bases employed. Eg PBC should be small and locally sensitive, DGHs one coterminal PCT—Specialist and tertiary commissioning from a PCT on behalf a number of PCTs to have responsibility on behalf of a larger population and the commensurate capacity to deliver.
3. Likely Impact on Provision of Local Services

We have concerns as outlined above that staff will feel destabilised and seek other employment if they do not have clarity and protection of pension and superannuation rights. There is also extreme concern about the prospect of being employed directly by GP practices and this is very likely to affect turnover, likewise if being moved back to a secondary Trust provider. There is real concern at the turnover of staff during a period of critical delivery, and that the only way to counter this will be by significantly driving up costs.

4. Likely Impact on Other PCT Functions, including Public Health

There are currently economies of scale being achieved by sharing backroom functions across commissioning and provider functions, which will otherwise increase cost wise to remain effective should they be separated. Merging with our neighbouring PCT will increase capacity in some areas where we have separate functions eg HR and Finance but we already have a shared Public Health Function and fear that mergers beyond five PCTs into a two PCT Essex model will reduce effectiveness and dilute capacity.

5. Consultation about Proposed Changes

Informal consultation in Essex has demonstrated that there is a significant majority in favor of the five PCT option and yet after assessment by the SHA against the criteria they have stated a preference for the two PCT option. They have said that this the five PCT option would not generate the requisite capacity, yet other SHAs who have gone for two–three PCT mergers creating 300,000–350,000 PCT populations seem to consider that this to be sufficient to create the population base, commissioning capacity and the financial savings. There is some concern therefore that the majority view is not being supported for sustainable reasons.

A particular area of concern is the lack of localism for the two PCT SHA preferred option. Partnership with Local Authorities have become vital in many aspects of PCTs work—sharing resources (shared appointments) commissioning of voluntary sector, shared priorities (LAAs), working with wider partners (LSPs) are all dependent on a strong local presence with strong local knowledge. This is probably the hidden work of PCTs where they have grown immeasurably in effectiveness in the last few years. Most Local Authorities (not County) support smaller more coterminous PCTs or at least ones where there is some synergy now or likely in the future, a two PCT Essex configuration is going against this direction.

Partnership working and localism is particularly important in our work in respect of LIFT (Local Initiative Finance Trust) and we are already in a LIFT partnership with our neighbouring PCT and the two associated local authorities. As a result planning for health in particular is the most effective our population has ever had.

The former North and South Essex HAs (which the two PCT model geographically mirrors) did not have the localism perspective to understand the importance of the relationship between planning in respect of health provision. As a result many housing estates were built with inadequate or no health provision. The relationship is now such that not one house is built without local planners informing PCT’s and working with us on the health impact.

There is also a concern that with a geographically remote and very large PCT the Non Executive Directors (NEDs) will be remote—this was the case with the former North South HAs. We have since the inception of the PCT had the benefit of NEDs who are local and County Councillors and NEDs who “live on the patch” and know the issues through living and breathing them locally. This will be a significant loss in a remote PCT model, with a locality structure without NEDs who hold the PCT to account but also have useful other roles or experience.

6. Likely Costs and Cost Saving

The two PCT configurations creates more disruption and destabilisation than the National average by the draconian reduction of 13 to two PCTs—the average elsewhere being in the order of two–three down to one. This is perceived as creating excessive disruption and significant risks in terms of lost organisational memory. It will also generate greater surplus than the per head of population contribution to the savings and therefore be disproportionate. Or it may create excessive resources either at SHA or PCT level with the deficit being the loss of localism and risk to delivery of the National Agenda. The five PCT option in comparison provides a balance of risk and fair contributions savings and capacity wise.

Mrs Maggie Shackell, Chair
Brendan Osborne, Chief Executive
Colchester PCT

31 October 2005
Memorandum submitted by Maldon and South Chelmsford PCT (PCT 26)

I am Chair of Maldon and South Chelmsford PCT and have been asked by my non-executive colleagues to prepare evidence for this inquiry

Likely Impact on Commissioning of Services

There is a significant risk that the emphasis on Health Improvement and Public Health will be reduced. Our Trust has introduced approximately 800 service changes in the past four years. The PEC (clinicians) has enthusiastically engaged in introducing new and improved services to treat patients locally. However they have not been the force behind changes to improve health and prevent illness. The latter have been achieved as a result of strong local partnerships with patient groups, business, the voluntary sector, local government, the executive and non-executive directors. Resources may well be directed away from what is after all the traditional role of GPs—the treatment of sick patients. The danger is that we will concentrate on Illth rather than Wellth (apologies to Wm Morris).

Likely Impact on Provision of Services

This is potentially the most damaging area. At present deprived areas such as Hastings—Yarmouth—Tendring receive significant support which they did not receive when they were part of larger health authorities covering predominantly wealthy counties. Under the new proposals every one of these Trust areas will join other richer areas which have large debts. The new Trusts will have to take resources from the most deprived in order to balance financially. Patient choice will most probably be exercised most effectively by those wealthier areas of the new Trusts and less so by the patients of deprived and socially isolated communities. There will therefore be a real risk that inequalities will increase.

Consultation about Proposed Changes

This has been dreadful. Conflicting advice has left my staff bewildered and demoralised. The public do not understand how the process of setting up new bodies can begin before the consultation process is complete. The process is creating deep cynicism following as it does after a campaign to promote “patient choice” which coincided with the decision not to require GPs to work in the evenings and weekends which was taken with no public consultation and clearly would not have been agreed by the patients.

Likely Costs and Savings

My personal experience of working in large organisations has been that increasing size does not reduce costs. The whole process of revolutionary change is destructive as it breaks up effective networks and creates uncertainty. Evolutionary change has worked well in the past four years and the huge gains made under the present system should be recognised.

Tony Plumridge, Chair
Maldon and South Chelmsford PCT
7 November 2005

Memorandum submitted by Philip Barrett (PCT 5)

I am writing in respect of the enquiry next week regarding changes to Primary Care Trusts. The opinions I express below are personal, and as a consequence I will not disclose the identity of the Primary Care Trust for which I work.

I joined the NHS in 2002 from a senior position in private industry, having been enthused by the principles behind Shifting the Balance of Power. The concept of a local body providing the best health services for its own population was particularly appealing. The benefits of local accountability and focus were clear.

In the ensuing three years, my PCT has made significant progress in achieving these aims. Local initiatives have been developed of major benefit for our local population, which arguably would not have occurred had the organisation been subsumed in a larger body with conflicting priorities. We have achieved excellent clinical engagement, and we are consequently making good progress on the development of practice based commissioning.

We are now facing assimilation into a county wide PCT, with a population in excess of one million compared with the 100,000 for which we are currently responsible.

The arguments for this change leave me unconvinced. We are accused of failing as commissioners, without any evidence being provided. In our local health community a well developed system of lead commissioning has been in place, leading to a critical mass for negotiating with our providers, most of whom are Foundation Trusts.
The real driver for merger is said to be financial, with the target of £250 million to be saved. In reality such reorganisations rarely actually save significant sums, given the requirement to establish locality structures below the county wide PCT in order to attempt to preserve local clinical engagement and local focus.

The existing mature systems of relationships, governance arrangements and risk management structures will need to be re-invented in the new organisation, and it will take at least 18 months and a huge effort to restore the effectiveness of systems back to the level we are currently achieving.

The distraction this exercise will generate, together with the demoralising impact on staff, will certainly make it more difficult to address the financial positions of the PCTs over the next 12 months. Trust Boards with a limited life expectancy may not be over interested in making the necessary service reconfigurations for long term benefits but with short term pain.

The whole process of Commissioning a Patient Led NHS to date has been badly handled, with conflicting guidance particularly about timing and the future of Provider Services. This does not help senior managers implement the reconfiguration, with ground rules changing with no notice and all giving a clear impression that the policy is being developed on the hoof.

It is disingenuous to argue at the centre that the impetus and direction of change has come from the grass roots. We have been left in no doubt that a minimum number of PCTs had to be achieved on financial grounds.

To summarise therefore:

- Primary Care Trusts were established to serve the particular needs of a local population. How will this be preserved with one body serving a shire population?
- Local Primary Care Trusts facilitate clinical engagement. How will this be preserved with one body serving a shire population? How will Practice Based Commissioning be facilitated by having one county wide PCT?
- Primary Care Trusts can commission effectively through lead commissioning arrangements.
- The new organisation will not save money in the short to medium term.
- The progress made in the last three or four years will be lost.
- The distraction from reorganisation will damage financial performance.
- The process seen to date has been poorly thought through and guaranteed to bewilder and demoralise staff.
- The NHS does not need such a reorganisation. I am not convinced it is broken, so why try to fix it?

Philip Barrett
28 October 2005

Memorandum submitted by Karen Rhodes (PCT 3)

I don’t doubt that there are opportunities in the proposed reforms to save on management costs, strengthen commissioning and to create improvements for patients but would like to ask the Select Committee to consider the following in their deliberations:

- Is it realistic/possible to transpose the Choice agenda in secondary health care to primary and community services and has this been given the due consideration it needs? How can plurality of provision and contestability be delivered in rural areas? I believe a wider range of services is needed outside of hospital but this does not mean duplication, especially given the existing recruitment challenges within certain key professional groups.
- How will accountability and performance assessment work in a mixed economy for out of hospital care?
- Why is the Government making these changes when PCTs’ efforts to improve local services are only just taking effect?
- One of the real benefits of PCTs’ has been the ability to provide front line clinical involvement in all aspects of commissioning (through engagement of Independent Primary Care Contractors and PCT employed clinical staff working within community services). I understand the reforms are intended to strengthen commissioning by separating it from provision however if commissioning decisions in the future are to be made largely by primary and community health care professionals through Practice Based Commissioning why are PCTs’ being told they must separate provision and commissioning?
- The delivery of care to highly vulnerable people in the community requires increased coordination and integration. How will diversity and multiple providers achieve this?
— A briefing for senior PCT officers prior to the publication on the statement on future of PCT provision within Commissioning a Patient led NHS would have been helpful. The impact this has had on highly committed NHS staff within PCTs’ has been regrettable.

Please note the comments I make are from a personal not a PCT perspective. I hope you find them helpful.

Karen Rhodes  
Director of Primary & Community Care  
North Lincolnshire PCT  
28 October 2005

Memorandum submitted by Milton Keynes Council (PCT 15)

Executive Summary

Milton Keynes Council believes that the reform of PCTs should be along clear lines of principle. Milton Keynes Council enjoys a robust partnership with the PCT and co-terminous boundaries and the benefits derived from this arrangement have been cited in the paper. We believe that the important principles that relate to securing public health services to make PCTs fit for purpose include:

— As the core purpose of the DoH and this service transformation is to improve health and tackle inequalities, it is important that reconfigured services maximise influence of resource allocation in both the NHS and local government.

— It is essential that there is effective public health input at each level of commissioning (Practice Based, PCT, supra-PCT, Local Government).

— As public health goals are at the core of the purpose for PCTs, it is essential that the corporate leadership of the PCT includes visible, high level public health expertise.

— The NHS should be able play its full part in the negotiation and delivery of Local Area Agreements and maximize the benefits of co-terminosity with local government.

— To be effective commissioners and to provide effective support to practice based commissioners, PCTs will need access to a range of public health skills.

— PCTs will need to be able to discharge their range of mandatory public health duties and responsibilities.

— A restructured NHS should be able to support teaching and training of public health specialists and practitioners and support constructive links with academic public health teams.

— Public health services should be provided in ways that maximize efficiency and value-for-money.

— It is unlikely that there is a “one-size-fits-all” model that will be right in every area. New organisational structures should be tailored to the circumstances of local areas and reflect variations in the structure of local government.

— New organisational structures should build on arrangements that work.

Introduction

1. Milton Keynes Council welcomes the opportunity to submit a brief memorandum on the Government’s proposed changes to Primary Care Trusts (PCTs). The information which we have submitted reflects the views of both the Milton Keynes PCT and the Local Strategic Partnership (LSP). We have set out a principled vision of how we believe that PCT reform would best serve communities across England, grounded in evidence of effective partnership work in the Milton Keynes area.

Background

2. The purpose of restructuring is to make the NHS and health care system fit for purpose ie able to implement The NHS Improvement Plan, Choosing Health and Creating a Patient Led NHS. Together, these documents describe how the Department of Health intends to deliver its overall aim for 2005 to 2008 as set out in the 2004 Spending Review Public Service Agreements, which is to:

“transform the health and social care system so that it produces faster, fairer services that deliver better health and tackle health inequalities.”

3. Implementation of these plans and realisation of the DoH’s aim will require substantial organisational change for both commissioners and providers of health and social care services. In particular, it is intended that:

Provision

— A health and social care market should be created in which an increased number and type of provider will participate—ie there will be plurality of provision. This is intended to enable patients to choose where, when and how they receive care from among a greater variety of public, private and voluntary sector organizations.

Commissioning

— Primary Care Trusts (PCTs) should become more powerful commissioners that can manage a new health and social care market so that the public have dependable access to a full range of high quality responsive health services and that the health and social care system as a whole delivers improvements in health and reductions in health inequalities to the population as a whole.

4. As the overall purpose of the system transformation is to produce faster, fairer services that deliver better health and tackle health inequalities, if the organisations created are to be fit for purpose, it is important they are designed from the outset with a view to maximizing their impact on health and inequalities.

It is with these issues in mind that we have set out our principles and proposals below.

Principles for the Reform of PCTs

5. Milton Keynes Council believes that there are a number of important principles that relate to securing public health services to make PCTs fit for purpose include:

(i) The majority of public funds that are likely to contribute to improving health and tackling inequalities are channelled through the NHS and local government. As the core purpose of the DH and this service transformation is to improve health and tackle inequalities, it is important that reconfigured services maximise influence of resource allocation in both the NHS and local government.

(ii) Services will be commissioned at a variety of levels and by a variety of bodies including:

(a) Practices and groups of practices—through practice based commissioning.
(b) PCTs.
(c) Supra-PCT bodies for specialized commissioning.
(d) Local government—sometimes acting alone and sometimes jointly with the NHS.

It is essential that there is a strong public health input at each level of commissioning if the maximum improvements in health and health inequalities are to be achieved.

(iii) As public health goals are at the core of the purpose for PCTs, it is essential that the corporate leadership of the PCT includes visible, high level public health expertise.

(iv) Efficient provision of health services, and the design of relevant multi-agency care pathways is greatly facilitated if the agencies involved are responsible for the same population. In practice, this means maximizing the opportunities and benefits of co-terminosity between PCTs and local government.

(v) In future, Local Area Agreements will become an increasingly important vehicle for the planning, delivery, local target setting and accountability of local public services. The NHS will be expected to play its full part. NHS restructuring must allow the NHS to participate effectively.

(vi) If they are to be effective commissioners and to provide effective support to practice based commissioning, PCTs will need access a range of public health skills that include:

— Strategic planning for health and inequalities.
— Access to and interpretation of the evidence base.
— Needs assessment.
— Data analysis and information management.
— Service evaluation.
— Priority setting.
— Change management—including clinical credibility and clinician challenge.
— Partnership and multi-sectoral/multi-agency working.
(vii) As well as generic commissioning skills, PCTs will need access to specialist advice to commission specialised public health services (many of which will contribute to demand management) including:

- Screenings services.
- Vaccination and immunization services.
- Sexual health and teenage pregnancy services.
- Dental public health services.
- Health promotion and health improvement services.
- Addiction services (includes substance misuse, alcohol, tobacco).
- Prison health services.

(NB This paper focuses on the commissioning aspects of specialist public health and does not address the options and implications for the organization and continued delivery of the provider aspects of these specialist public health services).

(viii) PCTs also have a range of mandatory public health duties and responsibilities, which they will need the skills to fulfil. These include:

- Emergency planning—including planning for pandemic flu; chemical, biological, radiological and nuclear terrorism (eg “dirty bombs”).
- Child protection/safe-guarding.
- Local authority “proper officer” functions.
- 24/7 public health/health protection out-of-hours emergency cover.
- provision of expert advice from Joint Health Advisory Cells—when called by police in emergencies.
- Production of an annual report on the health of the population.
- Statutory consultation responses as part of Integrated Pollution Prevention Control (IPPC).
- Port Health duties (where relevant).

(ix) The ability to teach and train is essential for the sustainability of health care in the UK. A restructured health service should ensure that it is able to support the teaching and training of public health specialists and practitioners.

(x) Similarly, it is important that a restructured health service is able to support constructive links between service and academic public health teams.

(xi) Public health services should be provided in ways that maximize efficiency and value-for-money. For some public health services this is likely to mean organization at a supra-PCT level eg literature review and analysis of the evidence base; support to specialised commissioning. Other services require detailed local knowledge and will need to be provided locally eg multi-agency working with local government, clinician challenge, aspects of health protection and emergency planning.

(xii) The characteristics of local health economies and the structures of local governments vary substantially across the country and within the Thames Valley. It is unlikely that there is a “one-size-fits-all” model that will be right in every area. New organisational structures should be tailored to the circumstances of local areas and reflect variations in the structure of local government.

(xiii) New organisational structures should build on arrangements that work ie they should aim to consolidate rather than destroy successful arrangements and change and strengthen recognised organizational weaknesses.

The Benefits of Co-terminous Arrangements—the Milton Keynes Example

6. Milton Keynes is a former New Town, with one of the fastest rates of population growth in the UK. As a major city and growth centre in the South Midlands, it has specific needs which need to be addressed. The city has adopted a consensual, partnership approach to growth and service delivery, which encompasses all of the major public sector providers, including the PCT. The city enjoys a clear strategy through to 2034, set out in its Community Strategy.

7. Milton Keynes firmly believes that the interests of its citizens are best served by the creation of an integrated commissioning model and the retention of a PCT which closely matches the local authority. It is fundamentally important that commissioning services are reconfigured in order to maximise the resource allocation in both the NHS and local government. Through co-terminous arrangements, it will be possible for local authorities, such as Milton Keynes, to continue to maximise benefits of joint working arrangements and tackle health inequalities. The creation of Local Area Agreements (LAAs) will further refine opportunities for local target setting and local service redesign.
8. Milton Keynes Council and the PCT, for example, currently have co-terminous boundaries, which has enormous benefits for the city. The city prides itself on its reputation for innovative delivery patterns and original thinking. This applies to the health economy just as much as to other local government initiatives. The local authority and PCT have aligned their plans, budgets, commissioning and agendas over a number of years, delivering an integrated approach to public health. Milton Keynes has also pioneered the joint appointment of a Director of Public Health, recognising the importance of partnership working between the PCT and the local authority.

9. All partners in Milton Keynes represented on the Local Strategic Partnership see health and health inequalities as a key issue, and health services as an integral part of the city. Application of the principles set out in this paper—reinforced by the experience of recent years—lead them to believe strongly that the best interests of this rapidly growing city and its people—both present and future—will be best served by a PCT that is co-terminous with the Unitary Authority.

10. Many other parts of the country have come to similar conclusions about the relationship between unitary authorities and new PCT boundaries. Appendix 2 sets out a list where SHA proposals are that unitary authority and PCT boundaries should remain co-terminous. The Thames Valley Strategic Health Authority has submitted three proposals to the Department of Health: two would combine Milton Keynes with Mid and South Buckinghamshire PCTs and so lose many of the benefits of co-terminosity; the third would keep the PCT and UA co-terminous. We believe, in the interests of the people of Milton Keynes are best served by this last option.

11. Conclusion

In conclusion, it is the view of the major statutory stakeholders in Milton Keynes, that the development of new structures and guidelines for PCTs should be grounded in a number of core principles. In particular, we believe that PCTs should aim to maximise resources and benefits through joint-working arrangements with local authorities and this can only really be properly achieved through the adoption or retention of co-terminous boundaries, including at a unitary council level.

Milton Keynes Council
November 2005

Memorandum submitted by Norwich City Council (PCT 32)

This letter is in response to the Health Select Committee request for information about the Reconfiguration of PCTs, and the lack of opportunity for consultation on this matter.

The first issue we would like to draw your attention to is the timescale that the PCTs, and local interested parties and stakeholders were given to respond to the consultation document issued by the Strategic Health Authority.

The “Consultation Paper on the Future Configuration of PCTs in Norfolk”, dated 5 September 2005, was sent to Norwich City Council by the Chair of the Norwich PCT on 8 September 2005. This letter was received in the Council on 9 September 2005. The Council was asked to submit a response to the PCT by 16 September 2005, so the PCT could respond to the Strategic Health Authority by 23 September 2005. The letter from the PCT says:

“We recognise that the timescale is very short and it will nor give organisations the opportunity to respond formally. However, we are seeking views to shape and influence the future and would welcome comments by individuals.”

The Chief Executive at the time, Anne Seex, wrote to the Chair of the PCT on 21 September 2005 to give a view on this important issue pointing out that:

“the timescale given to respond was hardly reasonable on such a significant matter”

and

“Although I have not had an opportunity to consult Councillors on this issue . . .”

Given the scale and significance of the issue Norwich City Council would normally have taken the opportunity to elicit the views of Councillors on this matter and have approved a response at the Executive. To indicate the importance that Norwich City Council places on this subject, the Council, at its meeting on 25 October 2005, resolved unanimously that—

“Norwich City Council is concerned that the planning process for the reconfiguration of Primary Care Trusts (PCTs) in Norfolk did not allow sufficient time for effective engagement between PCTs and their local stakeholders. The Council is concerned that the Strategic Health Authority, in

4 Not printed.
promoting the idea of a Norfolk wide commissioning PCT, has ignored the favoured option put forward by the Board of Norwich PCT for a commissioning PCT for the residents of Norwich exclusively.

Norwich City Council urges the Strategic Health Authority to consider creating a commissioning PCT for Norwich for the following reasons:

1. Such a body will be able to concentrate more effectively upon the urban related health issues which affect much of the population of Norwich and which are likely to receive less attention in what will be a predominantly rural area.
2. Citizens will be closer to and able to have more influence upon the health commissioning decisions that will affect them.
3. Co-terminosity with local government at district level will enable easier joint working on areas such as housing, environmental health, benefit administration etc.
4. An independent local body is more likely to achieve effective engagement with GPs and other local Health Trusts and thus better outcomes for local people than a locality group working within a larger organisation."

In addition to this the views of other stakeholders would also have been sought through the Norwich Partnership, in particular the Social Issues Round Table of the Norwich Partnership, which is chaired by the Chair of the PCT.

In view of the fact that the Secretary of State for Health, Patricia Hewitt, has said that she will reject recommendations from Strategic Health Authorities that have not been put to widespread local consultation, we would urge the Select Committee to call for adequate time for proper consultation in those areas where this has not taken place.

_Councillor Ian Couzens, Leader of the Council, Councillor Steve Morphew, and Councillor Adrian Ramsay_  
November 2005

**Memorandum submitted by Telford and Wrekin Council (PCT 19)**

**EXECUTIVE SUMMARY**

Telford and Wrekin Council believes the Committee should note the following with regard to the principles underlying the reform of PCTs:

— the new roles for Primary Care Trusts (PCTs) require the local health economy to become everyone’s business, with other local strategic partners interacting fully;
— co-terminosity with local authorities with social services responsibilities allows greater scope for the implementation of local policies to meet specific local needs;
— compatible authorities can share common strategies, and plan and deliver excellence in health improvement and tackling health inequalities;
— there will be better overall outcomes for local people, particularly the poorest and the sickest who have complex health and social care needs that require a multi-agency approach when co-terminosity applies; and
— early examples of working with Local Area Agreements underline the opportunities that arise when working to a common geography.

Sharing boundaries between PCTs and local authorities is practical as it recognises:

— a standardised nominal working size for PCTs does not match most delivery catchments;
— most unitary and metropolitan PCTs are already co-terminous with their local authorities; and
— growing towns and cities have specialised and changing requirements, to which their PCTs need to be closely geared.

Sharing boundaries between PCTs and local authorities achieves funding transparency.

**INTRODUCTION**

1. The Borough of Telford and Wrekin is delighted to have the opportunity to submit written evidence to the Health Select Committee and its inquiry into Changes to Primary Care Trusts. As a local authority with a close and effective relationship to the Telford & Wrekin PCT, in terms of shared agendas, budgets and tackling health inequalities, we would like to restrict our submission to the likely impact on the betterment of local services and delivery of cost-efficiency. In general, we believe that there are three principles which support the retention or creation of co-terminous boundaries, namely:

— It promotes better local healthcare, underpinned by multi-agency initiatives.
— It is practical, accepting that standardization of PCTs is impractical and recognizes the fact that most unitaries currently share boundaries with their PCTs.
— It achieves funding transparency and provides scope for shared budgets.

We have set out the benefits arising from each of these in our submission below.

**BACKGROUND**

2. The purpose of restructuring is to make the NHS and health care system fit for purpose ie able to implement *The NHS Improvement Plan, Choosing Health and Creating a Patient Led NHS*. Together, these documents describe how the Department of Health intends to deliver its overall aim for 2005 to 2008 as set out in the 2004 Spending Review Public Service Agreements, which is to

3. “transform the health and social care system so that it produces faster, fairer services that deliver better health and tackle health inequalities.”

4. Implementation of these plans and realisation of the DoH’s aim will require substantial organisational change for both commissioners and providers of health and social care services.

5. As the overall purpose of the system transformation is to produce faster, fairer services that deliver better health and tackle health inequalities, if the organisations created are to be fit for purpose, it is important they are designed from the outset with a view to maximizing their impact on health and inequalities.

6. It is our contention that these objectives are best met through local PCTs, with a shared agenda and boundary with the local authority. With these issues in mind we have set out our principles and proposals below.

**LIKELY IMPACT ON PROVISION OF LOCAL SERVICES**

7. The Committee will be aware that most unitary and metropolitan PCTs are already co-terminous with their local authorities. An examination of current PCT boundaries demonstrates that most unitary authorities already enjoy co-terminous boundaries. It is essential that this is maintained and, where possible, this policy is applied to as many of the unitary authorities as practicable and/or desirable.

8. Growing towns and cities have specialised and changing requirements, to which their PCTs need to be closely geared. For example, in Telford, with a current population of around 165,000, the area is the fastest growing within the Region, and is expected to grow to around 200,000 over the next 15 years. It will be vital that new PCT structures are capable of reacting to this pace of change and have a co-ordinated approach agreed with the local authority.

9. PCTs should be constructed in such a way as to ensure that they can meet the needs of local populations. We would not welcome the creation of large PCTs, which would not be sensitive to local needs. Co-terminosity allows greater scope for the implementation of local policies to meet specific local needs. In Telford & Wrekin, the PCT have been a key member of the Local Strategic Partnership (LSP) and a major driver of our Community Strategy Ambitions. Through the Agenda Group, the LSP Executive, the PCT (and formerly as the PCG) has been a critical player in developing the necessary trust relationships and common agenda which have gained the T&W LSP national recognition for the maturity of its partnership working, recognised in the Council’s Comprehensive Performance Assessment, and which most recently led to it being chosen as the only “Single Pot” Local Area Agreement. The PCT, because of its common boundaries, has been instrumental, along with the Council and the Police, in establishing what is now locally as “Team Telford”. Undoubtedly, the fact that we are now planning and delivering services on a common geography is a critical factor in the improvements we are now beginning to make to the quality of life of local people.

10. PCTs which are closely related to their corresponding local authorities and have co-terminous boundaries deliver better overall outcomes for local people, particularly the poorest and the sickest who have complex health and social care needs that require a multi-agency approach. With the emerging market-based funding for PCTs, they have to work more collaboratively within the catchment, including (within the Borough of Telford and Wrekin) making better use of the LAA single pot arrangements. Whilst the PCT is accountable to the DoH, it is providing a “new model” public service function. An example is the POP project—Participating with Older People. Telford & Wrekin PCT is becoming patient-led, based on five clusters of schools and communities, which matched the LAA zones.

**RATIONALE BEHIND THE CHANGES**

11. We believe that the new roles for Primary Care Trusts (PCTs) require the local health economy to become everyone’s business, with other local strategic partners interacting fully. The benefits of having a common geography between the PCT, local authorities and local Police Division transcend the health, social care and education agendas. Working within a common boundary has enabled PCTs, such as at Telford

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and Wrekin, to work pro-actively with other partners to engage them in addressing what is now seen locally as a commonly held health improvement and health inequalities agenda. By seeking to address the wider determinants of health through the various partner agendas, and collectively through LSPs itself, the PCT has successfully ensured that “health” is truly “everyone’s business”. This we feel would be lost, or at least severely diminished, if this focus on the local health economy was compromised by any reconfiguration of local PCT boundaries.

12. Telford and Wrekin Council believes that compatible authorities can share common strategies, and plan and deliver excellence in health improvement and tackling health inequalities. To provide an example, the development of Telford and Wrekin Council’s Local Public Service Agreement (LPSA) Round 1 involved only two partner agencies—the PCT and the Fire & Rescue Service—in a lead role, with the PCT leading on two “stretched” targets, focused on infant mortality and teenage conceptions, out of our “basket” of 13. This has lead to the development of the innovative community parenting scheme, which we have now agreed to continue funding by reinvesting performance reward grant. Again, in the development of our Round 2 LPSA, the PCT are leading on two priorities around lifestyle change which seek to improve life expectancy in both children and adults, and are jointly leading on challenging targets to prevent teenagers becoming looked after and to improve the educational and health outcomes for children already in the looked after system. This degree of involvement in LPSA2 undoubtedly derives from the PCT’s single-minded focus on, and knowledge of, health needs within Telford & Wrekin, and the confidence in their working relationships with other partner agencies upon which they will depend if they are to meet these challenging “stretched” targets.

13. Early examples of working with Local Area Agreements underline the opportunities that arise when working to a common geography. The strength of local partnership working, the trust, relationships and consensus around key priorities, and our ability to deliver against challenging timeframes, were, we believe, instrumental in Government awarding us pilot status as the only “Single Pot” Local Area Agreement (LAA). Whilst there are no specific health non-mainstream funding streams identified within the LAA, the PCT were able to feel confident in aligning their mainstream budgets to achieve the key priorities identified within the LAA. We see the LAA pilot as still evolving, with potential opportunities to bring other funding streams into the single pot and possibly move towards more integrated budgets through a form of Local Public Service Board. This opportunity would be diminished if the key agencies were not working to the same geography.

**Likely Costs and Cost Savings**

14. At a time when the Government is pursuing cross-cutting agendas and greater reliance on local partnerships, it makes sense to ensure that there is full transparency as to where funds are being spent and allocated. That can best be achieved by ensuring that PCTs and local authorities match up in terms of boundaries as closely as possible.

15. A standardised nominal working size for PCTs does not match most delivery catchments. Just as there is no standardised size for local authorities, so it should be with PCTs. There is little correlation between administrative efficiency and delivery of targets. Telford & Wrekin PCT is achieving innovation in small practice groups, and has secured integrity of delivery whilst driving down management costs. The PCT is one of only two (out of 10) which are solvent within the Strategic Health Authority area, and all high level targets except one have been delivered.

16. An example of the level of co-operation between the Council and PCT in Telford and the efficiencies which can be gained includes town centre redevelopment proposals to co-locate the Council and PCT in new civic offices enabling the sharing of back-office costs. This would not happen with a Shropshire wide PCT.

17. This area has already achieved efficiencies as there are only two PCTs within Shropshire (as opposed to six Primary Care Groups originally). We understand that in some areas many more PCTs serve a similar number of social services authorities. For example, Staffordshire has two social services authorities but eight PCTs.

18. The Telford & Wrekin PCT has had to operate in a highly cost effective way as it is severely under-funded which is only now being addressed under the Fair Shares mechanism. Despite this under-funding, it is one of only two PCTs (out of 10) within the Shropshire & Staffordshire Strategic Health Authority area that is not overspent.

19. For these reasons we consider that the requirement to deliver at least a 15 per cent reduction in management and administrative costs should be applied at the Strategic Health Authority level rather than to specific PCTs which is how this target is being interpreted in other parts of the Country.

*Telford and Wrekin Council*  
3 November 2005
Memorandum submitted by Thurrock Council (PCT 20)

CHANGES TO PRIMARY CARE TRUSTS

1. I am writing in my capacity as Managing Director of Thurrock Unitary Council to bring to the Committee’s attention a number of generic concerns which fellow Unitary Chief Executive’s share. These observations are based upon a survey I personally conducted amongst the 47 Unitary Authorities over the summer period.

2. Whilst Unitary Chief Executives have welcomed some of the rationale behind the changes, particularly regarding the closer congruence between health and social care and indeed children’s services) there is we believe a potential unintended consequence that will cause major difficulties and put in great jeopardy joint working between Unitary Councils and PCTs. There are a number of issues.

3. CO-TERMINOSITY

(a) Examining the recent submission by the SHA’s Chief Executives it is quite clear that the vast majority of the 47 Unitary Councils stand to lose their current boundary alignment which they currently enjoy. The issue seems to be particularly severe in those Councils which were created in the mid to late 1990s out of the two tier County Council/District areas. From what I can gather from colleagues, the consistent theme emerging is for SHAs to be proposing larger PCTs which erode current Unitary co-terminosity with the result that the newly formed PCTs will cover both the existing Unitary Council and significantly include a geographical part of a County Council. This would be a retrograde step as it ignores the functions and responsibilities of the upper tier Unitary Councils and will marginalize their influence.

(b) Although Unitaries are smaller in size than County Councils as all-purpose Councils I would contend that they indeed have more functions.

(c) Whilst it is acknowledged that the present configuration of Councils is less than ideal it is the contention of Unitary Chief Executives that where present co-terminosity exists between PCTs and the 47 Unitary Authorities that these should as a minimum be retained. This would be consistent with the principle set out in Sir Nigel Crisp’s letter 28th July letter under Stage 1, para 4a “As a general principle we will be looking to reconfigured PCTs to have a clear relationship with local authority social services boundaries”). In support of above I would make the following observations:

4. COLLABORATIVE WORKING AND INTEGRATED COMMISSIONING

(a) Dismantling a coterminal PCT and Unitary Council is likely to have fundamental consequences with regard to collaborative working and integrated commissioning. Led through the ODPM, both the introduction country-wide of Local Strategic Partnerships and more recently the accelerated focus on Local Area Agreements (to be implemented across England from 2007) are indicative of the wide-spread move towards geographical area based public sector working and community planning. In many areas under a Council’s Local Strategic Partnership, the local PCT plays a vital role, not only in leading on the Healthier Communities agenda, but also as active senior partners (“responsible authority”) in local Crime & Safety initiatives, the sustainable communities agenda and over the past year or so, in the work towards developing Children’s Trusts. There is also a strong commitment to joint local leadership in implementing Local Area Agreements.

(b) The Department of Health have recently embarked upon a consultation, entitled “Your Health, Your Care, Your Say” as a precursor to an integrated Community Health and Social Care White Paper which I believe is due in December. We are genuinely very optimistic in relation to the impact that such a policy initiative will have and believe that it will further enhance the opportunities for Councils to more imaginatively exercise their well-being powers. Losing alignment could seriously weaken the practical impact of the proposed policy.

(c) Since 1998 following the formation of Primary Care Groups there has been over recent years gradual moves towards greater co-terminosity between Primary Care bodies and Social Services Authorities. There is a real danger that if PCTs spanning a Unitary Council and part of a County Council are established then we could see collaboration amongst groups of GPs which will cross social care boundaries. This will complicate joint commissioning arrangements with upper tier Councils.

(d) We fully accept the financial realities within the NHS, and indeed across the public sector more generally and the requirement to find substantial savings. Retaining current co-terminosity does not mean preserving the status quo but does retain the integration that has taken place at a local level to modernize the health and social care system. In many areas joint posts between the Unitaries and PCTs have ensured an effective and co-ordinated approach to commissioning and service provision.
5. **Reconfiguration Supporting Co-terminosity for Unitary Councils**

(a) Whilst there would indeed be differential sizes (in terms of population covered) in terms of the new PCTs, as now there could be an agreed split of functions between NHS bodies with groups of PCTs agreeing lead arrangements but still maintaining co-terminosity with Social Service Authorities. This co-terminosity will further enhance the possibility of new governance arrangements being put in place and new roles and responsibilities being defined. More imaginative arrangements than those being put forward by SHAs should be actively encouraged resulting in new commissioning bodies between the NHS and Local Government. This would build upon the current joint sharing of posts between the two sectors and the practical benefits this level of integration has brought to many contentious and difficult issues.

(b) With regard to the reconfiguration of SHAs can I stress that it will be important that each SHA take a consistent approach in proposals relating to Unitary Councils. It is illogical to have a different treatment of Unitaries who subsequently end up post-merger under the same SHA. For example, in the East of England we have four Unitary Councils—Peterborough, Luton, Southend and Thurrock. If the existing SHAs merge into one, it would be sensible to pursue a common approach.

6. Focusing particularly on Thurrock all Elected Members have unanimously passed a resolution seeking to retain the local PCT on the present Thurrock boundaries. We are at the heart of the Government’s major regeneration area—the Thames Gateway—and now have our own Government appointed Development Corporation which will oversee the introduction of c26,000 new jobs and 18,500 new dwellings over the next decade or so. Given the major regeneration changes planned alongside the significant health inequalities across the borough we believe it is essential that effective joint working is not dismantled by the NHS adopting a short term and hurried approach to structural change.

David White, Managing Director
Thurrock Council
3 November 2005

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Memorandum submitted by Wychavon District Council (PCT 38)

**Introduction**

Wychavon is in South Worcestershire and local health services are currently provided by South Worcestershire Primary Care Trust. The Council was recently consulted by West Midlands South Strategic Health Authority on initial proposals for “Commissioning a Patient—Led NHS”.

Wychavon’s Managing Director framed our response, having consulted the full Council and the Health Scrutiny Team. The Team involved representatives of neighbouring authorities, the Local Patient and Public Involvement Forum and community organisations involved with health—such as the Friends of Hospitals—in discussions. We have attached a copy of the letter, which summarises Wychavon’s concerns about the current process. (Annex 1.)

For ease of reference, we have drawn these out against the Terms of Reference of the Health Committee for this exercise:

1. **Rationale behind the changes**—whether the proposals locally are really geared to improving health services for patients or towards saving money. Our impression was that the main driver locally appeared to be saving £7 million in the West Midlands health economy.

We also expressed concern at the criteria of co-terminosity of PCT boundaries with Social Services authorities, in our case, Worcestershire County Council. We referred to our experience of existing organisational arrangements and partnerships that work well across parts of the County Council areas. Examples include the Local Strategic Partnership and Community Safety. We work with the PCT and County Council in the provision for Disabled Facilities Grants, and the Housing Improvement Agencies are split on a North/South basis in Worcestershire.

We are concerned that the use of pooled budgets to provide services risks funding from health partners reducing and the Council Tax payer has to fund the deficit.

2. **Likely impact on commissioning of services**—our response to the Strategic Health authority refers to a local example of where commissioning services has not been successful—the Independent Sector Treatment Centre at Kidderminster. Our local PCT has signed up to use a set number of treatments per month but has so far not met that number. The PCT thus bears the risk on the contract. Our suggestion to the Strategic Health Authority is that it would now be timely to re-examine the contract so that the risk is not with the public sector.
3. Likely impact on provision of local services—we are concerned that any proposals should involve a clear statement on the options for the management of community hospitals. From the options we were consulted on, it was not clear how far the PCT’s would remain involved with the provision of these valuable local services—if at all.

4. Likely impact on other PCT functions—we did not address this specifically.

5. Consultation about proposed changes—we were extremely concerned at the timing of the launch of the “Commissioning a Patient—Led NHS” by Sir Nigel Crisp—at the start of the summer holidays. The timescale for responses to the Strategic Health Authority initial proposals was extremely tight. We were fortunate in having the will of fellow Councillors to engage in the discussions around this topic. Indeed, we were the only District to respond in time for our comments to be included in papers for the SHA Board Meeting. The County Council’s response was from an Officer and their Members were involved very late on. The impression all along was that the proposals were rushed and we await the public consultation—due at the end of this month—with interest.

The forthcoming proposals from the Department of Health need the widest possible publicity and to focus on informing and involving the public. Our impression has been that the proposals submitted by the Strategic Health Authority looks like a fait accompli.

6. Likely costs and cost savings—we refer to this aspect briefly in paragraph 1 above.

Councillors Mrs Judy Pearce and Malcolm Meikle
Wychavon District Council
9 November 2005

Annex 1

Letter from Wychavon District Council to West Midlands SHA

“COMMISSIONING A PATIENT-LED NHS”—STAKEHOLDER PRE-CONSULTATION COMMENTS

I am responding to the letter from David Nicholson dated 26 August 2005 seeking views on the Strategic Health Authority’s options and proposals for the future configuration of various health bodies. The proposals circulated with the letter have been considered not only by the full Council here at Wychavon, but also by a special meeting of the Council’s Health Scrutiny Team, which involved representatives of other interested bodies in South Worcestershire in its discussions.

OVERALL OBSERVATIONS

Nature of proposals—the general view emerging from our meetings is that the proposals are premature, piecemeal and lacking in full information. In our view the key objectives for this exercise should be quality health services, based locally. Instead, the main driver appears to be saving £7 million in the West Midlands health economy. Structural change should be to the benefit of the health service and its key stakeholders, ie the patient, but the options paper does not show how any structural change would benefit the patient.

Prematurity—bearing in mind the forthcoming White Paper on health and care services, there is no justification for this change (especially at PCT level) at this time.

Effect on morale—locally we are concerned at the effect the various proposals are having on the morale of staff in the health service. We have heard from health professionals that they need a period of stability to enable medium and long term planning. The uncertainty generated by changing organisation structures ultimately impacts on service delivery—those at the “sharp end” cannot give of their best in such circumstances.

Democratic Deficit—the proposals do not address how accountability for the delivery of health services will be arranged if organisations are merged. We are concerned that developing larger organisations will move accountability away from the local area.

In South Worcestershire, the local authorities have built up a productive working relationship with the local Primary Care Trust although, as with all partnership working, it might not always be a comfortable one! Responsibility for the Overview and Scrutiny of health rests with the County Council, but locally our Executive Board member for Health and the Health Scrutiny Team Leader and his Team provide an active “critical friend” role. We would like to see this aspect addressed in the Strategic Health Authority’s proposals to the Department for Health. It would be misguided to underestimate the importance of local accountability in health. As you will know, health is always at the top of our community’s concerns, and is a prime driver in the Community Strategy.
There has been far greater public interest and involvement at Primary Care Trust meetings precisely because they are physically closer to the public they serve. In South Worcestershire the PCT Board has rotated its meetings around the whole of its area, from Pershore to Tenbury Wells, and this is much appreciated. We are not convinced that an authority which covers a much larger geographical area will be able to achieve this level of involvement and interest.

Financial Deficits—we are aware that some Worcestershire PCT’s and the Worcester Acute Hospital Trust are grappling with inherited financial deficits. The proposals do not show how these deficits will be addressed in any successor authorities.

Strategic Health Authorities

The proposals here appear to be a fait accompli for the following reasons:

— The way in which the proposals are presented;

— Recent developments in WMSSHA where the Chief Executive is shared between three Authorities.

Our concern at the proposal to create one SHA for the West Midlands area is that the rural communities will lose out to the more urban areas. A significant part of the West Midlands Region is rural and it must be demonstrated how a single Strategic Health Authority would ameliorate the health economy at a strategic level for this proposal to gain support. That justification is lacking at present.

Ambulance Trusts

The proposals here appear to involve radically changing the service at the same time as changing the structure of the organisation. The role and function of those at the front line in the service would require significant “up-skilling” and training. We consider that the service changes should be implemented and their impact assessed, before structural change is considered. Otherwise we fear that there will be confusion and a risk that the delivery of the service itself will be adversely affected, with a loss of confidence in the service.

Another concern is that the rural parts of a West Midlands wide authority would potentially see a reduction in performance once merged with urban areas. However, it is difficult to comment further on the proposals without having more detail on service delivery.

Primary Care Trusts

We suggest that costs/savings should be shown for each option in this section of the consultation.

Our view is that, for completeness, an additional option should be included—that of no change. We say this because we understand that the current proposals are likely to be a precursor to further change. This is referred to in paragraph 2.4 which mentions the forthcoming White Paper on health and care services outside hospital. As practice based commissioning and likely aspiration for “locality based management” develops, it is likely the role of the Primary Care Trusts will diminish over time, and their future would be in doubt. If we are entirely wrong in this assumption then we would be grateful for clarification. We question whether the expense and disruption resulting from change now is sensible given there are likely to be further changes in the medium term.

The phrasing of Para 2.3 of your letter implies that the only key driver for change is coterminosity with Social Services. Is that really a justification for massive structural change? We challenge the weight applied to coterminosity as a measure for changed boundaries, as if Social Services is the only service that the PCT works with. We have experience of organisational arrangements and partnerships that work well across part of the County Council area. Examples are the Local Strategic Partnerships and South Worcestershire Crime and Disorder Reduction Partnership, where the existing PCT is an active partner. The District Councils work with both the County Council and the PCT in the provision of Disabled Facilities Grants, and the Housing Improvement Agencies are split on a North/South basis in Worcestershire.

Where coterminosity has been applied across the County, budgets are often pooled for the services involved. A potential issue with this approach is that funding from the health partner reduces and the local Council Tax payer has to fund the deficit.

If we have to have change, our view is that the option set out at para 2.3.1 is preferable for the South Worcestershire area.

Services Managed and Provided by Primary Care Trusts

We challenge the ominous statement at the end of the first paragraph that there will not be consultation on the provision of PCT managed services in 2005. As all levels of health authorities are included in this review, we suggest it would be an appropriate time to re-examine the decision to use the private sector to deliver health care. An example is the Independent Sector Treatment Centre at Kidderminster Hospital. Our
clear impression is that the PCT’s which use the Treatment Centre have effectively not had any control over the terms of the contract, and as a result bear the risk of the contract not being met. If this is an example of PCT’s commissioning health care, it has not been an impressive one.

A clear statement on the options for the management of community hospitals should be set out. This is critically important to all of our communities who rely on local community hospitals and need and deserve to have an open and constructive period of consultation.

I do hope that the next stage of your consultation will put the “patient” first ahead of a single aspiration for a minimum of £7 million savings. It should clearly demonstrate the positive and negative impacts of the proposed change on those who both use and provide the health services in the region.

Thank you for including Wychavon District Council in your consultation and we look forward to participating further as your options develop.

C J Hegarty
Managing Director
Wychavon District Council
14 September 2005

Memorandum submitted by the Association of Directors of Social Services (PCT 41)

INTRODUCTION

The Association of Directors of Social Services (ADSS) represents local government directors across England and Wales who hold any one of the statutory roles of Director of Social Services, Director of Adult Social Care and Director of Children’s Services. Directors of Children’s Services all hold accountability for the local authority’s education functions as well as its children’s social care functions whilst in many councils Directors of Social Services and Directors of Adult Social Care also hold responsibility for functions other than social care, such as housing and leisure.

The ADSS has discussed the proposed changes at a number of recent meetings and the views expressed are reflected in this response.

THE CHANGE PROCESS

ADSS has registered concern with the Department of Health on four counts:

— The haste with which such high impact changes are being discussed. The timescales are not conducive to the process of seeking stakeholder views.

— The initial exclusion of Directors and the local government community from a debate that fundamentally affects the delivery of social care, particularly as there is legislation in place that enables Councils to deliver health services and the NHS to deliver social care.

— The timing of this debate—it is taking place ahead of the proposed White Paper and ahead of any meaningful discussions with stakeholders about how practice based commissioning might operate.

— The possible impact of these changes on another critical programme of change (improving the lives of children under the Every Child Matters agenda, which includes implementing a new national health service framework for children.) This programme has only a fragile foothold within the NHS at present and there are fears of further distraction.

THE QUESTION OF BETTER LIVES

ADSS is focused on the question of whether users of the health service and communities in general will be better off as a result of these changes.

Practical examples

These are just two examples of our experience of working towards people being better off:

— Putting in place halfway houses between hospital and home to ensure that older people recover their independence more quickly than they would if they remained in the hospital ward environment and can return to live in their own homes.

— Running healthy school programmes where health staff and school improvement specialists work together to raise pupil awareness of healthy lifestyles.
PARTNERSHIP AND ALIGNMENT

These practical examples arise from partnership work. Partnership work only happens when people in different agencies are able to get together, identify how they want to make things better and trust each other to work together to find solutions. Some degree of alignment between the partner agencies is necessary to do this and it is necessary at a number of different levels:

- strategic, whole population;
- specialist eg a clinical specialism such as cancer treatment or a population group specialism such as children; and
- local community/neighbourhood.

The ease with which people can get together, build trust and take action is a defining aspect of partnership work and ADSS argues that focused partnership work is the key next step for an improving NHS. There is a very strong argument that the NHS cannot deliver either better treatment or better health on its own and that the time has come for the NHS to raise the profile of its commissioning partnership with other public agencies, particularly local government. The notion of “powerful commissioning” should be associated with partnership as much as with clout. This makes the issue of alignment with local government and of making it easier for agencies to work together a pre-eminent one.

CURRENT THREATS TO BETTER LIVES

It is arguable that one of the major threats to the future health of our nation has crept up on the sidelines whilst the NHS battled with response times. Public health analysts are warning that the generation of children growing up now could be the first in several centuries to see their life expectancy reduce. The main cause of this is obesity and tackling this will require activity beyond the boundaries of the NHS, whatever its organisational form.

In this scenario it is vital that practice based commissioning and the arrangements for PCTs are aligned with the ways in which key partners, particularly local government, are mapping themselves onto local communities and ensuring responsive delivery to users. The question of who talks to whom about which community of need and how easy it is for this conversation to take place is not a marginal one. It goes to the heart of how things get delivered at local level.

THE CURRENT ARRANGEMENTS AND DESIRED CHANGES

The current situation is that for some Directors the degree of alignment in their local context makes it easy to have this conversation whereas in others it does not. ADSS wants a high degree of alignment to be available in all local authority areas and this clearly means that the NHS needs to promote a flexible template for its commissioning structure and allow for PCTs of varying sizes.

There is strong support amongst Directors for smaller numbers of PCTs in counties but with robust arrangements for specialist and locality based commissioning and for retaining co-terminosity in unitary and metropolitan areas but with robust arrangements for partnering between smaller PCTs on commissioning functions that are more effectively performed across larger populations.

These are not issues that can be determined through a national template of structures. They are matters for assessment at local level and it is regrettable that the time for such local deliberation has been so limited and that the debate has become uncoupled from the more important debate about achieving better lives for people.

DEVELOPING OUT OF HOSPITAL SERVICES

The desire for the NHS to create a strong community based service that is complemented by, and not driven by, the acute hospital services is a shared one that Directors support. However, it is not the only issue that impacts on meeting needs and improving health and well being. A solution needs to be sought at local level that harnesses both partnership and commissioning strength. It is our argument that creating the conditions for effective partnership is in itself a means of delivering powerful commissioning within the NHS.

THE WAY FORWARD

There is a way of organising local partnerships to deliver better lives for people that is being developed at present. This is the Local Area Agreements. These are agreements between all the publicly funded local agencies (and their partners, who should include users and citizens) and central government about how the lives of people are to be improved—the priority outcomes to be achieved, the performance measures to be used and the delivery programmes to be deployed (based on what works).
These agreements are being heavily promoted by the Office of the Deputy Prime Minister and it is a source of concern to Directors that the potential of these agreements to deliver on the health and well being agenda is not visible in the current discussions.

ADSS would like to see the NHS organising itself locally in the best possible way to support the work within the Local Area Agreement. This enables the NHS to couple itself with national and local ambitions to improve outcomes, including health outcomes.

*Association of Directors of Social Services*

*9 November 2005*

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**Memorandum submitted by the British Dental Association (PCT 27)**

1. The British Dental Association (BDA) is the trade union and professional association for dentists practicing in the UK, representing 20,000 members working in all aspects of dentistry, including general practice, salaried services, the armed forces, hospitals, academia and research.

2. For the purpose of this inquiry the BDA is responding on behalf of the Salaried Primary Dental Care Service (SPDCS), which includes the community dental service (CDS) and the salaried personal dental service. Both of these services would be directly affected by the changes proposed in the *Commissioning a Patient-led NHS*, as most services fall within the range of services provided by PCTs. The interface between the SPDCS and other primary care services provided by PCTs is also crucial, for example, health visitors, and community nurses.

3. The SPDCS treats patients in vulnerable groups for example people with disabilities, those with complex medical histories, people with challenging behaviour or the homeless as well as undertaking school and other screenings, outreach oral health promotion schemes and other dental public health activities.

**Likely Impact on Commissioning of Services**

4. The patients that the SPDCS cares for are people who require more clinical and non clinical time than those who can access high street dental services. As the dentists are salaried, they are able to allocate an appropriate amount of time to each patient, to meet their clinical and other needs. It is essential that when PCTs commission services, they are mindful of the needs of more vulnerable members of society, who may not always voice their anxieties or service preferences. It is imperative that these services are recognised and primary care commissioning is not just focused on the most popular services or services for the most vocal patients. The impact on a move to practice based commissioning for the provision of dental services has not been thought through in detail and it is clear that a debate on this is needed.

5. For PCTs to fulfil their responsibilities to commission appropriate local dental services they need specialist advice both on determining oral health needs and how local commissioning can appropriately meet these needs. Since April 2001 there has been unprecedented change in the organisations and structure of health services and public health functions including dental public health. This four-fold increase in the number of organisations with responsibilities in this area has had the effect of spreading the Dental Public Health workforce across more organisations.

6. This shortage has been identified in the *Dental Public Health Workforce in England* status report (January 2005). The preliminary findings show that the number of Consultants in Dental Public Health (CsDPH) working in England has remained relatively stable over the last five years. However, there has been an increase in part-time working which has resulted in an overall reduction of the dental public health workforce. Furthermore, almost half of the current CsDPH in England will retire in the next 10 years. The changes to PCTs as part of the *Commissioning a Patient-led NHS* will do nothing to alleviate this situation.

**Likely Impact on Provision of Local Services**

7. There is currently a Department of Health Review into SPDCS in England and we are awaiting the outcome. At the same time the further reorganisation of the NHS healthcare system has created even more concern and anxiety within those dental teams employed by PCTs. This has a knock on effect on clinicians’ morale and recruitment and retention in the SPDCS, already very difficult, is becoming impossible. The BDA is concerned that this bureaucratic change will create uncertainty within patient groups, some of whom are the most vulnerable in society, about how they are going to be treated and the services they are going to receive.

8. The reform to the General Dental Service contract is also raising extreme concern among the SPDCS. SPDCS teams are very worried that they may have to deal with the overflow of more mainstream dental patients because high street GDS dentists may withdraw from provision of NHS dental services. This would dramatically compromise the service provided to the most vulnerable groups in society, further exacerbating dental inequalities.
9. All this is raising concerns about future employment security in the SPDCS. Dentists working in the SPDCS are concerned that yet another upheaval is going to put their specialist role at risk and puts their future service provision to their special needs patients within a newly restructured PCT in jeopardy.

10. The Department of Health has yet to publish the review of SPDCS from March 2005 and the BDA will be interested to see if the proposed change to PCTs is going to complement or conflict with the findings of the review.

11. However, the BDA is encouraged by the general proposal to reconfigure PCT boundaries in line with local authority borders. This would ensure a more joined-up and holistic approach to local dental public health and oral health promotion activities between consultants in dental public health, local authority health scrutiny committees and social services departments.

**Consultation about Proposed Changes**

12. The BDA welcomes the long timetable for the implementation of changes to PCT service provision by December 2008 (as outlined in Sir Nigel Crisp’s circular on 28 July 2005), and the decision to implement a three-month consultation to include local stakeholders and staff views over the reconfiguration of PCT boundaries. However, we recognise that the forthcoming White Paper “Your Health, Your Care, Your Say” will set out the policy framework for developing primary and community services and it is therefore essential that decisions on new structures are not made in advance of this.

*British Dental Association*

2 November 2005

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**Memorandum submitted by the British Geriatrics Society (PCT 6)**

**The British Geriatrics Society**

The British Geriatrics Society (BGS) is the only professional association, in the United Kingdom, for doctors practising geriatric medicine. The 2,200 members worldwide are consultants in geriatric medicine, the psychiatry of old age, public health medicine, general practitioners, and scientists engaged in the research of age-related disease. The Society offers specialist medical expertise in the whole range of health care needs of older people, from acute hospital care to high quality long-term care in the community.

**Geriatric Medicine**

Geriatric Medicine (Geriatrics) is that branch of general medicine concerned with the clinical, preventive, remedial and social aspects of illness of older people. Their high morbidity rates, different patterns of disease presentation, slower response to treatment and requirements for social support, call for special medical skills. The purpose is to restore an ill and disabled person to a level of maximum ability and, wherever possible, return the person to an independent life at home.

The Society welcomes the opportunity to contribute to this debate and would comment as follows:

1. **Rationale behind the changes**

   1.1 We welcome the enlargement of PCT borders which makes it potentially easier across much of the country to co-ordinate the planning of services between a Hospitals Trust and one large area which that Trust serves. This will often create co-terminosity with Local Authority boundaries which again could assist integrated working.

2. **Likely impact on commissioning of services**

   2.1 We feel that the combination of commissioning and providing has increasingly created perverse incentives as Payment By Results has developed, which has not necessarily been in the best interests of patients or in efficient use of resources. One large commissioner for a city or county, with a number of provider organisations, should be an improvement, although sounds very much like a reversion to Health Authorities. However, this should open up ways of commissioning an integrated service.
3. Likely impact on provision of local services

3.1 The proposals have left much ambiguity about the commissioning and delivery of local services. One large commissioner will obviously be more distant from localities: will practice-based commissioning replace this? And yet most services, including most secondary care services, do need to be commissioned at a “higher level”. The PCT’s were just beginning to develop effective planning and development of services within their locality, and this may be lost.

4. Likely impact on other PCT functions, including public health

4.1 Public health services were weakened and fragmented by the current PCT structure, and so should be strengthened again by coming together at county level.

5. Consultation about proposed changes

5.1 There has been little appreciation of the likely changes, and this is leaving many staff groups most uncertain about the future. One major concern within elderly care is around who will be providers of Community Hospitals and Intermediate Care. More widespread discussion might have developed solutions to such problems which are now causing anxiety.

Dr Jeremy R Playfer
President, British Geriatrics Society
31 October 2005

Memorandum submitted by the British Heart Foundation (PCT 29)

1. The British Heart Foundation (BHF) is the largest independent funder of heart research and cardiac care in England. We play an important role in funding specialist heart nurses to support people living in the community with coronary heart disease. Our role is to pump prime these positions by contracting with local trusts for a period of three years. We currently have over 100 contracts with Trusts in England who employ over 200 specialist heart nurses.

2. There are two million people living in England with heart disease. As the nation’s leading heart charity our main concern about Commissioning a Patient-Led NHS is about the potential impact of these primary care reforms on patient care.

3. These proposals could lead to the most fundamental changes to the NHS since its foundation. Ninety per cent of patient contacts are in primary care and the reorganisation will have a significant influence over the effective management of long term conditions including heart disease.

4. Given the scale and timeframe for these changes we are concerned that the DH has failed to foster a vision of future service delivery that is shared by central government, PCTs, the voluntary sector and patients themselves. Without a shared vision these changes will lead to a fragmentation of patient care. We understand the current inquiry will focus on the mechanics of the consultation process and we encourage the Committee to consider a more in-depth inquiry that will consider the impact of these proposed changes on patient care, particularly those with long term chronic conditions.

5. The BHF is working hard to gather information on what the proposed changes may mean for how we can best support patients. We would be happy to share this information with the Select Committee should a more in-depth inquiry be held.

6. The changes proposed in Commissioning a Patient-Led NHS have significant implications for how the BHF delivers quality care for heart patients. The document suggests that there will be a progressive move towards greater use of other providers, including those from the voluntary sector. Clearly this will mean the BHF will need to seek new partners/models to provide specialist heart nurse services. There may also be opportunities for the BHF to become a national provider of other elements of cardiac service provision.

7. These opportunities are not without risks. The Foundation is concerned that these moves are being pursued without proper consideration of the implications on the voluntary sector.

8. The announcement appears to assume that the voluntary sector is eagerly waiting in the wings to pick up PCT functions and directly provide services. This is simply not true. A decision to directly provide services is not one that the BHF would take lightly. It would take a massive investment for the Foundation to position itself to directly employ staff. In addition we would need to carefully examine the impact of additional government contracts on our independence. The BHF values our reputation as an independent voice on coronary heart disease and would not want service contracts to jeopardise this.
9. The Foundation is also concerned about the influence that the private sector may have on the provision of quality services for people living with heart disease. Private companies may cherry pick the most profitable areas of cardiac care and as the nation’s heart charity we could be expected to pick up the rest and potentially less profitable services.

10. The BHF has long advocated for better cardiac services for people living with heart disease. Cardiac rehabilitation has traditionally been the poor cousin to other parts of the National Service Framework for CHD. It is not clear from these announcements on whether the NSFs will gain in importance or lose influence as decisions are devolved closer to the local level.

11. Commissioning a Patient-Led NHS has a strong emphasis on patient involvement. There are resource implications to ensure that patients are recruited, trained and supported to fulfil their role in local commissioning. The BHF believes we can play an important role in encouraging people living with heart disease to engage in local commissioning.

12. The Secretary of State for Health has recently announced that PCTs can continue to directly employ staff for as long as they wish. This can be interpreted as contradicting the earlier Commissioning a Patient Led NHS announcement. Whether or not it is a contradiction or simply a clarification, it contributes to the air of uncertainty that makes it difficult for voluntary organisations to plan for the future.

13. To reiterate, the BHF’s chief interest is to ensure that people living with heart disease are receiving the best quality of integrated care possible. Regardless of any changes we will continue to play a key role in funding specialist heart nursing services as we believe they are the key to providing heart patients with high quality integrated care. We welcome the acknowledgement that the voluntary sector has a key role to play in creating a patient-led NHS but we are concerned that the lack of collective vision will undermine and fragment patient care.

Peter Hollins  
British Heart Foundation  
7 November 2005

Memorandum submitted by the British Medical Association (PCT 17)

Health Committee inquiry into Changes to Primary Care Trusts

The BMA is pleased to submit written evidence to the above inquiry and would be happy to provide additional information for the Committee’s deliberations should this be appropriate.

We welcome the Committee’s focus on this issue because there has been too little discussion around the far reaching changes set out in Sir Nigel Crisp’s letter of 28 July 2005. Subsequent clarifications, such as John Bacon’s letter and announcements from the Secretary of State have only added to a general feeling of confusion.

While we would agree that some reconfiguration is necessary, doctors and others are increasingly frustrated by the process of implementation, which is neither clear nor engaging. The whole process has added to an already uncertain climate about the direction of health policy.

The BMA’s comments on the proposed changes are provided below, under headings that were suggested for the inquiry. We have added one more—“thinking across the spectrum of healthcare”—because, given the huge change agenda that has been set in place, it is necessary to think about change across health and not only in primary and secondary care. This is particularly important in relation to developing care pathways for patients and strengthening commissioning.

The Rationale behind the Changes

The direction of change and the rationale for changes are not clear. There is no overarching explanation from the Department of Health of how the wide-range of changes proposed—of which Commissioning a patient-led NHS is part—will improve healthcare for patients.

There seem to be two major drivers behind the changes proposed to PCT structures. The first is to help achieve the target of a 15% reduction in management costs. The second, as the NHS ceases to be the sole provider of health care, is to create a framework in which PCTs can act as “market managers”. By moving to divest the provider role, the theory is that PCTs will become more effective commissioners.
The Likely Impact on Commissioning of Services

One way in which PCTs can improve commissioning is by effectively working with local professionals to better engage them in the process. Among the suggestions in Nigel Crisp’s letter that we welcome is a commitment to better engagement with local clinicians. We would like clarification on how this will be achieved.

Practice-based commissioning is an important vehicle for the development of care pathways and the strengthening of teams of professionals to provide more community based care. One of the negative consequences of the uncertainty in the direction of current policy is that its development is not being taken forward in the way it should. The lack of clear guidance is that it is adversely affecting the day-to-day functioning of many PCTs and their ability to implement key areas of government policy. Until the likely reconfiguration of PCTs is set out clearly at a local level, it will not be possible for PCTs to determine what their role will be in practice-based commissioning.

In addition, there appears to be an assumption that local clinicians are solely general practitioners, but whilst GP engagement is absolutely critical, especially in taking forward practice-based commissioning, there are also consultants in a range of specialties working in the community as well as public health that need to be involved in the redesign of health services. Whilst many consultants are largely hospital-based, they are also “local clinicians” and have a valuable contribution to make to the debate, particular on the development of care pathways and the medium-term ambition of moving more specialist-led services into the community.

The Impact on the Provision of Services

The Nigel Crisp letter indicated that PCTs should only act as a provider as a last resort. A subsequent letter of clarification from John Bacon said plans to do this should be developed over a longer time-frame. Despite this supplementary letter, we are concerned that some PCTs are still making detailed plans to divest themselves of their provider functions with no clear thinking about who will take over these roles.

We are concerned that even though there has been some back-tracking on the plans to divest PCTs of provider functions, the 28 July letter still represents a policy ambition. This will see the eventual transfer of more than a quarter-of-a-million staff (mostly nurses, but also doctors and other professionals) move to new providers—such as GP practices, private providers, secondary care providers, or perhaps new consortiums. This level of uncertainty is not conducive to successful implementation of such a large change agenda. In addition, the managers that are being asked to take change forward inevitably worry about their own roles and whether they will still exist following reconfiguration.

The BMA has advised doctors to discuss with local SHAs and PCTs any issues that they would wish to see addressed as a result of possible PCT reconfiguration and also, in future, to seek information on how the PCT provider role is likely to change. But this can only be done if PCTs and SHAs show a greater willingness to work in partnership. We believe that PCTs should not be rushing to change their commissioning structure or shed their provider status without consultation or before they can demonstrate that there will be no detriment to the delivery of services and patient care.

Over the last several years there have been several changes that have seen community staff move to new employers. In addition to the financial costs (which have never been quantified) the critical relationships between teams of professionals which have taken time to strengthen and make effective are at once undone and have to be recreated within new structures.

The Impact on PCT Functions, Including Public Health

In paragraph 10 of Nigel Crisp’s letter it is indicated that “the Department will test proposals” submitted by PCTs regarding organisational reconfiguration. We would like clarity on the bases by which these proposals will be tested and whether professional associations, like the BMA and patient representatives will be given the opportunity to influence this “testing” process.

The BMA would like to see doctors represented on the panel that will assess proposals.

A key concern for the BMA, in the changes proposed, is that public health is not at the forefront of local managers’ minds in responding to central demands for reconfiguration. There is a danger that this focus is being lost in the wider programme of “system reform”. The current review of NHS structures presents a valuable opportunity for improving arrangements for Public Health, in particular that commissioning teams should include Public Health trained clinicians, and that local Public Health departments should be coterminous with Local Authority boundaries whenever possible. Public health is critically important to the development of multi-disciplinary care pathways, to the success of disease-management initiatives and in providing a strategic focus to commissioning.

The BMA supports the appointment of a Director of Public Health (DPH) to the population of a management unit of a local authority. Also that where a PCT covers a group of unitary authorities then we feel that a separate DPH should be appointed for each of the authority areas and conversely where a large local authority is divided into several PCTs a DPH should be shared.
The BMA has sent a paper to all Strategic Health Authorities and the Department of Health, which sets out the contribution of public health and the role it should play in the future. This is attached as an appendix.

**Consultation About Proposed Changes**

The BMA has received a number of reports about PCTs rushing into the merger process with little or no consultation with local stakeholders including GPs, consultants and their representative bodies, and patients.

The Nigel Crisp letter was addressed to Strategic Health Authorities and professional groups were not invited to offer their views, likewise patient representatives. In response to unhappiness with the changes, the Secretary of State has belatedly said there will be local consultation on proposed changes from December. An important question is whether this will involve a fundamental review of what is needed locally and how policy strands can be used to support these needs or whether it will be a consultation designed to “sell” a pre-identified solution.

There are two fundamental reasons why the lack of consultation needs to be addressed. Firstly, change will not be successful without meaningfully engaging doctors and other professionals. The current change programme is wide-ranging and local professionals, managers and the public need to come together to make sense of how policy can be fitted together locally. These changes include new entrants to the provision of healthcare, choice of provider offered to patients, an ambition to overcome some of the divide between health and social care, a new payment system which will threaten provider stability, and changes in the commissioning structure.

Some liken the change strands to different pieces of a jigsaw, but these pieces can only be put together locally if groups are given the opportunity to construct a picture of what they want to create locally.

A second and important reason consultation is a critical issue is because current Government policy—particularly Payment by Results—unleashes competitive forces that mean service configurations are likely to change. This necessitates some kind of local forum in which these changes can be explained to local people and be influenced by them.

**The Likely Cost and Cost Savings**

As noted above, one of the main drivers for change is to use resources more effectively. There is an explicit ambition to cut management costs by 15%.

Nigel Crisp’s letter states that a focus in taking changes forward will be on “internal capacity and capability to discharge new functions, and particularly leadership ability”. We would agree that one of the needs of the NHS is more effective management and leadership in some areas and would hope that it will be made a priority to involve clinicians in meaningful management and leadership roles. However, we are concerned that this focus on leadership (and the Government’s stated aim of enhancing clinical leadership) may be diluted if the reconfiguration process is required to “deliver at least 15% reduction in management and administrative costs”, as it states in paragraph 3. Whilst administration may be reduced, higher calibre management may require further investment.

Resources could be used more effectively, but it is important that a strategic view is adopted. Cutting back costs now without looking ahead to what is needed could end up being more costly in the future.

As noted above, one key ambition that should not be forgotten in the huge change agenda that has been set in motion is the aim to improve the management of long-term conditions, which necessitates better care of people in the community. It will mean the movement of some specialist services from hospital settings into the community. This will take time and resources.

A key vehicle is practice-based commissioning. Moving this function closer to patients with more clinical involvement has the potential to produce more innovative and patient-centred services, as well as creating pathways that enable more care in community settings. But while this will achieve savings over time, it will also require some investment in developing expertise among new commissioners. We are concerned that the requirement to reduce management costs may impede the development of such skills within PCTs.

**Thinking Across the Spectrum of Healthcare**

The BMA is positive about the potential for practice-based commissioning to draw together and strengthen care pathways. Public health has a key role to play in providing strategic support for changes. There is also potential for new ways of working across primary and secondary boundaries and a key role for consultants in contributing to service improvements.

The Government’s changes to the NHS have introduced a deliberate tension between secondary and primary care, in the hope, we assume, that this tension will be creative. However, we are concerned that cooperation within and between health sectors will be reduced and potential benefits to health and healthcare from closer co-operation could be lost.
For example, it is possible that while a hospital doctor might want to work with colleagues in community settings to design new care pathways they will be prevented from doing so by hospital managers who are understandably concerned about the loss of income to their institution that will result. In this submission we do not have the space to expand on solutions to this problem, but more thought needs to be given to the establishment of care pathways that cut across traditional settings. Achieving this requires important changes to the financial system (Payment by Results) to allow tariffs to be apportioned to different providers—a process known as “unbundling”.

It is critical that discussion of these changes does not only concentrate on primary care. The redesign of care pathways and the aim of moving more care into the community cannot be done discretely, but must involve discussions across the spectrum of health care and doctors in a variety of settings.

British Medical Association
2 November 2005

Memorandum submitted by the British Psychological Society (PCT 44)

The British Psychological Society is the learned and professional body for psychologists in the United Kingdom. It has a total membership of over 42,000 and is a registered charity. Under its Royal Charter, the key objective of the Society is “to promote the advancement and diffusion of the knowledge of psychology pure and applied and especially to promote the efficiency and usefulness of members by setting up a high standard of professional education and knowledge”. The Society maintains the Register of Chartered Psychologists and has a code of conduct and investigatory and disciplinary systems in place to consider complaints of professional misconduct relating to its members. The Society is an examining body granting certificates and diplomas in specialist areas of professional applied psychology.

We are pleased that the Health Select Committee has decided to undertake an inquiry into potential changes to primary care trust functions and numbers arising from “Commissioning a Patient-Led NHS”. Primary Care Trusts are responsible for commissioning and (at present) providing a large proportion of the Applied Psychology services in the NHS. We therefore follow your inquiry with interest.

In general terms, the Health Select Committee will know that change is ubiquitous in the NHS and especially noticeable at present. Nevertheless, as psychologists as well as workers in the NHS, we must point out that change is stressful, and stress can be harmful. Without labouring the point, the Health Select Committee should enquire as to how these proposed evolutions in the role of the PCTs can be implemented without unnecessary disruption to staff or services.

Applied psychology, including the provision of expert psychological therapies, is a growing profession. It is hugely desired and valued by service users, and there exist many quite large-scale plans to expand massively the provision of psychological services within the health service. It is not surprising, therefore, that central bodies within the NHS and Department of Health (such as NIMHE) are highly positive about their workforce projections and personal development plans for psychologists. At present in the UK psychology is a popular subject at undergraduate level and very large numbers of graduates wish to work in health and social care. The bottleneck between the high levels of demand for our services and the ready supply of willing and competent workers is at the professional, postgraduate, training level. Although we are aware that PCTs (in most cases) do not now and will not in the future directly commission training, we feel that the Health Select Committee should be aware of the demand for applied psychology provision from service users and some of the problems in delivering these services locally.

Moreover, the very positive National vision for applied psychology services seen from the Department of Health (Ministers, the National Clinical Director and CSIP/NIMHE) is unfortunately not always translated to local action by commissioners of services—many local psychology departments find their budgets and service development plans squeezed. We believe that the Health Select Committee should consider the extent to which National equity and National priority-setting can be equated with local autonomy. It is also possible that expectations to save £250 million nationally could impact on services which, although very highly valued, are often perceived as not being “front-line”. In addition, the prospect of various autonomous commissioning PCTs developing different strategies leads to the unwelcome prospect of “postcode provision”—that such highly valued services could be supported in some areas and not in others.

Psychologists work particularly with socially disadvantaged groups (older people, people with mental health problems, people with learning disabilities). Psychologists also tend to stress the value of preventative and rehabilitative services. Psychology, moreover, tends to suffer from the fact that if we do our jobs correctly, our interventions look common-sensical, but the level of expertise demonstrated by applied psychologists is very great (an average 13-year training for a Consultant Clinical Psychologist). We therefore believe that it is very important that the Health Select Committee attempts to ensure that any changes in the PCT commissioning or provision framework be paralleled with clear systems for ensuring adherence to National clinical guidelines (for instance NICE guidelines), and that proper emphasis is placed on preventative services and services for socially disadvantaged groups.
The concept of a “Patient-led NHS” is one that is very strongly supported by applied psychologists. Psychologists’ principle aim, in very many cases, is to help develop autonomy and self-efficacy in service-users. We, moreover, strongly support the emphasis on personal responsibility for decision-making as discussed in Halpern and Bates’ (2004) report for the Prime Minister’s Strategy Unit.

We therefore fully support patient-led services. It is, of course, not surprising that (when asked) patients in the NHS express an overwhelming preference for talking treatments in mental healthcare and the support and help offered by applied psychologists throughout the NHS. We welcome the Health Select Committee’s inquiry into the future of PCTs, because we wish to ensure that the PCTs will, in the future, echo patient choices by increasing the commission applied psychology services.

Dr C M Crawshaw
Chair, Professional Practice Board
9 November 2005

Memorandum submitted by the Centre for International Public Health Policy, University of Edinburgh
(PCT 43)

The creation of a marketised NHS is resulting in the loss of area and population planning for services and local needs assessments for services. In turn, this will lead to lower levels of efficiency, equity and quality within the NHS because of:

1. higher transaction and administration costs, leading to constraints on resources;
2. fragmentation of services and risk pools;
3. loss of mechanisms for fair distribution and monitoring of allocation of resources;
4. loss of central and local accountability; and
5. an increase in the likelihood of fraud and embezzlement.

In contrast, a maximally efficient, equitable and high quality NHS requires:

1. needs based planning and funding;
2. a resource allocation mechanism based on the needs of the population and not price or tariffs;
3. an integrated, not fragmented, approach to care;
4. salaried GPs and primary care health workers, working within the NHS, not as independent contractors to it;
5. buildings and services that are in public ownership and control; and
6. stronger systems of public accountability.

1. **DoH Guidance requires the Privatisation of Primary Care Provision in spite of Ministerial Assurances**

1.1. Recent Ministerial statements, designed to reduce the degree of controversy generated by the current market driven policies still require Primary Care Trusts to divest themselves of their primary care provider function.

1.2. On 28 July 2005, the Department of Health sent to Strategic Health Authorities a guidance note, Commissioning a Patient-Led NHS. It states: “the Department will not approve proposals for restructuring unless they satisfy the criteria set out in this document.” These criteria specify that: “arrangements should be made to secure services from a range of providers—rather than just through direct provision by the PCT.” These criteria were reiterated on 14 September in the Department’s Green Paper, Your Health, Your Care, Your Say, which was published for public consultation. It confirms DoH policy, that: “the resulting White Paper will be used to inform the process of divestment of services from PCTs in line with the wishes of patients and the wider public” [our emphasis].

1.3. In a statement to the House of Commons on 25 October 2005, the Secretary of State Patricia Hewitt appeared to contradict both the guidance and the Green Paper, saying that: “community staff employed by PCTs will continue to be employed by PCTs unless and until the PCT decides otherwise, following full public consultation.” However, the instruction to PCTs to divest themselves of their provider role has not been withdrawn by the DoH in spite of the Secretary of State’s assurances. PCTs are therefore still subject to existing DoH guidance, Commissioning a Patient-Led NHS which requires them to divest themselves of provision. Meanwhile, the Green Paper only gives PCTs an opportunity to offer views on how they would like divestments to proceed, not whether they should do so.
2. **BACKGROUND TO THE PRIVATISATION OF PRIMARY CARE Provision**

2.1. The government’s decision to change the role and responsibilities of PCTs from providers to commissioners of care must be seen within the context of the break up, fragmentation and marketisation of primary care and the NHS more generally including the establishment of foundation trusts and a regulator or Monitor.

2.2. The government argues that GPs have always been independent practitioners and that therefore the involvement of the private sector in primary care is not new. While this is true, it is misleading. GPs within the NHS cannot have private patients; they cannot charge patients; they have had a duty of care that has been carefully laid down in regulations and professional codes. The sale of good will has been proscribed until recently. Providers of primary care services have not operated in a market or had to compete for patients and money.

2.3. However, the new GP contract means that, from April 2004, contracts for the delivery of care are between PCTs and general practices, rather than between the Secretary of State and individual GPs. This contract ended the GP monopoly on care. As of April 2004, GPs’ duty to provide 24-hour comprehensive general medical service was dissolved. Instead, they will provide a “minimum package of healthcare” and can opt to provide care at one of three levels.

2.4. The first level is classed as “essential”, and must be provided by all practices. It includes services whose provision is initiated by patients who are, or believe themselves to be, ill and services for patients who require terminal care. GPs will be paid a global sum for providing these essential services, plus what are now termed “additional services”, including contraceptive services, maternity services and cervical screening (hitherto seen as key elements of general practice). GPs may, however, choose to opt out of providing such “additional services”, in which case a fixed sum is deducted from their global payment for each service not provided.

2.5. Providing “out of hours” service is also now an “additional service”. General practices have first refusal of providing it; thereafter, the PCT is responsible for finding another provider, making a deduction from the budget of the practice concerned. This money is then available to be competed for by other providers. GPs have no automatic right to opt back in.

2.6. A third level of care, not included in practice budgets, is classed as “enhanced” services: these include care for pregnant women during labour, and anticoagulation monitoring for certain people at risk of a stroke, and will be commissioned locally, according to a national tariff.

2.7. PCTs must ensure that all these optional services are provided in one way or another. Currently, they are free to employ salaried staff to provide the services themselves, if they can show that they can offer value for money. The changes outlined in Commissioning a Patient-Led NHS mean that PCTs will instead be expected, in almost all cases, to commission these services from other providers, including the for-profit sector.

2.8. The requirement to break up and subcontract primary care services to numerous for-profit providers brings an end to the much copied and admired model of British family medicine which predates the NHS. The level and type of primary care services available under the new system, and the methods of provision, will vary from place to place.

3. **RELATED MOVES AND FURTHER PRIVATISATION IN PRIMARY CARE**

3.1. The privatisation of primary care and community based services will in part be accomplished through LIFT, the equivalent of PFI in primary care. There are currently 42 LIFT projects, either completed or in procurement, but the programme has never been evaluated (see Memorandum to Public Accounts Committee attached). A further nine schemes are now in the process of being tendered. These schemes differ from their predecessors in that the PFI industry is now being asked to manage clinical service provision. A document from the DoH-owned agency Partnerships for Health, circulated to the private health care industry in February 2005, showed that LIFT companies are being encouraged to become clinical providers: “Health corporations are being encouraged to find new niche markets linking into LIFT, as subsidiaries of LIFT and members of LIFT’s supply chain.”

3.2. The clinical services that will be included in LIFT’s fourth wave and thereby opened up to the market, according to documents circulated to the industry, correspond to the services outlined in 2.4, 2.5 and 2.6 above.

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7 Not printed. The submission was made to the Public Accounts Committee Inquiry into NHS Local Improvement Finance Trusts, which is ongoing at present.

4. Conflict between the Treasury and DoH over the Role of the Market in Health Care Provision

4.1. The requirement on local NHS organisations to create markets for the provision of health care runs against stated government policy. In a document published in April 2003, Public Services: Meeting the Productivity Challenge, the Treasury outlined the economic arguments which justify a “publicly-funded, publicly-provided” NHS. This states that, from both an efficiency and equity point of view, markets are unsuitable for the provision of NHS care because of a number of failures, including: the absence of consumer sovereignty; the difficulty of writing and enforcing contracts to protect the public interest; and the existence of providers that cannot be allowed to fail.

4.2. “It is important to ensure that choice is not promoted at the expense of equity or efficiency, particularly where there are market failures and capacity constraints,” the documents states. The Treasury outlined in a precise and theoretically cogent way the advantages of an integrated NHS. Government health policy-makers have, apparently, abandoned this reasoned approach, but no rebuttal of its logic has been presented.

5. Some PCTs have Decided to “Strengthen” Commissioning Functions through Privatisation

5.1. Oxfordshire PCT has revealed that it is to contract out its commissioning budget— that is, the 70% of local NHS funds that are held by the PCT—to a private company. The DoH has backed Oxfordshire PCTs’ decision. The front-runner to take up the new role is the American Health Management Organisation United HealthCare.

5.2. United HealthCare has been forced to pay some $7 million in fines in the two years to 2004. The company paid $2.9 million in November 2002 to settle claims that it had charged the US government for care to patients who it falsely claimed were in nursing homes. In July 2002, the New York State Insurance Department fined United HealthCare $1.5 million for “ cheating patients out of money”; when patients were denied payments under their insurance programme, some were given wrong information by the company on how to appeal against this. Since March 2000 United HealthCare has also paid out almost $2 million in penalties in nine different US states for a variety of different offences, including passing work to a doctor whose medical licence had been revoked.

5.3. The nature of this company was made clearer when Vice-president Michael Mooney was jailed for three and a half years in August 2002 and fined $220,000 for insider trading. The firm also has a record of denying care to the vulnerable— or “cream skimming” as this feature of market-driven healthcare delivery is known. Similarly, a subsidiary of United Health Group, “Evercare”, is under contract to provide services to the NHS in the UK. Evercare has been publicly praised by President George Bush—but academic research shows that it operates by restricting care to the patients it thinks it can make money out of.9

5.4. United is targeting the NHS, and in particular the emerging primary care market in provision and commissioning functions. In May 2004, Tony Blair’s senior health policy adviser, Simon Stevens, (previously policy advisor to the former Secretaries of State for Health Frank Dobson and Alan Milburn) and Richard Smith, the then editor of the British Medical Journal, announced that they were leaving their jobs to join United HealthCare, now renamed the United Health Group, as the Group’s Europe President and CEO, respectively.

6. The American Model of Health Care that is Emerging

6.1. The new model which is emerging parallels the changes in acute hospitals where foundation trusts and a regulator distance government from public accountability and allow a market to operate. In addition to the privatisation of provision we are now seeing the privatisation of the commissioning function. This is to be done either by the direct privatisation of the commissioning budgets that PCTs hold or indirectly through practice based commissioning where, as with GP fundholding, practices will receive an indicative budget based on their practice lists. In this way the market will be operationalised.

6.2. These developments suggest that the government is now restructuring the NHS along the lines of the US Health Maintenance Organisation (HMO) system. The distinctive feature of an HMO is that risk is passed to providers through a remuneration and reimbursement system. The resulting financial incentives mean that providers manage risk by the careful selection of patients, treatments and services—restricting eligibility and entitlements to care through “cream skimming”. This is already happening in the intermediate care sector where time-limits are placed on entitlement to NHS continuing care at the health and social care interface.

6.3. These strategies create new mechanisms for user charges, top up fees and co-payments for those elements of care which are no longer deemed part of the NHS package. The assurances by the Secretary of State that NHS care will continue to be free will be difficult to monitor in practice. Commissioners and providers are likely to have increasing discretion to decide what benefits and packages of care NHS patients

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will be entitled to receive and what levels of remuneration staff will command. There is a risk that in the absence of systems to assure service planning and population needs assessment, and the monitoring of access and the distribution of resources, there will be growing inequities in access to care.

6.4. Already, under the current resource constraints, evidence is emerging of the ways in which PCTs are scaling back what patients are entitled to. The key question is how the new structures and incentives and the duties of providers and commissioners of care will be consistent with the principle of universal coverage.

6.5. Questions too arise over the efficiency of a privatised NHS. In this new, “marketised” NHS, evidence shows that transaction and administration costs will grow. The management reforms of the 1980s and the introduction of the internal market in the early 1990s saw the NHS’s administrative costs rise from 6% to 12%. With the creation of a full market, these costs are certain to rise again. Making and monitoring contracts, billing for every treatment (to achieve payment by results and related pricing mechanisms), and paying for accounting, auditing, legal services, advertising and shareholders’ profits, will swallow an increasingly large chunk of NHS money, adding to resource constraints.

6.6. Transparency and accountability for public funds will suffer as the public has no right of access to private institutions. The serious fraud office is now considering establishing a system, along the lines that the US Department of Justice established to monitor fraudulent billing practices such as those employed by United in response to the US equivalent of payment by results.

6.7. As the NHS approximates more and more to a full health market, its administrative costs are likely to move closer to those of established market-based systems. In the USA in 1991 administrative costs accounted for between 19.3% and 24.1% of total hospital costs. By 1994 these costs had increased to 22.9% in public sector hospitals, 24.5% in independent non-profit hospitals, and 34% in for-profit hospitals. We are currently unclear what payment mechanism will apply to the planned market in primary care services. However, there is no reason to assume that these extra costs will be avoided in primary care services and the effect on efficiency is likely to be similar.

7. Conclusions

The creation of a marketised NHS is resulting in the loss of area and population planning for services and local needs assessments for services. In turn, this will lead to lower levels of efficiency, equity and quality within the NHS because of:

1. higher transaction and administration costs, leading to constraints on resources;
2. fragmentation of services and risk pools;
3. loss of mechanisms for fair distribution and monitoring of allocation of resources;
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In contrast, a maximally efficient, equitable and high quality NHS requires:

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5. buildings and services that are in public ownership and control; and
6. stronger systems of public accountability.

Mark Hellowell
Centre for International Public Health Policy
University of Edinburgh
10 November 2005

10 Gainsbury, Public Finance, 4 November.
INTRODUCTION

1. The Chartered Society of Physiotherapy (CSP) is the professional, educational and trade union body for the 45,000 chartered physiotherapists, physiotherapy assistants and students in the UK.

2. The CSP welcomes the Health Select Committee inquiry into changes to primary care trusts (PCTs), particularly as it is currently the only public scrutiny to which the proposals have been subjected.

3. The CSP is concerned both about the content and the manner in which the proposals were launched. We consider that a Green Paper would have been the appropriate way in which to proceed with such wholesale change in terms of number and function of PCTs. Furthermore, we are disappointed that this process runs in parallel, rather than in partnership, with the consultation exercise leading to the forthcoming White Paper on care out of hospitals.

4. The CSP is very keen to see the evidence base which supports the proposals in terms of delivering more effective patient care. While it is clear that some PCTs are not operating and commissioning at the highest level, it is not clear that Commissioning a Patient-Led NHS will resolve their problems. Furthermore, it seems illogical to proceed with restructuring PCTs when it is not yet clear what their function will be.

PHYSIOTHERAPY IN PRIMARY CARE

5. About 52% of our NHS members (about 10,000 physiotherapists, as well as a significant number of physiotherapy assistants) work in settings outside of hospitals, in GP practices, in schools, leisure centres, in workplaces and in people's homes, either with other physiotherapists or as part of a team of health and social care workers.

6. Physiotherapists are increasingly moving out of the acute sector, and are employed in the primary care team. This is a trend that the CSP encourages as it involves physiotherapy earlier in the patient journey, thereby improving patient outcomes. It also supports multi-disciplinary working providing a seamless service.

7. Pivotal PCT posts that were traditionally filled by nurses are now being opened to AHPs, expanding opportunities for staff to move into clinical management and clinical leadership roles. This has resulted in physiotherapists and other AHPs being involved in service development at a strategic level. Patient services have improved as these clinicians are able to use their frontline experience to design both innovative and modernised services, understanding and putting together the needs of the users of these services and the health and social care standards and targets. We believe this critical clinical input must remain, inputting into the commissioning process along the lines of the current Professional Executive Committee (PEC) system, in order to maintain and further develop clinical and cost effective patient pathways.

8. Career openings for physiotherapists in community and primary care settings can be expected to expand further following the roll out of practice based commissioning and national agendas which emphasise patient choice, public health and better management of long-term conditions. The success of these initiatives will depend on employing more healthcare staff in the patients' local community, and developing their roles appropriately. We are, however, concerned that the impact of Commissioning a Patient-Led NHS will result in poor staff morale, retention and recruitment difficulties and limited opportunities for continuing professional development for physiotherapists and other AHPs working in the community. Patient services will be significantly affected as the cohesiveness of the current system is lost. The Secretary of State’s recent statement that PCTs will be able to decide on a case-by-case basis whether to continue providing services does little to allay staff's fears about the security of their jobs and the continuity of patient services. It also means that the principle of removing the provider function of PCTs will not be debated at a national level.

PROPOSALS FROM THE STRATEGIC HEALTH AUTHORITIES

9. The CSP has examined the commissioning submissions on proposals for the changes to primary health care services provision from the Strategic Health Authorities. While we recognise that this is the first step in a local consultation, we are very concerned that:

- Physiotherapy and other Allied Health Professions (AHPs), as providers of healthcare in the community, are not visible in the consultation processes of a large majority of submissions. All documents referred to GP engagement in the commissioning process, but only 5% stated explicitly that physiotherapy services should be consulted. Another 30% mentioned physiotherapy or AHP services, but did not make clear on what basis they would be considered.

- It is also apparent that the CSP is not being properly recognised as a trade union in the consultation process, with only two thirds of proposals including staffside and union involvement in the commissioning consultation process.
CSP position on Commissioning a Patient-Led NHS

10. The Chartered Society of Physiotherapy is deeply disappointed that Commissioning a Patient-Led NHS was launched without any kind of advance consultation, despite its profound implications for members and patients alike. We do not see the logic of producing such a strategy before the publication of the forthcoming White Paper on care outside hospitals. We also believe that after many years of almost continual change, what the NHS needs most is a period of stability and consolidation, so that current structures can bed down and produce the further improvements needed.

11. Of concern to the Society is the limited evidence base to support the contention that introducing contestability or competition improves the quality of public services. It also seems illogical to suggest that it is inappropriate for PCTs to continue to both commission and provide services, when GPs will be doing precisely this under practice based commissioning. We recognise the desire to strengthen the commissioning role of PCTs, but it is important to recognise too that some PCTs have already developed excellent models where there is a clear split between provider services and commissioners. These models can be built upon and extended to other areas as an alternative to hiving off all provider functions.

12. A further inherent contradiction in Commissioning a Patient-Led NHS lies in the possibility of community services being taken over by acute trusts and Foundation Hospitals. This is difficult to reconcile with existing policy to develop as much care as possible in integrated primary care settings and organisations.

13. Overall, while the Society is keen to develop opportunities for all members around the delivery of health care, we believe that the potential risks of dismantling current PCT services and outsourcing them to alternative providers outweigh any potential benefits. In our view, these potential risks include:
   
   — Destabilisation and fragmentation of services.
   
   — “Cherry picking” of the most profitable parts of services, leaving other services more vulnerable and potential gaps in services for some client groups.
   
   — An increase in health inequalities due to a lack of interest by alternative providers in areas of social deprivation where profit margins would be reduced or non existent.
   
   — Less opportunity for members to influence commissioning decisions, as the involvement developed in PCTs over recent years, including on PECs, is potentially devalued by the changes and lack of clarity of the policy.
   
   — An undermining of the real achievements of PCTs to date in developing services, driven by the process of modernisation and service improvement which the Government has supported and facilitated in recent years.
   
   — Diminishing of key partnerships and collaborations which have been created by PCTs and which have been proven to offer value to patient care and quality, especially focusing on working across patient pathways.
   
   — The potential for services to retract into acute provision, thereby hindering service development in health promotion, admission avoidance etc.
   
   — Increasing the difficulty for new graduates to find jobs and physiotherapy students (via higher education institutes) to find placements.
   
   — Undermining staff terms and conditions, job security and development opportunities, which will be difficult to maintain if staff end up being employed in much smaller professional groups, across a wide range of different service providers.
   
   — Poor staff morale, with the potential for this to impact on recruitment and retention within community areas, should these changes be driven through as they stand with little effective choice given to those directly affected.

14. Physiotherapy staff across the NHS, private and independent sectors have led and embraced innovation and modernisation, and have pioneered many new ways of delivering faster and more cost effective services. The Society is therefore opposed to change. However, we do not support the wholesale dismantling of existing services where these are already based on effective local partnerships, effective engagement of clinicians in commissioning, and are delivering the modernisation agenda.

15. We will be advising members, both in the NHS and independent sectors, to be extremely cautious about entering into alternative models of service provision without a full evaluation of the potential gains from these models compared to the existing provision.

16. In terms of PCT reconfiguration, while the Society recognises the potential economies of scale from rationalising the number of PCTs, we believe that the focus should be on encouraging co-terminosity with local authorities and integrated working. We also believe that there should be maximum transparency around the proposals being drawn up by PCTs and Strategic Health Authorities, and a timetable which allows meaningful consultation to take place.
CONCLUSION

17. The CSP is disappointed that Commissioning a Patient-Led NHS has been handled in such a poor manner. We believe it is a retrograde step which will have an impact on patient services for months and years to come. With this in mind, we have decided to back the call by the Royal College of Nursing for a judicial review.

18. We are pleased that there has been some movement by the Secretary of State in her recent statement, but we are keen that there is more in order to provide security to both staff and patients alike.

Rachel Haynes
Head of Public Affairs
Chartered Society of Physiotherapy
9 November 2005

Memorandum submitted by the Commission for Patient and Public Involvement in Health (PCT 50)

1. The Commission for Patient and Public Involvement in Health (CPPIH) was established by the NHS Reform and Healthcare Professions Act 2002 and set up in January 2003. It is an independent, non-departmental public body, sponsored by the Department of Health.

It oversees and supports 569 statutory Patient and Public Involvement (PPI) Forums, made up of local volunteers, one for Primary Care Trusts, NHS hospitals trusts, mental health trusts and ambulance trusts. It also gathers information and opinion from PPI Forums, in order to ensure that NHS bodies are acting upon patients’ and the public’s views.

It is responsible for submitting reports to and advising the Government on how the Public and Patient Involvement (PPI) system is functioning. It liaises with national bodies on patient and public involvement issues, and makes recommendations to these bodies and the Department of Health.

CPPIH has a remit to make sure the public is properly involved in decisions about health and health services.

2. The principles and objectives of patient and public involvement first emerged in the NHS Plan 2000 and were elaborated on in Shifting the Balance of Power within the NHS—Securing Delivery.13 Derek Wanless’ scenario of a fully engaged NHS requires the views of patients and the public to be built into the decision making processes.14 Since 2000 the agenda has been given additional impetus.

NHS Trusts, Primary Care Trusts and Strategic Health Authorities have a statutory duty, under Section 11 of the Health and Social Care Act 2001 to consult patients and the public in service planning and operation, and in developing proposals for changes. This includes consulting on:

— ongoing service planning, not just major proposed changes;
— not just in the consideration of a proposal, but in the development of that proposal;
— decisions about general service delivery, not just major changes.15

3. Consultation is pointless unless the views of consultees are capable of influencing the outcome. CPPIH takes the view that is important for consultation to feed into the planning process and should not simply be an afterthought once decisions are close to being reached. Failure to consult, or “token consultation”, is a source of immense public frustration and disenchantment with public sector decision-making. It also provides a disincentive to active citizenship which extends way beyond the health sector.

Where significant consultation is indicated, as it is in the case of the major changes to Primary Care Trusts proposed, significant resources and significant amounts of time should be made available to make the consultation meaningful.

4. With a dedicated infrastructure in place to promote involvement in decision-making, funded by the public purse, it is unfortunate that efforts were not made by the Department of Health to seek the advice of CPPIH and its network of Patient and Public Involvement Forums, especially those with primary care responsibilities, in consulting patients and the public on PCT reconfiguration proposals.

15 Section 11 (1, a, b and c); see also Policy Guidance Strengthening Accountability—Involving Patients and the Public February 2003.
**Reconfiguration of PCTs—Process and the Need for Consultation**

5. “Commissioning a Patient-led NHS”, the document issued on 28 July, was an instruction to SHA and PCT Chief Executives. This and other related proposals are aimed at creating a decentralised NHS structure, with services delivered through a range of providers. This represents a very substantial change in the NHS and should have provided an opportunity to develop best practice in engaging the public in major NHS reforms.

The Department of Health’s review of how health services are commissioned locally is likely to result in the merger of Primary Care Trusts (PCTs). Any proposed changes will inevitably affect service delivery and CPPIH believe the public should be fully engaged in decisions here too.

6. The Commission would expect Strategic Health Authorities to consult with PCT Patient and Public Involvement Forums at an early stage on any proposed changes to the numbers of PCTs, changes in boundaries, mergers and reconfigurations, and give them the opportunity to comment. Ideally this would take place during the pre-consultation stage and prior to proposals being submitted to the Department of Health.

We would also expect arrangements to have been put in place to canvass the views of the public, NHS staff, local voluntary sector and community organisations and other local stakeholders on possible options.

7. The Commission is concerned that the Section 11 consultation requirement was ignored when “Commissioning a Patient-Led NHS” was first announced on 28 July 2005 by Sir Nigel Crisp.

As a result of this we believe that some NHS bodies were possibly under the impression that the proposed reconfigurations fall into the category of administrative changes, and consequently they were not required to consult. Since Section 11 of the Health and Social Care Act has been in existence for several years, and Strategic Health Authorities are aware of their responsibilities, questions need to be asked about what instructions or guidance on consultation were issued by the Department of Health.

8. It is also unfortunate that the decision to make the announcement of “Commissioning a Patient-Led NHS” at the end of July, and the short-time scale available for SHA’s to submit detailed plans, may have hindered those bodies’ ability to consult widely and involve Patient and Public Involvement Forums. As stated above, meaningful consultation takes time.

We know from our experience of working with PPI Forums over the last three years, that volunteer bodies require substantially longer than other bodies to plan any submission. Many PPI Forums do not hold meetings in August and early September. Many Forum members will have been away and have been unaware until late in the day that any PCT reconfigurations were in the “pipeline”. This removed the opportunity for Forum members themselves to canvass views from within the local community.

Despite the aspiration in the NHS Plan, the most profound changes in the NHS since 1948 were initially destined not to be the subject of public consultation.

9. Following letters and telephone calls from PPI Forum members with concerns about local consultation arrangements, CPPIH conducted an on-line poll between 18 and 25 October 2005 to find out whether Forum members had been consulted about the reconfiguration. We received 353 responses. The general feeling appears to be that there was inadequate meaningful consultation of patients and the public in many areas.

Only 39% of PPI Forum members said their Forum had been consulted and only 22% said they had found the consultation meaningful. 52% of respondents said that patients and the public had not been consulted over the proposed changes.

We suggest these figures are a cause of concern, particularly as only 14% of Forum members said patients and the public had been consulted and only a minority were aware of any opportunities available to the public to express an opinion.

10. We invited comments as part of the survey. Here are just a few examples:

“We were actually consulted after the cut-off date for written submissions . . . This means that I have not been able to discuss the proposals with my Forum or for us to have time to submit any kind of proposal. This seems to be a frequent occurrence where consultation/information by the SHA is withheld until the last possible moment.” (East Staffs PCT PPI Forum)

“Re-organisation has been explained to us . . . However, to me, consultation means the opportunity for discussion, to put forward opinions and to question the proposals prior to decisions being made. We have not had the opportunity to do this.” (North East Region)

“Our PCT has told us about the process but has made the point that is not their duty, or the duty of the SHA, to ask our views.” (South East Region)

“There has been no official consultation with the Forum or its members or with members of the public . . . We have strong views on the matter, but meetings with the PCT are cancelled by them at the last minute. Comments from the DH indicate that there is no consultation requirement as this is merely an administrative change.” (East of England)
Since the survey was conducted, the government has announced that there will be a three month formal consultation exercise on the reconfiguration of PCTs. This consultation will begin in early December 2005. CPPIH welcomes this announcement, but again regrets that its representations were not heeded at an early stage.

11. Sharon Grant, Chair of CPPIH wrote to the Secretary of State for Health on 3 October 2005 urging greater clarity about how communities are able to share in local decision making about health services, as the effects of current policies begin to emerge.

12. CPPIH’s view is that in areas where there are already good arrangements for patient and public Involvement, PPI Forums are more likely to have been kept informed and involved in meaningful discussions. Some Forums members have told us they were happy with the information and consultation arrangements in place. It is clear that some sections of the NHS give much greater priority to Section 11 than others. The level and quality of consultation differs substantially between different areas and different NHS bodies.

13. CPPIH is aware of some encouraging examples of good practice in involvement and consultation arrangements. One such is the Avon Gloucestershire and Wiltshire Strategic Health Authority which informed stakeholders, including Forum Chairs, at an early stage, held stakeholder meetings and produced regular newsletters sent to staff, unions, MPs, Overview and Scrutiny Committees, Forum Members and voluntary and community sector organisations. PPI Forums were invited to complete the assessment framework document, the whole process was publicised on the SHA’s website and the final decision was made at a meeting held in public. Conclusion and recommendations.

14. Patients and the public deserve an explanation as to why such momentous change in the NHS was intended to be implemented without reference to Cabinet Office guidelines on consultation and Section 11 of the Health and Social Care Act 2001. We believe Cabinet Office guidelines were breached and Section 11 requirements were overlooked.

15. We recommend that in future Section 11 consultation requirements are made explicit at the beginning of any process involving changes to the mechanisms by which services are delivered as well as changes to the services themselves.

16. We would also recommend consideration be given to strengthening Section 11 to introduce sanctions in cases where NHS bodies are failing in their statutory duties.

17. We note the Secretary of State’s recent announcement of a 3 month formal consultation period in respect of changes to PCT boundaries and we welcome this. However, the proposed changes in PCT functions will also require consultation and we recommend the White Paper on healthcare outside hospitals be used as a springboard for further public debate to ensure the changes proposed for the NHS are what the public want. There should be a major public debate on the principles enshrined in Creating a Patient-led NHS. If resource constraints are a key driver in this process then this ought to be openly and honestly be shared with patients and the public.

18. We recommend that the Department of Health should heed early warnings that indicate consultation mechanisms are not working. PPI should be part and parcel of Department of Health and NHS practice at every stage in the future.

19. We recommend that consultation arrangements are properly resourced and that adequate time is set aside to allow patients, members of the public and PPI Forums to have a meaningful input into the decision-making process. Existing systems for PPI should be supported.

20. We recommend an effort be made to reach uniform standards in patient and public involvement and where there is good practice this should be captured and used to set standards that are universally applicable.

The Commission for Patient and Public Involvement in Health
24 November 2005

Memorandum submitted by Community Investors Development Agency (PCT 47)

1. Summary

1.1 If stakeholders are to make informed choices about the proposed changes to primary care trusts, evidence should be provided on why the proposals are expected to lead to desirable results, including more consistent access to appropriate health and social care services and improved coordination. Potential risks as well as benefits should be considered, including the effects of reducing local coordination and control, which was previously a central feature of much health policy. It may appear that the proposals involve a shift of direction: those steering the changes should explain more clearly why they are proposing this route. There should also be transparency about the degree of local flexibility which would exist in practice. The
costs of frequent reorganisation should be taken into account, and meaningful consultation undertaken with service users, carers, frontline NHS personnel, partner agencies and other stakeholders before new structures are finalised.

2. Introduction to Community Investors

2.1 Community Investors is a strategic development agency. Our ethos is faith in the knowledge and experience of the people and communities we serve, and the belief that local people, with their intimate knowledge of the needs of their communities, have a critical part to play if there is to be effective and sustained economic, social and environmental transformation.

2.2 Our areas of interest are wide-ranging. They encompass supporting user and public involvement in health (including enabling a primary care trust to develop a patient and public involvement strategy and action plan and being a forum support organisation), promoting social enterprise and community infrastructure, and combating disadvantage among young people. Many of our activities are strategic and innovative and involve networking, support to others, acting as a third sector interface between government and community and making recommendations on policy and standards. Research is a critical part of our work, including managing studies of issues which matter to communities, producing briefings and discussion papers and helping to bridge the gap between academic researchers and local people.

2.3 Community Investors has a diverse staff team with backgrounds in a variety of fields, including health and social care, local government, the voluntary sector (including intermediary organisations) and business, largely within areas of high deprivation. Our experience has underlined to us the challenge of trying to be objective when considering public services, the risks of a culture of conformity, the value of the insights gained by those working at a grassroots level, and the importance of frontline staff, partner agencies and local agencies feeling some degree of ownership over goals and standards. The understanding we have developed over the years, as well as our theoretical knowledge, is reflected in this submission.

3. Rationale Behind the Changes

3.1 Our understanding is that proposals arising from Commissioning a Patient-Led NHS are intended to reduce administrative and management costs and increase fitness for purpose. The Department of Health July 2005 document (http://www.dh.gov.uk/assetRoot/04/11/67/17/04116717.pdf) set out a number of criteria for assessing proposals, including improving health and reducing inequalities, improving public involvement, improving effective use of resources and improving coordination with social services.

3.2 These objectives would appear broadly acceptable and in line with what members of the public want. It is interesting to note the emphasis on availability and ease of access and the need for joined-up services emerging from reports on the Department of Health website on Your health, Your care, Your say events, suggesting that these concerns are still current. Moreover, there are major changes in overall health policy to which structures must adjust, including patient choice and practice-based commissioning. If used imaginatively, these could potentially enable services to become more responsive to local patients’ wishes, for instance for a more holistic approach to health.

3.3 However, as far as we are aware, the evidence that some of the proposals under discussion will lead to the desired results is weak. Where radical changes are being advocated by senior figures in government and the NHS, the reasoning should be explained more clearly if there is to be informed public debate. Risk assessments should be undertaken. It would also be useful to have more detailed information on the probable effectiveness of various different approaches, including focusing on cultural rather than structural change to achieve more consistently high-quality and accessible patient-focused services. If patients, carers, health professionals and other stakeholders are to be persuaded that options under discussion are evidence-based and not driven by ideology, more explanation is required.

3.4 In July 2001, Shifting the balance of power within the NHS: Securing delivery (http://www.dh.gov.uk/assetRoot/04/05/94/58/04059458.pdf) set out certain guiding principles for future development. To quote, “The balance of power must be shifted towards frontline staff who understand patients’ needs and concerns. A shift in the balance towards local communities so that they reconnect with their services and have real influence over their development. Frontline staff need to be in charge of frontline services and have the power to manage to meet the local communities needs—always within the context of clear national standards and a strong accountability framework… PCTs will work as part of Local Strategic Partnerships to ensure co-ordination of planning and community engagement, integration of service delivery… PCTs will take on responsibility for all family health service practitioners. This will allow for a coherent view of the development of all NHS services in the area. PCTs will have responsibility for the management, development and integration of all primary care services… PCTs will have a clear lead in developing local services and will be able to tailor services to local needs… The opportunity for PCTs as primarily local organisations to engage and empower local communities, patients and frontline staff should bring improvements in local services… Directing the flow of funds to frontline organisations will be an early move in ensuring that frontline staff are fully involved in resource decisions and are empowered to shape service development.” Though in practice the shift of power towards frontline staff and patients, and local coordination and integration of services on the basis of local needs, has been uneven, the underlying
principles would appear to have considerable support. However Commissioning a Patient-Led NHS would appear to signal a major change of orientation towards greater centralisation of control and fragmentation of delivery. If indeed the direction of travel has changed, it would be useful to know why.

4. Likely Impact on Commissioning

4.1 Having the same PCT and social services boundaries would seem likely to be helpful in achieving “joined-up” services for children, older people and others with health and social care needs. In itself, however, it is not enough: it would be useful to examine in more detail why breaking down barriers has proved so difficult, and how new structures could best be designed to improve coordination centred on users’ needs. Certainly, where PCTs and local authorities are already co-terminous as in most of London, there are strong arguments against changing boundaries, as acknowledged in the 1 November 2005 letter from London Strategic Health Authorities to John Bacon at the Department of Health (http://www.nclondon.nhs.uk/foi/foi_docs/2637_londonreport.pdf). This would not prevent PCTs from buying in expertise on particular kinds of commissioning, eg in mental health.

4.2 If PCT mergers are being considered, or indeed joint commissioning in certain areas, the risk of disrupting formal and informal partnerships built up locally over the years should be considered. These play a part in gathering and sharing local needs and preferences, coordinating arrangements and collecting and considering patient and carer feedback, and may include local authority officers and members, the police, user and carer groups and other community and voluntary organisations. In addition, members of professional executive committees get regular feedback from patients. This can help to ensure that commissioning decisions are influenced by local realities. For example, money has been saved in the NHS in the past by cutting cleaning costs, but poor hygiene has had serious consequences. The more remote decision-making is from frontline experience, the greater the chance of hidden costs.

4.3 The impact on equity should also be considered, and the challenge of ensuring that allocation of resources was fair; there is a risk of intensified rivalry between different geographical areas if some are perceived to be getting more than their share. It would be useful for proposals to explain how new commissioning arrangements might take account of health inequalities and varying cultural and communication needs among patients. Reports from bodies such as the London Health Commission and London Health Observatory show the extent to which such inequalities have persisted in communities living in close proximity, indeed different sections of the population in the same neighbourhood (and this is not unique to London), and this is borne out by experience. In addition to visible minorities such as asylum-seekers, there are others such as frail and chronically sick older people who experience much hardship. Sometimes those with greatest need may have the greatest difficulty in accessing appropriate services, and it would be useful to know how proposed new commissioning arrangements might at least prevent health inequalities from increasing.

4.4 Mechanisms for accountability and involvement are important. It cannot be assumed that commissioners covering a wide geographical area, and under pressure to meet centrally-set targets, will be automatically aware of the effects of their decisions on diverse communities or responsive to their views.

5. Likely Impact on Provision

5.1 In provision as well as commissioning, formal and informal partnerships play an important part, and changes to PCT arrangements—especially “out-sourcing” of provision—could seriously disrupt these.

5.2 Drawing on the experience of some private sector social care provision as well as privatisation of services such as hospital cleaning, there is a risk that providers may seek to provide seemingly economical services by cutting back on pay (making it harder to recruit and retain appropriately qualified and motivated staff) or training. It may also be hard for patients to get redress if the services they receive are unsatisfactory, which may have a major effect on their quality of life.

5.3 Any proposals should take into account the shortage of allied health professionals and other personnel in some areas, and the strong possibility that some may leave the field of healthcare if they are dissatisfied with new arrangements for provision. It would be useful for the public to be informed of the expected losses and gains for any proposals put forward (including the impact on ethical recruitment and staff retention), how these have been calculated and any assumptions made.

5.4 Among the thousand participants in the national Your health, Your care, Your say consultation event, there was reportedly very little enthusiasm for the idea that non-NHS providers should be asked to offer community health services. If the NHS is indeed to be patient-led, the lack of wide support for these proposals should be borne in mind. The in-depth knowledge of the challenges of achieving adequate care coordination and quality held by people with chronic conditions and their carers, in particular, should not be dismissed too easily by policy-makers.
6. OTHER PCT FUNCTIONS INCLUDING PUBLIC HEALTH

6.1 The view has often been expressed that there should be a shift towards prevention. It would be useful for proposals to draw on available evidence to explore how changes to PCTs could strengthen their effectiveness in improving public health, especially for those experiencing the highest levels of preventable illness and injury. In this as in other areas, the value of local coordination, grassroots-level feedback and community engagement should not be overlooked.

7. CONSULTATION ABOUT PROPOSED CHANGES

7.1 While local consultation has been promised, there is a strong possibility that, if those considering responses are aware that government policy is strongly leaning in a particular direction, they will pay more attention to responses which take the same line, and end up drawing predictable conclusions. Reports of a 27 October 2005 letter to John Bacon from Mike Farrar, leader of the commissioning/provision implementation workstream of Commissioning a Patient-Led NHS, indicate that decision-makers considering the future of the NHS may feel that they are under pressure to conform, regardless of the opinions of patients, carers and other stakeholders. However, the history of initiatives which have been based on political trends and have not paid enough attention to the evidence base and frontline experience suggests that meaningful, not token, consultation is required.

7.2 Service users and carers invest considerable resources in prevention and healthcare, and are most directly affected by the quality of commissioning and provision, though those most affected by NHS changes do not always find it easy to lobby and be heard. Local NHS personnel directly engaged in meeting people’s health needs, many of whom are also local patients, also have valuable insights, and their cooperation if not enthusiasm is important if new arrangements are to work. Community organisations provide individual and collective advocacy and other health-related services, of particular importance to those facing disadvantage and social exclusion. Other local agencies such as social services, schools (including those with school nurses) and police (who along with GPs and the voluntary sector play a critical role in mental health provision in community settings) help to shape and monitor the health of their communities and are important partners in maintaining and improving health. Genuine consultation with key stakeholders and the wider public is vital if the proposals adopted are to be constructive and realistic. This includes a willingness to listen, and not dismiss all questioning as resistance to change, or assume that national and regional planners have all the solutions. The timetable should be realistic, and methods used which engage those most profoundly affected by changes to the NHS but whose views often tend to be overlooked.

8. LIKELY COSTS AND COST SAVINGS

8.1 It is not clear how the government arrived at its targets for overhead costs, and what evidence there is that these are realistic. There are sizeable direct and indirect costs attached each time there is a major reorganisation. While some savings might be made by sharing commissioning arrangements, there will presumably be the same number of patients, for whom complex transactions will still need to be tracked. In addition, the costs of patient choice (eg explaining options to patients and communicating their preferences to providers) need to be met, unless GP practices are generally able and willing to absorb these, which as far as we know is not the case. We know is not the case. If we know is not the case. The roll-out of practice-based commissioning, and making the “payment by results” system work reasonably smoothly, will presumably also result in certain administrative and managerial costs, at least initially. If services are to be outsourced to private providers, there will be costs associated with drawing up contracts, negotiating changes whenever there are alterations in patterns of need or standards of good practice, monitoring, and enforcement if there are disputes about the quality and quantity of services provided.

8.2 Whatever proposals are finally adopted, they are more likely to be cost-effective if they have been subjected to thorough public scrutiny and informed debate, in which patients, carers, local communities, voluntary organisations, frontline NHS staff and other stakeholders have played a part.

9. RECOMMENDATIONS

9.1 Greater clarity is desirable on how the proposed primary care trust reforms fit in with previous priorities for changes to the NHS, including increasing local coordination and control (especially in the areas of care for frail older people and others with long-term needs, children’s services and public health), reducing health inequalities, improving consistency in access to high quality services and strengthening patient and public involvement. If a change of direction is anticipated, this should be clearly signalled and the reasons explained.

9.2 To enable informed choices to be made, proposals should be evidence-based, and risks as well as potential benefits taken into account, including disruption to existing partnerships (formal and informal), planning and provision which is insufficiently responsive to the needs and experiences of local users and carers, and alienation of frontline staff. The strengths and weaknesses of different options should be discussed.
9.3 How the target for savings was determined and how it might be achieved should be addressed in detail, taking into account the costs of reorganisation, support for patient choice and roll-out of practice-based commissioning and legal costs associated with outsourcing services.

9.4 There should be meaningful consultation with stakeholders, including users, carers, local communities, frontline staff and partner agencies. The government should make it clear that those considering the future of, and making decisions about, primary care trusts will not be penalised if they do not reach a pre-determined conclusion: instead an open and responsive approach should be encouraged.

Community Investors Development Group
14 November 2005

Memorandum submitted by the Continence Foundation (PCT 4)

The Continence Foundation is a small UK-wide charity concerned with bladder and bowel weakness. Our membership includes members of the public as well as a wide range of health professionals (clinicians, GPs, nurses, therapists etc.) We have always maintained a close interest in NHS policy in our field and sought to influence its development at both national and local level.

SUMMARY

The Foundation does not understand the rationale behind these changes: they are certainly not “patient-led”. We are not opposed to a reduction in the number of PCTs, provided this is a development from existing forms of joint working: for some services (such as continence) to function adequately, a population base larger than that of most current PCTs is necessary. Practice-based commissioning requires a level of strategic expertise and specialist knowledge that most GPs are not interested in acquiring. There is profound unease among staff in our field that could exacerbate an existing shortage of qualified nurses. Yet another round of major changes will produce planning blight: what most professionals and voluntary organisations would like to see in the NHS is a period of stability. Public consultation should have been undertaken before so much work went into options for change, especially since “no change” is not offered as an option.

1. We are at a loss to understand the rationale behind the changes, since the amount of money to be saved is relatively small in terms of the NHS total budget. Cynicism would suggest that the motive is the introduction of private providers into community health services. We also note that the proposals take the system round in circles: many areas will end up with PCTs that cover the same populations as the Health Authorities of the 1990s. The claim that that is “patient-led” cannot not be upheld since the consultation on what ordinary people want from non-hospital services only started after the structural changes were announced, and in any case, the questions in Your health, Your care, Your say are not about structures. Submissions from some SHAs do show some consultation with Patient Forums, but these were but a small part of the process.

2. However, the Foundation is not opposed in principle to a reduction in the number of PCTs. Nevertheless, is extremely concerned that any proposals should be based on evidence regarding how services are already working across PCT boundaries. It is possible that some SHAs have considered current joint-working and SLAs between PCTs when deciding which PCTs should merge, but this is not apparent from the submissions available.

3. Our evidence for the need for some services to cover more than the population of the average PCT at present is as follows. An important aspect of our research findings concerned the number of PCTs that need to work together to have a sufficient critical mass to justify employing nurses with the special interests that need to exist within every community continence service if they are to meet the needs of their population. These special interests include children, men, learning disability, nursing homes (a full list of all the special groups can be found in the Guidance though not all on the same page.) Unless funding is available for a team of at least four continence nurse specialists (and support staff), it is not possible for them to have the necessary special interests. The services that have achieved or moved close to creating integrated continence services are working across three to six Trusts: note that in some cases, an acute, mental health or learning disability Trust is included to ensure smooth transitions for patients across boundaries. The ideal population appears to be at least 400,000 but most have gone for about 600,000—clearly geographical factors and county boundaries are relevant considerations.

4. The proposal to move to Practice-Based Commissioning could undermine everything that has been achieved on a strategic level for continence services in the last five years. It has been extremely difficult to get PCT Boards to take an interest in developing integrated services. One of the problems seems to be a lack of people with the ability to plan at a strategic level. However, persistence by senior continence advisors (some at nurse consultant level) backed up by consultants in acute trusts has been effective in some places. At GP level, it is extremely rare for individuals to have any interest in incontinence (Dr Colin-Thome recognises that he himself is an exception). Thus most practices will have insufficient knowledge to commission a continence service and especially to understand how many practices would need to co-operate
to create a viable service. Various attempts have been made over the last 15 years to get GPs more interested in the design of services, but the results have always been patchy. More in depth study into GP motivation would seem to be called for, rather than another total redesign.

5. Continence services across the country are already struggling to maintain a service. Part of the problem is the shortage of qualified specialist nurses for the substantive posts. This will not be helped by the general feeling of bewilderment and even fear among continence advisors at present, generated by the uncertainty about who will be their future employers and whether they will still have NHS careers (almost all continence advisors in the community are employed by a PCT). There is also confusion about whether PCTs will be able to continue to be providers as well as commissioners—it depends which document you read or who you ask within the Department.

6. The consequences of yet another reorganisation could produce planning blight: when the main change over to PCTs took place in April 2002, many continence services had to put a hold on previous plans for further integration and improvements in “the patient journey” until they could sort out who was responsible for what. Some actually found themselves landed with contracts for the provision of continence products that had been signed by Health Authorities that no longer existed and with no mechanism for discovering who had authority to change them.

7. Consultation on the whole idea of yet another reorganisation should have gone out to the public and NHS stakeholders before so much work was undertaken by SHAs for their submissions.

Dr Judith Wardle
Director, Continence Foundation
28 October 2005

Memorandum submitted by Diabetes UK (PCT 24)

Diabetes UK is one of Europe’s largest patient organisations. Our mission is to improve the lives of people with diabetes and to work towards a future without diabetes through care, research and campaigning. With a membership of over 170,000, including over 6,000 health care professionals, Diabetes UK is an active and representative voice of people living with diabetes in the UK.

Introduction

The Health Select Committee has decided to undertake an inquiry into potential changes to primary care trusts’ functions and numbers arising from Commissioning a Patient Led NHS, including:

— Rationale behind the changes.
— Likely impact on commissioning of services.
— Likely impact on provision of local services.
— Likely impact on other PCT functions, including public health.
— Consultation about proposed changes.
— Likely costs and savings.

We welcome the opportunity to submit evidence to this enquiry. We would like to use this submission to examine and highlight our fears about these proposals for people with long term conditions, especially people with diabetes. Diabetes UK feels that some issues have not been fully addressed in the development of these PCT changes and would like them to be examined further and, where necessary, changed.

Likely Impact on Commissioning of Services

1. Monitoring quality and delivery

Diabetes UK would like to raise questions around the ability of PCTs to effectively monitor and assess the quality of services in their area under the new system. They will have responsibility for monitoring services such as practice based commissioning and the pharmacy contract in their areas but we fear that they will not have enough capacity to do this effectively for small clusters of practices. This monitoring and assessment will be essential to ensure that the new systems and services being provided are of high quality but there is no assurance that this will occur.

2. Economies of scale

Diabetes UK has concerns that practices may be too small to establish and deliver practice based commissioning effectively. It doesn’t seem to be realistic to expect all practices to have the skills and capacity to be able to achieve all the prioritising, budgeting, managing, contracting and monitoring that the PCT previously did. There will be a need for some practices to work together to achieve the right outcomes and
this brings its own problems with willingness to co-operate. There needs to be further investigation into the cooperation required of practices and adequate support to encourage this. Without joint working the likely results will be that those patients registered with proactive practices will benefit at the expense of those smaller practices, thereby increasing inequalities in care and access.

LIKELY IMPACT ON PROVISION OF LOCAL SERVICES

3. Service fragmentation

Diabetes UK has consulted with our UK Advisory Council which consists of healthcare professionals and people with diabetes. They have fed back to us that they are very concerned that new systems introduced may lead to increased fragmentation of services. The reconfiguration of local services that will occur must ensure that people with diabetes are not disadvantaged by unstructured re-organisation of service providers. People with diabetes and existing and future care providers must be fully involved in decisions made about changes to service providers. These changes should be structured, agreed and take into account individual needs and preferences. Contestability within the health service could lead to further fragmentation of services because it could lead to a change of providers and unclear pathways of care between routine, ongoing and specialist care. It is likely that these changes of providers will not be discussed with the patient and might in fact not be what patients want.

The key to successful diabetes management and service delivery is co-ordination across multiple care providers and care settings. The nature of diabetes care means that each person with diabetes will have different healthcare needs that the healthcare system has to meet, according to NSF standards. Individual needs will vary from person to person according to the progression of the condition and individual management needs. This relies on the individual being able to make informed choices about their own, complex and changing care needs, with the support of competent practitioners who are willing and able to work collaboratively. Emphasis must be on enabling everyone to have access to the level of care they individually need, as well as reducing health inequalities for people with diabetes who are disadvantaged because of educational, physical, emotional or demographic barriers.

Integrated diabetes care is very important to the management of diabetes and it should aim to be organised and individualised to the person with diabetes. The appropriate care providers will change over time according to the wishes of the person with diabetes, the progression of the condition and the need for optimum management. Integrated care is about:

(a) Putting the patient first.
(b) Providing a high quality service matching skills to the needs of the individual patient.
(c) Colleagues working together, learning together eg multi-disciplinary training programmes, and reviewing outcomes together; and
(d) Involving the patient/carer as a member of the team.

4. Access to specialist care

The new system may put integrated care in jeopardy further because of problems that may emerge for specialist care. There needs to be a critical mass of funding in order to support specialised services and the changes will make funding uncertain and difficult to plan ahead of time. If specialist services only serve a small number of people with unpredictable severity of the condition, it may be difficult to keep to cost. If you look at the US experience, the evidence shows that unless some services are protected and mandated, you will see providers withdrawing from those services for economic reasons, which would disadvantage people with diabetes.

5. Payment by Results and the national tariff

Through Payment by Results there will be a fixed tariff for each “episode” of care. Under Payment by Results healthcare providers will be reimbursed on the basis of a standard tariff for the activity they undertake. The national tariff is set by the Department of Health, derived from average costs in all NHS providers. It is hoped that the tariff system will drive down costs for providers that currently have above average costs, as well as reinforcing incentives to deliver services efficiently in all providers. It is supposed to allow commissioners to focus on quality. Providers are paid on a per case basis, with funding being withdrawn if volume falls short. Diabetes UK has serious concerns about the tariff level for diabetes because the cost appears not to reflect the real cost and the differing complexity of care between conditions. This could make it difficult for complex diabetes cases to access appropriate care, especially where a multi-disciplinary team is required. The tariff doesn’t take into account the extra cost for the more complex cases and this means that providing these services will not be cost efficient. The Government has stated that if providers fail to provide services at or below the current tariff, funding will be withdrawn and the service

will close. Diabetes UK fears that if this happens patients will not be able to access these necessary specialist services. The closing down of specialist services goes against the patient choice agenda. It will cut down on the choice for patients of where they access their care because the number of the specialist services will be reduced and may not now be provided near to where they live. It will also mean that the services that do manage to survive will have many patients to see and this may hamper patients accessing the services.

6. Workforce

Altering the administration of the system will not increase the availability of crucial services such as psychological support, podiatry, dietetics, diabetes specialist practitioners and structured education because there still are not enough staff trained in diabetes care. There will need to be an increase in the number of administrators to work the new commissioning system but questions arise about the lack of investment to increase staff levels for crucial services. People with diabetes need to build relationships with their diabetes care team and prioritise continuity of care. Feedback from people with diabetes has told us that people feel it would be better to see someone who knows about diabetes at a less convenient time or location rather than see someone who knows less at a convenient time/location. They do not want a “dumbing down” of diabetes services in the rush to provide people with more points of access, contacts and advice. Care delivered by a variety of providers does not, in itself, constitute team care. A functional team is characterised by regular communication among its members and by the pursuit of common and agreed goals. The organisation of integrated care should be such that no unnecessary barriers are created between sites of health service delivery.

The pressure placed on PCTs to divest themselves of their provider function is likely to lead to job insecurity and a lack of continuity of services. Existing services are unlikely to be further developed and initiatives within PCT provided services stifled. PCT staff are unlikely to be in a position to exploit the opportunities presented by Practice based Commissioning if they are uncertain of their own futures.

Likely Impact on Other PCT Functions, including Public Health

7. Retinal screening

Diabetes UK supports retinal screening programmes remaining at PCT and managed diabetes network level. A bigger area for retinal screening can bring advantages for the programmes so PCT mergers could help retinal screening programmes become more effective. The programme needs to meet a minimum required size. It needs to be big enough to produce robust statistical data so that trends within the programme can be identified, to make sure that graders do not grade in isolation to avoid mistakes, that graders grade sufficient images to remain competent and that the system is assessed independently and externally to make sure that standards are met and sustained. All programmes need to have a centrally managed system, across a population, for call/recall and service provision to ensure consistency and quality care.

However, it has recently come to the attention of Diabetes UK that difficulties are being experienced in establishing a centrally funded, managed and independent quality assurance programme for retinal screening in England. Retinopathy is the leading cause of blindness in the working population, and regular systematic screening as part of a formal screening programme, to prevent retinopathy was therefore prioritised within the national diabetes framework. It is essential that the tried and tested monitoring systems used within existing screening programmes, such as cervical cancer, are in place for retinopathy screening. If the Quality Assurance programme is paid for by those also paying for and providing the services to be monitored, there is significant danger that commissioning bodies will provide self-serving responses. Furthermore, there will be limited incentive for poorly performing services to pay for the assurance. On the other hand, those perceiving that they are performing well will want to participate to prove this will pay. It will also benefit people with diabetes by providing an independent “watchdog” to ensure consistent quality standards, prevent errors and improve service delivery and practice across all local areas. High standards of quality assurance save both sight and the financial burden on both the disadvantaged patient and the taxpayer. Diabetes UK questions how such screening programmes can be adequately monitored and assured if a proliferation of providers are commissioned to deliver services across small populations.

There could be problems with retinal screening linked to the issues around contestability, mentioned previously. If private companies are bought in to carry out retinal screening the effectiveness of the programmes could be affected. Possible problems could be encountered if the NHS is unable, and the person with diabetes does not give consent for, passing on patient details to private organisations so patients will not be able to be called or recalled for services. These issues of patient confidentiality need to be resolved if contestability is introduced.
8. Public Health

A benefit of the new system can be seen in the recent move of the Department of Health to strengthen public health roles within PCTs. The Department of Health has stated that SHAs should not use posts working on Choosing Health as a way to make savings and that public health should be exempt from cuts. Savings can be achieved through cutting the number of director roles through the merging of PCTs but front line staff and consultant and specialist public health posts should be protected. This will be good for public health programmes and the prevention of diabetes and we hope that SHAs abide by this advice. However, we would like to raise concerns about public health prevention and health promotion programmes to be provided at practice level. Some GPs are enthusiastic about providing public health prevention services but others are not and do not always see it as their role. With GPs in the new system having responsibility for commissioning some prevention services, this might lead to problems. Patients won’t demand services from GPs that they don’t know they need or that they don’t want. The GPs mentioned above that are less keen to provide prevention services will not provide services that are not demanded. This could affect prevention programmes such as weight management and physical activity.

Diabetes UK
November 2005

Memorandum submitted by the Faculty of Public Health of the Royal College of Physicians of the UK and the Association of Directors of Public Health (PCT 33)

SUMMARY AND RECOMMENDATIONS

We feel that the momentum flowing from the Choosing Health White Paper, and some of the pragmatic structural changes coming from Commissioning a Patient Led NHS, present some real opportunities to make a progressive change in the future public health of the country.

These opportunities would be subject to the following statements.

The Faculty of Public Health and Association of Directors of Public Health:

(a) Recommend that the Department of Health clarifies the position of Public Health in the new PCT and SHA structures. There remains a possibility that the current re-organisation could reduce the number of Directors of Public Health in England from a little over 300 to around 150. This risks destabilising current Public Health teams who are delivering in their communities. We therefore recommend that there needs to be strong, local Public Health leadership at all levels of the NHS and local government, through clearly identified NHS Directors of Public Health.

(b) Recommend that Directors of Public Health must be accredited public health specialists. We acknowledge that the target of one DPH per borough is aspirational, and current limits on the numbers of public health professionals of sufficient seniority would mean that some local authorities would need to share a DPH. The Department of Health should urgently progress plans to review and develop capacity in Public Health through increasing the numbers of formal training posts for public health.

(c) Recommend that where possible, DsPH should be maintained and strengthened by using joint appointments with Local Authorities, ensuring executive-level public health representation on local authority management teams. The DPH should continue to be instrumental in setting Local Area Agreements (LAAs) and work with the wider community through the Local Strategic Partnership.

(d) Recognise that Commissioning a Patient-led NHS (CaPLNHS) should lead to stronger service commissioning arrangements, covering larger areas. These new arrangements should be strongly supported and in some cases led by Public Health specialists.

(e) Welcome the commitment of the Department of Health to exclude Public Health expenditure from the £250 million savings plan that this reconfiguration has been set to deliver.

(f) Are concerned that the significant financial pressures in many PCTs this year, combined with the need to deliver management cost savings, will result in money made available through Choosing Health being used to balance PCT deficits. Changes in the health of the population need sustained long-term efforts and for this reason, funds for public health improvement are vulnerable to PCT savings plans or targets that have to be met in a single financial year. We therefore recommend that money earmarked for Choosing Health should be ring-fenced by the Department of Health and that DsPH should be held accountable for its investment.

(g) Recognise and welcome the opportunities in CaPLNHS to strengthen local health protection and emergency planning arrangements. This might be particularly pertinent should the Health Protection Agency (HPA) start to take on delivery of some functions, such as immunisation and the control of Tuberculosis.
(h) Regional level Public Health should be closely linked with regional government offices as the focus of their health improvement work.

**Introduction**

1. The Faculty of Public Health is the Standard Setting body for specialists in Public Health. We are a joint Faculty of the three Royal Colleges of Physicians of the United Kingdom (London, Edinburgh and Glasgow). We are a registered charity, established in 1972.

2. The aims of the Faculty are:
   - To promote, for the public benefit, the advancement of knowledge in the field of public health.
   - To develop public health with a view to maintaining the highest possible standards of professional competence and practice, and to act as an authoritative body for consultation in matters of education or public interest concerning public health.

3. The Association of Directors of Public Health (ADsPH) has its origins dating back over 100 years. Its main function is to represent Directors of Public Health in the United Kingdom at national level. It is a separate organisation from the Faculty of Public Health, although most of our members are also Members or Fellows of the Faculty. Directors of Public Health provide advice to public bodies across the three domains of Public Health.

Some more detail about the ADsPH is available on the tri-fold leaflet. 17

**Faculty of Public Health and ADsPH response to the Inquiry**

4. The terms of reference for the Inquiry have been covered in detail by other witnesses. We have therefore focused on the likely changes to Public Health, whilst commenting on the other terms where appropriate.

5. We would broadly support the submission to the Inquiry made by the British Medical Association. This submission comments in detail on some of the other terms of reference that we do not propose to reiterate.

**Commissioning a Patient-led NHS**

6. The ADsPH drafted an initial response to Sir Nigel Crisp’s letter in September, which is included here as Annex 1. This was written at a time when Strategic Health Authorities (SHAs) had not sent in their submissions to the DH on Future PCT configuration. The picture as of mid-November is a little clearer, and most areas of the country are now aware of the likely changes that will go forward to consultation.

**Rationale behind the Changes**

7. The two main drivers appear to have been an intention to reduce management costs at PCT and SHA level and a political commitment towards greater contestability of PCT provider services.

**Likely Impact on Commissioning of Services**

8. There is currently some uncertainty as to how Practice-Based Commissioning (PBC), Payment by Results (PBR) and the changes that will result from CaPLNHS, will fit together. The Department of Health will need to ensure that these policies fit neatly together through a period of significant change.

9. One thing that is reasonably clear however, is that commissioning is likely to occur across wider areas than are covered by current PCTs. PCTs will remain responsible for the contracts with providers, GPs will influence the formation of these contracts, and will guide patients into secondary care of their choice. PCTs will need to manage demand for secondary care, and it is likely that Public Health practitioners will play a leading role in this function.

10. We welcome commissioning arrangements that will cover larger areas but remain concerned that there is scope for local inequalities and perverse incentives in the provision of care under Practice Based Commissioning.

**Likely Impact on other PCT Functions, such as Public Health**

11. Annex 2 contains supporting information, which outlines how public health should work with the new PCTs. 18

12. The new PCTs have two main functions—commissioning services for their population and ensuring public health delivery. The new PCTs are the basic unit of the NHS and have a public health responsibility. They will have a weighted capitation budget for their defined population. The PCT DPH will need to have

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oversight of the needs of the whole population and provide the overall corporate leadership within the PCT and across the public health network—ensuring academic, civil service and local authority and other public health resources are linked so there is an integrated public health system. The framework for the PCT DPH to use will be the three domains of public health—Health Improvement, Health and Social Care services and Health protection. The PCT DPH will need to satisfy themselves that these domains are being covered for their responsible population even if some are commissioned from other providers eg Sexual Health services and the HPA agreements.

13. Public health delivery under CaPLNHS will need to include:

13.1 A health Services Commissioning team to deliver the PCT commissioning process and Practice Based Commissioning. For critical mass this is likely to be a PCT headquarters function. This must be supported by a strong public health information team, something which is weak in many areas of the country, and which requires further development and investment.

13.2 Health Protection. The DH should ensure clarity about what the local HPA units provide and what the PCT needs to also provide (emergency planning) or commission in addition. Delivery will be at different levels and needs to include screening and Vaccinations and Immunisation. HPA units should be closely located or possibly co-located with PCT headquarters to make for strong and safe joint working arrangements.

13.3 Health Improvement. Agreement is required about what can be done at PCT level (social marketing and linking to regional strategies) and what should be done in LSPs. Local arrangements with joint appointments in unitary authorities and district/city councils may be the best option. Such posts would need to input at Chief Officer level and could also lead provider teams in local authorities (health development/promotion teams).

13.4 Provision of local Health Promotion services such as smoking cessation, Health Visiting, School Nursing, provision of health promotion materials. These functions may be commissioned by rather than provided by the local public health team.

14. We would envisage this happening at four tiers

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<tr>
<th>Tier</th>
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<tr>
<td>Tier I</td>
<td>Public health delivery teams in local authorities.</td>
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<tr>
<td>Tier II</td>
<td>Practice-based commissioning/Local Authority specialist Public Health work overseen by the Local PCT.</td>
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<tr>
<td>Tier III</td>
<td>PCT HQ/County/Unitary Authority work.</td>
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<td>Tier IV</td>
<td>Regional Government Office/SHA.</td>
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15. In order to avoid the fragmentation experienced with the NHS changes under Shifting the Balance of Power, it is important for PH networks to develop further. Scarce public health resources, such as dental public health and public health informatics will need to be shared across PCTs, including academic, local authority, commissioners and providers. To secure this, DsPH working at the tier of the LSP will need to be seen as part of the PCT NHS capacity and thus have Associate Director roles for the NHS whilst carrying the DPH role for the LA. New resources from Local Authorities should be enlisted to invest in these new local Public Health leaders and their teams derived from existing NHS and LA staff. The PCT would also be the environment to oversee training and develop R&D capacity, although this could also be supported at regional level.

16. In rural areas the County is likely to be the level for the PCT even if there are smaller unitary authorities in the area eg Peterborough in Cambridgeshire and Peterborough or Luton in Bedfordshire. The public service model outlined would still allow the PH leadership in these unitary authorities to be locally sensitive and linked to a Local Area Agreement. Indeed many of the Public Health and NHS providers will also be local (including PBC localities) so much of the joint working should be sustained. This vision can also apply to lower tier District or City Councils who contribute via their LSPs to the upper tier LAA.

17. In metropolitan areas such as Manchester and London the same economies of scale for PCT commissioning can be achieved while retaining locally sensitive Borough Council joint DSPH and teams.

Dr Tim Crayford
November 2005

Annex 1

LETTER FROM THE ASSOCIATION OF DIRECTORS OF PUBLIC HEALTH TO SIR NIGEL CRISP, DEPARTMENT OF HEALTH

COMMISSIONING A PATIENT LED NHS

The proposed restructuring of the NHS will have a profound impact on the public health function and the delivery of “Choosing Health”. The Association of Directors of Public Health executive team have considered the issues, particularly from a PCT perspective and enclosed a short paper for consideration (attached).
Our Association believes it important for the NHS and Local Authorities to understand and develop the role of a Director of Public Health. DsPH should be appointed at Executive Director level to statutory organisations with public health responsibilities for a defined population. As we move toward greater co-terminosity of local authority and NHS boundaries we should provide joint appointments between the NHS and local government.

Commissioning a patient led NHS risks the public health function at commissioning level being split from providers and local neighbourhoods. The tiered approach proposed in the paper will secure integration into local neighbourhood organisations and practice based commissioning. In order to secure an integrated public health function we believe PCTs DsPH need to lead a network of public health practitioners across the different tiers and settings. The DsPH needs to be assured—through commissioned or directly provided services—that the three domains of public health (health improvement, protection and service quality) are secure for their population.

The ADsPH who represent all DsPH across the country would welcome an opportunity to discuss these issues with colleagues at DH in order to make the changes proposed “fit for purpose” and not waste an opportunity for progressive development.

Dr Tony Jewell
21 September 2005

Annex 2

RESPONSE FROM THE ASSOCIATION OF DIRECTORS OF PUBLIC HEALTH TO COMMISSIONING A PATIENT-LED NHS

INTRODUCTION

“Commissioning a Patient Led NHS” does not focus particularly on public health or the public health function but leaves the door open for debate about functionality and delivery. The public health community must capitalise (and be seen to capitalise) on this opportunity. In recognition of PCTs statutory responsibilities and those of associated local authorities the public health function should underpin and drive evidence based strategies that demonstrably improve the health of populations and reduce health inequalities. Broadly speaking this will be delivered through the three domains of public health namely:

— Health improvement and reducing inequalities.
— Health protection and prevention.
— Health and social care quality.

Oversight of these three domains for a defined population is the role of a Director of Public Health for a statutory organisation. (Appendix 1)

Given the pace of the change underway following Sir Nigel Crisp’s July letter to the NHS and in recognition that structural organisation of new PCTs, this paper provides a view from the Association of Directors of Public Health (ADPH) on maintaining and developing the public health function. It is based on recent telephone conferences of the ADsPH executive and subsequent email discussions. It represents the views of the “jobbing” Director of Public Health (DPH) in the front line of delivery of the public health agenda.

THE CONTEXT

Public health policies and interventions work! Over the Queen’s reign public health initiatives have delivered sustained improvements in the public health. For example life expectancy rose from 66.7 years (males) and 71.8 years (females) in 1952 to 75.1 years (males) and 80.0 years (females) in 2002. Similarly Infant Mortality Rates fell from 27.6/1000 in 1952 to 5.3/1,000 in 2002. These dramatic changes are the result of many public health strategies for example through the three “Ps”:

— Prevention: reducing the prevalence of smoking, improved and increasing equity in education attainment, increasing wealth, improved housing.
— Protection: vaccination and immunisation, clean air, health and safety legislation.
— Provision: evidenced based management of life threatening and long-term conditions.

Despite unprecedented investment in the NHS over the last three years, the reality is a widening of health inequalities, an NHS that did not balance its budget in 2004–05, and the burgeoning costs of social care. This re-organisation we recognise is partly driven by the need to “save” £250 million. The Wanless reports informed HM Treasury that health and social care funded by taxation would by unaffordable in 2020 unless we all became “fully engaged”.

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The principal public health challenge facing the NHS and local authorities is the need to maintain quality, independent living in an ageing population. The duty of partnerships should address the social, economic, environmental and health/well being of their population. This means reducing the impact of disease processes on individual disability and handicap (during the final 15 to 20 years of life) through prevention or delayed onset.

**THE CHALLENGES**

Improved public health will need significant shifts in the lifestyle of individuals through:

- prevention strategies tailored to individuals living in supportive communities; and
- providing safe and appropriate health promoting environments in day-to-day activities at work, at home, and during leisure pursuits.

Some of this can be achieved through legislation and national health promotion campaigns. However existing PCT public health teams have shown that, like their forebears in local authority Medical Officer of Health teams, work with smaller populations and communities adds synergy to these campaigns. Likewise sustained, targeted community and neighbourhood approaches are essential in tackling local public health problems and health inequalities.

Secondly these changes will be delivered against a background of local authorities and the NHS facing significant financial problems over the next few years with the prospect of little significant above inflation investment.

Thirdly the reconfiguration will result in PCTs becoming “powerful” commissioning organisations that, together with local authorities, are charged with improving health and reducing inequalities. The majority of PCT commissioning will be discharged on the advice of Practice Based Commissioning (PBC) teams. In addition the current PCT provider functions will develop into separate organisations by 2008. Therefore public health specialist action needs to be set into the context of separated commissioning and provider roles.

**THE RESPONSE**

Outcomes: Success in implementing the Governments public health strategies means that the public health function must become locally focussed and outcome driven. A key benefit of the current PCT arrangements is a very local public health specialist presence in communities working through PCT front line staff and primary care as well as local authorities and voluntary organisations. These developments need to be built on.

Commissioning: The reconfiguration of PCTs means that the clear separation of commissioning from providing will need to be reflected in the public health function without losing the links.

The Association’s view is that in order to develop and sustain “powerful” commissioning, and deliver their statutory responsibilities, and demonstrably improving health PCTs and local authorities will require input from dedicated specialist public health teams. This will need to be at senior level with the continuance of the Director of Public Health (DPH) role. The DPH provides local leadership that, in partnership with others, ensures local population’s needs are assessed and addressed through public health programmes. Experience in a number of PCT areas has shown the benefits of having DPH presence at senior corporate levels of local authorities. Ideally, but not essentially, these are joint appointments. Such arrangements have supported the development of health improvement strategies and the functioning of Local Strategic Partnerships. These successes and the advent of Local Area Agreements highlight the need to make these arrangements more widespread.

To fulfil their task the DPH will need to be supported by a team of accredited public health specialists to support commissioning and to demonstrate health improvement through performance management arrangements. However bearing in mind the challenge of “Choosing Health” particularly promoting health as a desirable commodity new skills such as marketing expertise may prove essential.

Provision: Equally important is the need to provide appropriate public health interventions in the front line as this is where the three “Ps” of public health practice are delivered. Implementing “Choosing Health” demands realignment and boosting of current public health provision. For example services provided by health visitors or through the National Healthy Schools Programme. As with the provision of health services choice and provider plurality needs to be present in the provision of health improvement services. To some extent this already exists, for example smoking cessation support, exercise on prescription initiatives, and young adult services; these are provided by a range of organisations in the NHS, as well as the voluntary and private sectors. These should be built on. Increasingly such organisations are likely to require dedicated public health specialist support.
A Tiered Approach to Public Health Functions

The introduction of Practice Based Commissioning (PBC) as part of the reconfiguration of PCTs should provide a real opportunity to secure locally sensitive health promoting services in health and social care. PBC will give the local focus to public health programmes and outcomes. It introduces another tier for public health action and the need for appropriate public health specialist input and support. The three tiers (outlined in Appendix 2) make a distinction between the provision and commissioning functions in PCTs.

Consideration of the development of a tiered approach should not be done in isolation of reviewing the relationship and working arrangements with other public health organisation. Key to this will be integrating the roles of the Health Protection Agency and Public Health Observatories to the reconfigured PCTs. In addition there are likely to be significant opportunities for greater engagement with academic public health, civil service practitioners, local authority staff and training schemes.

Delivery

In response to the multi-faceted approaches needed to improve the public health many public health specialists are likely to be working in all three tiers of PCT public health functions. Some will be needed to work as part of clinical and other networks on behalf of other PCTs. This will continue through the transition to the reconfigured PCT. In addition there is a growing consensus that more public health specialists and practitioners will be spending dedicated time in the local authority setting and at reconfigured Strategic Health Authorities/Regional Government Offices. To secure a sustained public health function as well as reconfiguring, and enhancing it, plans need to ensure that during the transition:

— The good work undertaken by PCT public health teams and networks is built on.
— The existing positive relationships with local authorities, the NHS, and the voluntary sector are secured and developed further.
— Business continuity is maintained through the change.
— Public health risks consequent on the transition are identified and appropriate controls and assurance mechanisms are in place.
— Staff in each public health team are supported through the transition.
— Best use is made of existing resources but recognise additional investment from the NHS and local authorities may prove to be necessary.
— Public health high impact work areas continue to delivered.

Conclusion

The ADsPH recognises that this major reorganisation of PCT structures and the introduction of PBC provide significant opportunities to improve the public health. Prospects of this will be greatly enhanced through much closer working between PCTs and local authorities, in particular further integrating public health specialist work into the two organisations. This paper supports the concept of separating the commissioning and providing functions and indicates that public health specialists should be networked and play key roles in both. The paper stresses the ongoing important role for the DPH to provide public health leadership and strategic direction for local health improvement initiatives as well as performance monitoring progress. The ADsPH is ready to provide more advice and detail if required.

Memorandum submitted by the Health Foundation (PCT 13)

About The Health Foundation

1. The Health Foundation wants to make the quality of healthcare in the UK the best it can be. Working with others, we are helping to shape a future healthcare system that offers safe, effective and responsive care for all.

2. We are a charitable foundation and operate independently from government, political parties or other interest groups. Our endowment enables us to spend up to £20 million annually. We seek out the best people in healthcare and support them to learn and share with others. Through projects, research and evaluation studies we test and measure new ways of improving health services for the future. We actively inform healthcare decision makers so that we achieve sustainable and widespread improvements in the quality of patient care.

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Rationale Behind the Changes

3. The reforms announced in Commissioning a Patient-Led NHS have the stated intention of creating a step change in the way services are commissioned, to better reflect patient choices. The reforms are also located in the context of desired improvements in out of hospital care, being progressed through a forthcoming White Paper.

4. The Health Foundation has, over the past two years, been involved in a comprehensive set of research initiatives exploring different facets of patient engagement. The evidence we have generated suggests three main issues which will be critical to the achievement of a high quality, patient-led system of primary care:

   (i) a greatly increased ability to measure and monitor the quality of primary care services;
   (ii) improved co-ordination of care between acute care, social care and primary care providers;
   (iii) significant changes to the way services are delivered to patients, centring on increasing the ability of patients to assume a greater degree of involvement in their own treatment and care, and improvements in clinical outcomes for patients with chronic conditions.

5. We would encourage the Committee, in considering the evidence presented to it, to assess the extent to which these three improvements are likely to be achieved by the reforms outlined in Commissioning a Patient-Led NHS.

likely impact on commissioning of services

6. Being able to measure and understand the quality of healthcare is a prerequisite for quality improvement, and must surely be a cornerstone of any move towards a commissioner driven service. It is fair to say that while we don’t know enough about the quality of acute care, even less is known about primary care. The ability to secure safe and high quality care for the population—a defined responsibility of PCTs and SHAs under the Commissioning a Patient-Led NHS reforms, will continue to be severely impeded by the absence of a comprehensive framework for collecting and reporting on the quality of care and the patient experience in primary care.

likely impact on provision of local services

7. Surveys of patients and the public (notably the 2004 and 2005 International Health Policy surveys) reveal serious failings in the co-ordination and delivery of primary healthcare. The 2004 survey revealed that co-ordination of care between acute and primary care is poor, with patients reporting frequent problems with test results not being available during consultations, or with information about recent hospital care or medication apparently not being passed on. Significant numbers reported that test results or medical records were not available at the time of a scheduled appointment (13%); and/or they were sent for duplicate tests or procedures (5%); and/or they received conflicting information from different health professionals (14%).

8. There are also clear coordination gaps between primary and acute care. Among adults hospitalised in the past two years, one in four said their GP was not informed of plans for post-discharge care. One in three patients who had visited A&E reported that their GP was uninformed about care they had received.

9. Although reported by minorities of patients, the number receiving incorrect test results (3%) and experiencing delays in receiving abnormal results (6%) suggests some significant safety problems in primary care.

10. Clearly there can be no meaningful attempt by a healthcare professional and patient to arrive at shared decisions about treatment options when the most basic information needed to inform decisions is not available at the point of consultation. The timely flow of information between acute and primary care providers and other related quality issues are basic points which could be addressed through practice based commissioning—but which have proved resistant to improvement until now.

11. Readmission rates are generally regarded as a good proxy indicator of overall quality of care, and are highly reliant on the quality of communication across sectors. The 2005 International Health Policy Survey, which focused on the experiences of self-reported sicker adults, revealed that 10% of UK respondents had experienced an emergency readmission to hospital.

likely impact on public health

12. Consistent with the Wanless report’s “fully engaged scenario” (HM Treasury, 2002), effective health promotion and disease management are critical components for matching demand to supply in healthcare, whilst at the same time improving the nation’s health. The success of the Government’s public health strategy will therefore depend on the extent to which primary care health services promote and maximize patient engagement.
13. A highly functioning primary care system would actively encourage patients to adopt healthy behaviours and to self-diagnose and treat minor ailments, involve patients in treatment decisions, and support them in the active self-management of chronic diseases and other long-term medical conditions (Coulter and Rozansky (2004) BMJ: 329:1197–1198). This approach would also fulfill the Government’s policies around choice, responsiveness and equity.

14. The 2004 International Health Policy Survey looked at doctor-patient communication, with a particular focus on preventive care and care co-ordination. Compared to the other countries in the survey, UK patients ranked the quality of doctor-patient communications the lowest. One in five reported that their GP only sometimes, rarely or never makes clear their treatment goals. 72% reported that their GP was unlikely to initiate conversations about weight, diet, or exercise. The same proportion (72%) reported that their GP had not asked about emotional issues affecting their health. Preventive services are underused in the UK: only two out of three adults had their blood pressure taken in the past year. Only half of women patients report receiving reminder for breast or cervical cancer screenings (the survey results were adjusted for the right age groups). Disturbingly high numbers (37%) said that their doctor had not reviewed medications they were taking, including those prescribed by other doctors, and 39% of patients also reported that their GPs had not explained the side effects of medications.

15. In relation to patient centred care—a central objective of the reforms—half of patients in the UK report that their GP only sometimes, rarely or never tells them about treatment choices or involves them in treatment decisions.

16. The comprehensive review of the evidence conducted as part of the Quality Enhancing Initiatives project suggests that empowered and informed patients must be matched by trained and supported professionals if the two are to have an effective dialogue. Clinicians and their managers are frank in admitting the gap in skills, knowledge and capacity confronting the primary care workforce. Action to support and equip professionals with the skills needed for a radically different way of communicating and working with patients must be an essential part of any package of reforms intended to improve the quality of primary healthcare services.

17. This support for professionals is something that PCTs as employers in their existing form have struggled to provide. We would encourage the Committee to consider where the primary care workforce will access this type of development and support from in the new organisational landscape.

18. The findings of the Patient Activation Survey suggest that people with diabetes stand apart from patients with other chronic conditions as having fewer problems managing their condition, and receiving more support to do so. People affected by stroke, chronic pain, depression, fatigue, digestive and bladder conditions were least well equipped to manage their care.

19. These findings could be taken as evidence that the focus on self care for diabetes set out in the National Service Framework is proving successful. It is fair to say that diabetes care has been revolutionised over recent years, with real structural changes being made to the ways that care is delivered to patients.

20. We would encourage the Committee to consider what the impact of Commissioning a Patient-Led NHS will be on established high performing specialist teams such as those involved in diabetes care. Are the reforms likely to stimulate further innovation and improvement extending to other conditions? Or is it likely that the impact will threaten the achievements of such teams? To an extent it is the professions themselves who hold the answers to such questions, through the way they decide to respond to structural reform.

Natasha Govman
The Health Foundation
November 2005

Memorandum submitted by Kidney Research UK (PCT 14)

I am writing on behalf of Kidney Research UK (formerly the National Kidney Research Fund), with regard to the Health Select Committee’s forthcoming inquiry into Changes to Primary Care Trusts (PCTs). Founded in 1961, Kidney Research UK is the leading charity funding research into the prevention, treatment and management of kidney disease. We are also dedicated to raising awareness of kidney disease and improving patient care.

Part of this work involves ensuring that patients have access to the services and treatment they need, particular those such as dialysis and transplantation that are considered highly specialised and are only provided by a limited number of units around the country. The commissioning of these services fall under the arrangements for specialised services, which to date have raised a number of concerns over their effectiveness in meeting patients’ needs.

It was therefore with great interest that we read the terms of reference for this inquiry and kindly request the opportunity to submit this brief memorandum outlining our position with regard to renal services. We have set out our comments according to the order of the terms of reference.
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RATIONALE BEHIND THE CHANGES

Kidney Research UK welcomes the rationale behind the Government’s proposal to change the current makeup of PCTs, which is that in their current form they are unable to meet the necessary demands of patients. This is particularly the case in areas where services or treatments are highly specialised and therefore expensive to provide. Renal services fall within this group and have traditionally suffered from poor levels of access, particularly with regard to vascular surgery, dialysis and transplantation.

However, we are concerned that the changes, unless directed and overseen by Government, will create greater confusion and lead to even further delays in providing these services. It is not clear from the current process how PCTs in one area will compare with those in another, because each Strategic Health Authority area has been given the power to redesign the make up of its own PCTs.

This is of considerable concern if we are to ensure that service delivery is consistent across the whole country and to overcome the postcode lottery of care that currently exists.

LIKELY IMPACT ON COMMISSIONING OF SERVICES

At present, there is a general paucity of care in all areas of the renal field and service provision varies considerably across the UK. Without appropriate action, this situation is only set to worsen as kidney disease is forecast to increase significantly over the next 15 years.

One of Kidney Research UK’s ongoing priorities therefore is to promote the implementation of the National Service Framework (NSF) for Renal Services. Published in two halves in January 2004 and February 2005, the NSF is designed to establish a comprehensive structure for raising standards, reducing variations in services and improving the health care of renal patients across the country.

However, for some time we have had serious concerns over the arrangements for commissioning these services, which we believe have failed to meet the requirements of the NSF effectively. As renal services fall within the category of specialised services, they are, by definition, likely to benefit a smaller number of people than other disease areas and tend to cost more per capita to deliver than mainstream services. This means that they have historically suffered from low prioritisation when it comes to funding, particularly if there is little or no expertise in commissioning these services within the PCT consortia.

We therefore welcome the Government’s acknowledgement that there are concerns over these arrangements and support a review of specialised commissioning. In particular, we would like to see it address the financial constraints facing PCTs; the ability of PCTs to work well together to commission services; and measures to monitor the progress of PCTs in meeting the demand for services.

LIKELY IMPACT ON PROVISION OF LOCAL SERVICES

With regard to specialised services such as those for kidney disease, it is important both that patients have access to treatment locally and that the same standard of care is applied across the country. In order for some kidney patients to access services they have to travel hundreds of miles because their PCT only has a contract with a particular unit. For those requiring frequent treatment, such as dialysis, this can be extremely distressing.

Plans for the reorganisation of PCTs should therefore include a clear focus on access to services, with a particular emphasis on developing patient pathways around which services are provided. Where there are already such pathways available, for example in National Service Frameworks, PCTs should look to commission services in line with them.

Where highly specialised services are concerned, for which there are a limited number of providers, consideration should be given to commissioning them nationally, so as to ensure the same standard of care for all patients across the country. Again, we would stress that without a central Government steer on this reorganisation, there are fears that the existing inequities of access would continue to exist.

LIKELY IMPACT ON OTHER PCT FUNCTIONS, INCLUDING PUBLIC HEALTH

Kidney Research UK agrees with the Government’s emphasis within the proposed PCT changes on the need to shift the focus of services towards prevention. We have worked for some time to raise awareness of this issue, pushing for a stronger emphasis on prevention and early detection in renal care.

In particular, we have been keen to promote the dangers of kidney disease among ethnic minorities and other “at risk” groups, who are considerably more likely to develop kidney problems than the rest of the population. Our ABLE (A Better Life through Education and Empowerment) project for example has been running for over three years, working with African and South Asian communities to raise awareness of the risks of kidney disease and the importance of healthy living.

As the incidence of kidney disease is predicted to soar over the next decade, it is crucial that patients are educated about both the risks and symptoms of the disease. Of particular importance is the development of a clear treatment pathway between patients with coronary heart disease and diabetes, both of which have strong links with renal problems, and those with chronic kidney disease (CKD). Preventing progression to
CKD and, eventually, to end stage renal failure clearly has huge benefits for patients, but also relieves some of the pressure on the health service to meet the costs of expensive specialist treatment such as dialysis and transplantation.

**Consultation about Proposed Changes**

Kidney Research UK welcomes the Government’s intention to conduct a public consultation on changes to PCTs’ role in providing services. In particular, we would call for a full consultation to be held on any plans to change the current arrangements for the commissioning of specialised services.

**Likely Costs and Cost Savings**

We would agree that a more efficient health system, with more robust commissioning and funding arrangements, would help to streamline costs and could lead to cost savings, which could then be invested back into the system. This would be of particular importance to specialised services, such as those for kidney disease, which are expensive to provide.

*Kidney Research UK*

*1 November 2005*

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**Memorandum submitted by the King’s Fund (PCT 23)**

**Introduction**

1. This paper is a formal response by the King’s Fund to the Health Select Committee’s inquiry into potential changes to primary care trusts’ functions and numbers arising from the Department of Health document, *Commissioning a Patient-Led NHS*, which was issued in July. The King’s Fund is an independent charitable foundation working for better health, especially in London. We carry out research, policy analysis and development activities, working on our own, in partnerships, and through funding others. We are a major resource to people working in health and social care, offering leadership development programmes; seminars and workshops; publications; information and library services; and conference and meeting facilities.

**Overview—Rationale Behind the Changes**

2. The King’s Fund welcomes this opportunity to respond to this inquiry. While we support the broad direction of travel outlined in the document, we also have a number of concerns and suggestions.

   The changes heralded in *Commissioning a Patient-led NHS* represent a major structural reorganisation of the NHS over a very short period of time at a time when the health service is struggling to get to grips with all the other major reforms it has been tasked with introducing. While many of the proposed changes are wholly sensible in themselves, it is the volume and pace of change that concerns the King’s Fund and whether or not the health service can cope with all that is being demanded of it. We are already seeing the huge financial strain that new reforms, such as the implementation of Agenda for Change, patient choice and payment by results, are placing on the service. The demands of the service set out in *Commissioning a Patient-led NHS* will unfortunately divert the attention of managers and health professionals from this demanding agenda, as well as from improving services to patients. There is a danger that patient care will suffer as a result.

3. Despite these concerns, we believe there is much of merit in the rationale behind the proposed changes. There is merit in the idea of strengthening the commissioning function in the NHS. Commissioners need to become more efficient if they are to counter the power of incentives applying to hospitals—they face the distinct possibility of supplier-induced demand otherwise. PCTs need to develop skills in this area (for example, in analysing likely demand for care and how unnecessary hospital admissions could be prevented). They also need to sort out currently poor information systems. PCTs have always needed to do this, but they have been very slow in developing these skills. The answer in our view is not structural reform, but more that there need to be far stronger incentives designed to prompt commissioners to develop the skills they need, in particular to manage patient demand effectively.

4. One such incentive could be practice-based commissioning. It has the potential to create much more personalised care and so we support the idea that all practices should be encouraged to move towards it. The need to engage practices and GPs is critical and urgent if there is to be effective demand management rather than cosmetic responsibility for managing a budget. But again our work in this area has shown that much stronger incentives are required if this to be a reality—perhaps even going so far as linking GP income
with effective management of a commissioning budget. In particular, practices that operate in areas that are already financially challenged will face few incentives to take a budget. At present, few practices across the country are actively engaged.

5. However, the timetable for developing and implementing these plans is extremely tight and will be hugely demanding. We doubt that the target for all practices to be meaningfully engaged in practice-based commissioning by December 2006 can feasibly be met. The structural changes may all be sensible in themselves but we fear that the speed at which they have to be acted upon will divert attention away from patient care and disrupt working relationships, particularly between the NHS, social services, and housing organisations. More fundamentally, they, in our view, will do very little to strengthen commissioning which is the ultimate goal.

6. Longer term, the changes are also likely to bring about conflicts of interest, especially as practice-based commissioning is adopted more widely. Clarity on how these tensions might be managed is now essential.

Examples include:
- Practices, or groups of practices, may have an incentive to commission community or specialist services from themselves (or indeed to buy up local community services or introduce specialist consultants to their teams) rather than commission the most cost-effective service. This situation may be similar to the conflict of interest that GP fundholders had in the 1990s in setting up private limited companies to provide “outpatient” care (such as minor surgery) that would have been provided in hospital. It was very difficult to assess whether the service provided by these companies was cost effective compared to the alternatives, but this might be overcome with effective performance management and regulation.
- The suggestion in Commissioning a Patient-Led NHS that NHS Foundation Trusts should be allowed to provide community services is sensible from the point of view that it could promote better integration of care, or stimulating the supply of community services in areas not well served—but it is very possible that this will simply create new monopolies which will prevent competition and a diversity of supply.

WILL THE CHANGES BRING MORE EFFECTIVE PCTS?

7. There is no compelling evidence that large PCTs will be more effective. In fact, there is evidence (Bojke et al BMJ 2001; 322:599) that bigger is not necessarily better. Some PCT functions may be more effective with large scale, others less effective. For example, purchasing might be better, but engagement with practices worse. For those areas needing scale, PCTs are already creating alliances. A better approach may be to wait to see how this develops. Larger PCTs run the risk of being more remote from their patients and clinicians and arguably less publicly accountable (there will be fewer non-executive directors who currently add a degree of local representation to governance arrangements).

8. Also, it is well established that organisations entering periods of restructuring become less effective for extended periods (eg Fulop et al BMJ 2002; 325:246). Reorganisations are often a clumsy reform tool and may not deliver the promised goals they were set out to achieve. While we agree there is further scope for savings to be ploughed back into front-line services, this is the wrong time to impose structural change.

9. However, there are concerns about the way in which this programme of change is being implemented. First, Payment by Results is running far in advance of the strengthening of commissioning—this would seem to be the wrong way round or at least they should be in sync. Also, PCTs have had little time to prove their worth and further realignment is probably the last thing they need. There is evidence that mergers create unintended consequences and undermine the effectiveness of the new organisations they create for some time (Fulop, BMJ, 2004).

10. Our understanding of Commissioning a Patient-led NHS was that non-NHS providers would be allowed to provide primary and community services. If this is the case, then the question is raised of whether non-NHS providers of primary care will be allowed to take on the commissioning of secondary care and community services for the population served. This possibility is left open in Commissioning a Patient led NHS and the subsequent documents. We note a recent Guardian article which said that Oxfordshire PCT were putting some elements of commissioning out to tender. There may be merits of non-NHS commissioners using tax funds to commission care for a defined population, and indeed merits in having competition with NHS commissioners, but these and the potential drawbacks do not appear to have been thought through. This is a glaring lack in the policy documents to date in our view.

WILL THE CHANGES IMPROVE COMMISSIONING?

11. Commissioning a Patient-Led NHS considers the fundamental issue of how to strengthen commissioning. We support the proposals for PCTs to undergo a rigorous “Monitor-like” assessment of internal capacity and capability as interim measures, but think that a clear assessment of competence (with developmental support) should then be applied to groups of practices that are commissioning themselves.
12. There is evidence that practice-based commissioning will help to manage demand and there is good reason to involve primary care (particularly GPs) who create much of the demand for secondary care in its commissioning (Practice led commissioning—harnessing the power of the primary care front line, King’s Fund 2004). However, there is still a lot to work out around the relationship between PCT strategic commissioning and practice-based commissioning—in particular, what powers do the respective parties have? How can practices that do not participate or that overspend their budget be dealt with? These and other issues need more detailed work before the initiative can successfully be implemented. As we remarked above, we do not believe that there are enough incentives in the system to encourage universal uptake by practices by next year. Therefore, it is likely that the powerful incentives for hospitals to increase activity will come into force before the commissioning function has been sufficiently developed to counteract these effects. The recently published report of our inquiry into care services in London—The Business of Caring (King’s Fund 2005)—shows the extent to which local government still faces substantial challenges to every aspect of commissioning social care.

**Likely Impact on Provision of Local Services**

13. The idea of contestability in community services is complex. Does the government intend to break up PCT monopolies to become smaller (geographically overlapping) new organisations that will compete with one another? Is it acceptable for hospital trusts to offer community and primary care which, as we noted above, would mean very little competition and a complete monopoly over the supply of care? GPs have long wanted community services integrated into their own teams. This offers the prospect of good clinical collaboration but perhaps even less contestability than what we have now. It appears that there is a need for clarity and a longer term vision for community and primary care. We hope that this will emerge from the forthcoming “out of hospital” White Paper. In the absence of this, it is difficult for PCTs to plan for the future. We are concerned that the early announcement that PCTs should concentrate only on a commissioning role has introduced a significant element of insecurity for staff that may affect the delivery of services though loss of morale or poor staff retention in the interim. We would support the idea that divested community services providers might be established along “mutual” lines like foundation trusts, or indeed as private providers. However, the Department of Health will need to support this process as it is unlikely to happen on its own, and there are likely to be significant workforce issues with respect to NHS staff working in the community if they transfer to a non-NHS provider.

**Likely Impact on Other PCT Functions, including Public Health**

14. We believe that the reorganisation of PCTs will inevitably divert senior management time from their numerous statutory functions. For this reason, we would propose that any reorganisation should be more “organic” rather than according to a forced timetable. We were pleased that the recent announcement seems to suggest that this will be the case. However, given the dissonance of this message with the earlier letter from Sir Nigel Crisp (28 July 2005) we would welcome clarity on this point.

**Consultation about Proposed Changes**

15. We want to see the process outlined in Commissioning a Patient-Led NHS to be a local one, where PCTs are encouraged to come up with configurations that work best for their communities. To date it would appear that the tight deadlines imposed by the Department of Health have constrained the ability of PCTs and SHAs to engage fully with stakeholders in drawing up options for formal consultation.

**Likely Costs and Cost Savings**

16. We agree with the Government that wherever possible management costs should be reduced, for example, by consolidating PCT functions where this makes sense. However, we also believe that the commissioning function in PCTs lacks capacity and that, compared to other countries, the NHS might be considered to be “under managed”. We would be concerned if the work of PCTs was undermined, or unsuitable configurations agreed, simply to achieve an arbitrary savings target, particularly given that the commissioning function is responsible for determining the best use of the £76 billion that is currently spent on the NHS.

**Conclusion**

17. Overall, Commissioning a patient-led NHS has laudable aims but clearly there will have to be further support and guidance from the centre. The government has stressed the importance of people finding their own solutions at local level and within a national framework—that will be essential. We are pleased that the Secretary of State has clarified that PCTs and SHAs have local discretion in determining appropriate configuration and function. However, we wonder whether that had this clarity been available earlier in the
Summer the process for managing this change might have been smoother. The focus of Commissioning a patient-led NHS is far too skewed towards structural reform, for which evidence of effectiveness is limited, instead of strengthening incentives that might have a better hope of boosting commissioning.

King’s Fund
November 2005

Memorandum submitted by the Liaison Organisation for Business Investors in Local Improvement Finance Trust (LIFT LOBI) (PCT 31)

LIFT LOBI

1. LIFT LOBI is the Liaison Organisation for Business Investors in Local Improvement Finance Trust (LIFT) schemes; the representative body for private sector partners. The membership comprises 13 organisations with equity investments in over 90% of the LIFT ventures around the country.

2. LIFT LOBI acts as a forum for debate and decision-making for members on all issues relating to LIFT and represents the interests and consensus opinion of its members.

3. We are grateful for this opportunity to provide Committee members with our considered comments on potential changes to primary care trusts’ functions and numbers and hope that Members will find the information contained here useful.

LIFT: AN INTRODUCTION

4. LIFT is a government-endorsed finance scheme based on long term joint ventures at national and local level to improve investment in primary and social care services in England. It reflects Government policy to use the private sector where feasible to increase healthcare investment.

5. Unlike Private Finance Initiative (PFI) deals, LIFT schemes are based on the local private public partnership joint venture companies called LIFTCo’s owning and maintaining the new premises and leasing space to PCTs, General Practitioners (GPs) and other social care or voluntary sector tenants.

6. A recent National Audit Office (NAO) report on LIFT examined whether the scheme is able to support improved health care services while providing value for money. It found that LIFT is an “attractive way of securing improvements in primary and social care” and an “effective and flexible procurement mechanism”.

7. We support the opinion of the NAO: “whole life costs over the length of the partnership are inevitably uncertain. The cheapest option may not, therefore, be the option which offers best value for money”. Indeed, when compared to deteriorating and inappropriate premises, the improved facilities provided by LIFT can reduce costs per procedure. We do also recognise the need for greater and more effective testing for value for money, as identified by the NAO. A Value for Money system currently being developed by Ernst & Young in cooperation with the NAO, LIFT LOBI members and Partnerships for Health will ensure that potential individual LIFT ventures are accurately judged using long-term criteria and local communities receive full value for money.

8. Our experience supports the view of the NAO in that PCTs do indeed welcome “a long term approach under local strategic direction together with national support and standardised documentation” for the provision of new premises. It is for this reason that we have closely monitored recent communications from the Department of Health regarding changes to the future role and configuration of PCTs, and how these changes may impact upon LIFT ventures.

CONSULTATION ABOUT PROPOSED CHANGES

9. LOBInotes the timing and rapidity of recent Department of Health moves to alter the role of PCTs, from providers to commissioners of primary care. While we understand the desire to move forward with the modernisation of the health service, we hope that the Department will ensure full and open consultation takes place on the proposed changes.

22 Ibid; Report Summary, Paragraph 15.
23 Partnerships for Health, the agency responsible for establishing NHS LIFT, is jointly owned by the Department of Health and Partnerships UK. Partnerships UK is itself a joint venture between HM Treasury, Scottish ministers and the Private Sector; HM Treasury having a substantial minority shareholding. Partnerships UK work exclusively for the public sector to improve delivery of Public Private Partnerships.
24 Ibid; Report Summary, Paragraph 11.
LIKELY IMPACT ON PROVISION OF LOCAL SERVICES

10. That drastic improvements in local health care are needed is irrefutable but technological advances blur the line between primary and acute care (with specialist treatments increasingly available outside hospitals) there is potential for very different facilities being developed in community settings providing extended primary care, diagnostics, elective treatment, therapy, intermediate care and rehabilitation. The buildings which are needed to deliver this comprehensive range of services need new thinking and planning. It may be inappropriate for such buildings to have a single occupier providing all services but may be more appropriate to think of such facilities as “health malls” with a range of alternative providers taking space and providing services and care according to their expertise. The procurement route for such facilities needs careful selection but we believe that LIFT offers an effective and flexible mechanism which should continue to be used wherever appropriate.

LIKELY IMPACT ON COMMISSIONING OF SERVICES

11. Where LIFT Companies have been established they have been very successful in creating a supply chain to plan, design, fund, construct and maintain healthcare buildings. The more creative LIFT Companies have been working with their private sector partners to develop leading-edge thinking and practice in terms of the design of health facilities and helping to determine how changes in healthcare delivery, new models of care and new technologies all interact and impact on design.  

12. This model of creating and managing a supply chain has provided commissioning PCTs with extensive expertise which is responsive to their infrastructure needs. It is considered that a parallel framework could be put in place which concentrates not on infrastructure but on health care delivery. Such a structure would give PCTs, in their developing commissioning role, access to expertise which is not only focused on facilities but on the delivery of care from such facilities. 

13. Just as the infrastructure supply chain has a number of organisations with specific expertise so a new clinical services supply chain can be established comprising a range of organisations covering general practice, diagnostics, therapy, elective procedures, intermediate care, etc. Furthermore such organisations are likely to be varied in nature and would include Independent Sector operators, Foundation Trusts and the Voluntary Sector. Thus the LIFT Company acting as enabler is able to bring together best-in-class organisations which deliver high quality buildings and high quality care in line with commissioning requirements.

14. As the organisational and boundary changes to PCTs work through it is clear that what should emerge are robust commissioning organisations making informed investment decisions on healthcare priorities which have a demonstrable positive effect on health status for the population served. However, given the historical context of most health economies and the location of facilities there may well be difficulty in releasing fixed costs from such facilities as services potentially transfer. PCTs will therefore increasingly find LIFT Companies as effective agents for change, the LIFT Company can deliver new infrastructure and new methods of provision whilst existing services are transferred or phased out. The Commissioning body is thus less reliant on the existing provider network, and through working in partnership with the LIFT Company can introduce new entrants and manage the transfer of services in a low risk way avoiding organisational failure.

15. It would neither be appropriate for LIFT Companies to focus on the full range of healthcare delivery, nor to attempt to provide such services directly. They should concentrate their efforts and resources on the assembly of supply chains which can deliver and operate primary and community care facilities. Adopting this strategy will enable Commissioning bodies to have access to an expert partner that through a proven and established supply chain plans, designs, funds, constructs and operates such facilities. The resultant partnership will help unlock the current pattern of provision and act as a catalyst for creating new patterns of delivery in line with Commissioners priorities and emerging thinking on care outside of hospital.

RECOMMENDATIONS

16. Effective reconfiguration of PCTs and their functions will take time and is a process which must not be rushed. We would stress the need for full consultation with all stakeholders by the Department of Health.

17. In general, LOBI welcome the suggestion that PCTs will be responsible for larger geographical areas. Larger PCTs will be able to take advantage of greater economies of scale and improve the value of the services they commission and provide. Obviously, if this reconfiguration takes place, care must be taken not to lose the important sense of local service provision. LIFT can play a crucial role in achieving this; with local strategic direction ensuring primary health care is tailored to the needs of the local community.

18. The LIFT scheme illustrates best practice in positive public-private relationships and contractual mechanisms. This best practice should be replicated in wider commissioning scenarios.

19. It is essential that any changes to primary health care deliver tangible benefits for the poorest areas of the country. Under LIFT, private investment and experience has been targeted at areas of high deprivation. This example should be followed and primary health care improvements targeted at those communities which need them most.
20. The LIFT process has been tried and tested. It has been proven to work flexibly and effectively within a wide range of health frameworks to deliver on tangible health improvement goals. It strikes a vital balance between public and private sector involvement in an approach which offers breadth and focus. Reliable long term investment in healthcare facilities is ensured and can be channelled to areas of high deprivation which might otherwise be neglected under different procurement methods. We believe that the way forward is to accept these joint ventures as key enabling organisations which can bring together the best of the public and private sector in healthcare to deliver improvements not only in the quality of facilities but also the quality of care and ultimately to create healthier communities. As these inevitable changes to PCTs take place the role of LIFT schemes at the heart of primary health care must be ensured.

Christopher Whitehouse
LIFT LOBI
2 November 2005

Memorandum submitted by Lloydspharmacy (PCT 16)

1. SUMMARY

1.1 Lloydspharmacy, as the largest community pharmacy chain in the UK, welcomes and understands the intention to reorganise the current Primary Care Trust structure.

1.2 The proposed changes are causing a great deal of uncertainty amongst PCTs, who are reluctant to commission enhanced services, a critical part of the new pharmacy contract.

1.3 The Government needs to take a joined up approach to the reform of primary care in order to recognise that patients value the provision of health services in the pharmacy setting and to avoid jeopardising the new pharmacy contract.

2. INTRODUCTION TO LLOYDSPHARMACY

2.1 Lloydspharmacy is the UK’s largest community pharmacy chain with over 12,500 trained health staff in 1,400 pharmacies, offering widespread access to healthcare services and advice. Over two million people visit Lloydspharmacy each week and 90% of our business is directly related to healthcare. On a daily basis, our pharmacists and healthcare assistants provide information on general health issues, minor ailments, chronic conditions and advice on the medicines used to treat such conditions.

2.2 Lloydspharmacy specialises in providing expert pharmacy services to communities in many Primary Care Trust (PCT) across England and Wales, supporting and furthering NHS priorities not just in relation to minor ailments and long term conditions, but as part of an integrated strategy to combat major diseases. These services, many of which are provided in our 1,200 private consultation areas, currently include Smoking Cessation support, Diabetes Testing services, Blood Pressure monitoring, Medicines Management advice and we are currently piloting our new Coronary Health Check service.

2.3 By providing services that have been classified as “Enhanced Services” and which Primary Care Trusts are able to commission to meet local healthcare needs under the pharmacy contractual framework, we believe we are already delivering on our commitment to NHS reform.

2.4 Through our network of more than 30 managers dedicated to developing and enhancing customer relationships with key stakeholders within PCTs such as Pharmaceutical Advisors, Directors of Primary Care, etc, Lloydspharmacy come into contact with PCTs on a regular basis and are in a strong position to understand the impact of the changes proposed in July and October 2005.

3. RATIONALE BEHIND THE CHANGES

3.1 Lloydspharmacy welcomes and understands the Government’s rationale to restructure PCTs. In the long term, Lloydspharmacy believes that stronger PCTs, structured in line with local authorities and existing health and social care services, will deliver better services for patients.

3.2 Interacting with the existing 300 PCTs provides a huge commercial challenge for Lloydspharmacy, in terms of resources and the inevitable duplication of effort. The number of PCTs also means that inconsistencies exist in the way that services are commissioned, although Lloydspharmacy recognises that the type of services will be different to recognise diverse public health challenges across the country.

3.3 Rationalising the number of PCTs will release resources at a local health level to provide an increased number of improved and more focussed services for patients.
4. **Likely Impact on Commissioning of Services**

4.1 Lloydspharmacy believes that in the long-term the reorganisation of PCTs will create better services for patients.

4.2 A new pharmacy contract was agreed in April 2005, for implementation in October 2005. That contract defines the services provided by pharmacy: essential, advanced and enhanced. Lloydspharmacy is committed to this new contract and delivering its terms. We consider that its success is dependent on pharmacy engaging with NHS reform, part of which includes providing health services at a local level for patients.

4.3 The current hiatus on PCT reform and the uncertainty of the final outcome of that reform means that Lloydspharmacy has significant concerns that commissioning of enhanced services, a key part of the new contract that delivers innovative patient care outside of the traditional GP setting, is being delayed.

4.4 As part of the ongoing "Your Health, Your Care, Your Say" public consultation, on the question of how patients would like health services delivered outside of the GP surgery, 67% said that they would like to receive these local health services through pharmacy.

4.5 Lloydspharmacy believes that it is critical that the Government takes a joined up approach to primary care reform and that it meets the expectations that are being raised amongst the public that local services in the future will be provided in different settings, of which pharmacy is a key part. Lloydspharmacy is committed to delivering innovative local health services but it is absolutely critical that commissioners fulfil their part of primary care reform and, specifically, the new pharmacy contract by commissioning those enhanced services.

4.6 Lloydspharmacy has evidence that the commissioning process for enhanced services is being postponed. Commissioners are reluctant to make decisions concerning the commissioning of critical services for patients because of the uncertainty of the reorganisation and incoming Practice Based Commissioning which will ultimately give responsibility to GPs for commissioning these services. It is Lloydspharmacy’s view that PCTs are no longer operating on a “business as usual” basis which is to the detriment of the communities they serve and which jeopardises the entire ethos of the pharmacy contract.

4.7 Without better management of the ongoing change process and arrangements in place for the transition to whichever new structure is agreed—and a rigorous communications process for both those—Lloydspharmacy believes that it will become very difficult for the Government to realise its redesigned NHS that tackles key public health concerns with pharmacy as a part of that.

5. **Recommendations**

5.1 The Government needs to take a joined up approach to primary care reform in order to meet public expectations and to deliver the redesigned NHS.

5.2 The Government needs to reflect urgently on how the ongoing reorganisation of PCTs is impacting on the implementation of the new pharmacy contract to the detriment of the commissioning of enhanced services.

5.3 Communication about the PCT reform process and the transition to new arrangements needs to be managed rigorously to ensure that primary care functions as usual. Managing an effective change process requires strong leadership and direction and we would encourage the Government to recognise this in the current environment of transformation and reform.

*Lloydspharmacy*

*2 November 2005*

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Memorandum submitted by the Local Government Association (PCT 34)

**Introduction**

The Local Government Association (LGA) represents authorities across England and Wales and exists to promote better local government. We work with and for our member authorities to realise a shared vision of local government that enables local people to shape a distinctive and better future for their locality and its communities.

In compiling this response the LGA has received copies of local authorities’ correspondence with their SHAs, and in some instances to their MPs and to Ministers. We also held a meeting of elected members who are members of NHS bodies.
SUMMARY

— Local government through its democratically accountable community leadership role plays a key role in health, health improvement and social care.

— Successful outcomes in health, health improvement and social care are being achieved by effective partnerships and joint working between local authorities and PCTs.

— This joint working should be built on to deliver Commissioning a Patient-led NHS and the forthcoming White Paper on health and social care.

— The LGA, and partners, are developing an approach “The future of health and adult social care: a partnership approach for well-being” which seeks, through local authority and PCT partnerships, to create an environment which supports user choice and control through delivery of services that are built around what each person actually wants and needs to meet their health and care needs but also improves their well-being.

— The approach builds on existing developments currently taking place around partnerships, neighbourhoods and governance, and in particular local area agreements which can foster an effective partnership approach for the future. A summary of the approach is outlined in this evidence and a copy of the paper will be circulated to Select Committee members when published.

— For the approach to succeed PCTs will need a clear relationship with local authorities. Arrangements to take forward a shared public health and social care agenda work best where local authority and PCT boundaries are co-terminous.

— It is imperative that PCT reorganisation should not cause disruption where effective partnerships already exist or jeopardise arrangements which have led, for example, to joint posts, integrated teams and pooled/aligned resources.

— PCT reorganisation should not hinder other joint working for example in the delivery of Every Child Matters and development of Children’s Trusts or with Crime and Disorder Reduction Partnerships.

— The speed of consultation and communication process of Commissioning a Patient-led NHS is a matter of strong concern. The Department of Health and the External Panel should be clear that the SHA proposals clearly indicate the level of engagement with local authorities and reflect how their views have been taken into consideration in the recommendations.

— In recognising the impetus for efficiency savings there is a need to ensure detailed cost/benefit analysis has been undertaken. In taking forward “The future of health and adult social care: a partnership approach for well-being” this approach could help deliver efficiency and effectiveness through joint delivery of back office functions and processes.

RATIONALE BEHIND THE CHANGES

Local government provides the democratic local community leadership for an area to pursue community well-being and develop community strategies enabling them to target need. Local authorities therefore play a key leadership role in the health, health improvement and social care of their communities and ensure that this is embedded into the well-being agenda. Partnership working is key to health, health improvement and social care and local authorities have been developing successful and effective partnerships with Primary Care Trusts (PCT).

This joint working has included working through the Local Strategic Partnerships; developing strong health and social care outcomes within local area agreements; joint appointments, integrated teams and pooled/aligned resources.

For example integration has been achieved through joint appointments and arrangements—a number of local authorities and PCTs have jointly appointed Directors of Public Health. Joint appointments can be a powerful tool for achieving synergy and collaborative working. In Gateshead the Centre for Enabling Health Improvement was formed by the Council and the PCT as a public health network centre to support all the workforce responsible for improving public health in its area. It acts as a central point for resources for health improvement; promotes opportunities to network and learn and develop skills and knowledge. There are many areas in which joint working between local authorities and PCTs takes place including: promoting healthy lifestyles and health prevention; combating and treating drug addiction; promoting independent living; mental health learning; equipment for older people; and safeguarding children.

The Association understands the impetus for a more patient-led NHS to ensure that local people are more involved within the services they wish to see delivered. This needs to be set into a context within which partnership working is able to flourish and where we can create an environment which supports user choice and control through the delivery of services that are built around what each person actually wants, not only to meet their health and care needs but also to improve their well-being.
LIKELY IMPACT ON COMMISSIONING OF SERVICES, PROVISION OF LOCAL SERVICES AND ON OTHER PCT FUNCTIONS INCLUDING PUBLIC HEALTH

It is important that the changes outlined in Commissioning a Patient-led NHS are considered in conjunction with the development of the White Paper on health and social care. In many respects it would have been more appropriate for any restructuring to take place once there was clarity on provision. A number of authorities have commented on the logic of “form following function.”

The White Paper, and the changes from Commissioning a Patient-led NHS, could provide a real opportunity to meet the needs of local communities by building on the strong local partnerships between local authorities and health organisations. The LGA, together with the NHS Confederation, the Association of Directors of Social Services and other partners, is developing an approach based on key strategic developments currently taking place around partnerships, neighbourhoods, governance and, in particular, local area agreements, which would ensure the delivery of health, health improvement and social care tailored to the needs of the community and responsive to local circumstances. It could join up health care, health improvement and social care in a stronger and more cohesive way, making services more reflective of local needs, whether at the strategic local authority or neighbourhood level.

This approach works through the local partners agreeing, following extensive local consultation and engagement, the strategic vision for the area with the local authority and PCT working in partnership to deliver the vision. This would be supported by integrated commissioning and quality assurance processes, joint workforce planning and development and an effective, shared local performance management framework. With the well-being agenda focussed firmly at the centre of local strategic planning, there would be increasing focus on ensuring that NHS and local government planning processes are closely aligned.

It would be imperative that local partners have the local flexibility to determine commissioning arrangements, as this would ensure that local delivery arrangements fit the pattern of local needs and place peoples’ needs, entitlements and rights at the centre of new arrangements for delivery. Partners across the public, community, voluntary and independent sectors would decide local solutions for delivery through developing an integrated strategic commissioning framework. They would work together and share good practice, streamlining local commissioning and contracting arrangements to ensure efficiencies are maximised.

It would also bring the opportunity to look at the development of local provider vehicles, which in some cases could be for the local authorities to provide some of the services contracted out by PCTs possibly establishing joint provider vehicles for local health improvement and for health and social care provision. These vehicles could include social enterprises, social firms and other models. It would enable services to be built around different access points in local communities such as schools, GP’s surgeries and existing council premises.

This is very much an approach rather than a model as each locality should decide its own partnership components and structures depending on local circumstances. It will be able to build on existing developments, such as Local Area Agreements and existing examples of effective partnership working across all local agencies. The partnership would be accountable through strengthened health scrutiny built on extensive public involvement and participation of local partners. It would require the support of GPs to engage in the well-being agenda and an integrated inspection framework.

For this approach to succeed it will be important that PCTs have a clear relationship with local authorities. We believe that arrangements to take forward a shared public health and social care agenda work best where local authority and PCT boundaries are co-terminous, at an absolute minimum with upper tier local authorities with the flexibility to develop strong locality arrangements. It is imperative that PCT reorganisation should not cause disruption where effective partnerships already exist, or jeopardise arrangements which have led for example to joint posts, integrated teams and pooled/aligned resources. Within reconfiguration “one size will not fit all” and there will need to be different local solutions.

There are also concerns that change can create a hiatus, as it can be time consuming, and could deflect NHS focus from partnership working. This could lead to some local authorities also pursuing developments on hold and being concerned about entering into further pooled budget arrangements where there appears to be instability. This is particularly important as the next round of local area agreements are being developed. If there is to be change it will be important that there are detailed discussions on how existing relationships should be maintained, expanded and managed through the transition period.

The partnership working between health and social care also impacts across may other areas and it is important that the changes to PCTs do not hinder the arrangements, for example, to the delivery of Every Child Matters and Children’s Trusts or the work of the Crime and Disorder Reduction Partnerships where PCTs are actively engaged with local authorities in community safety work and the drugs and alcohol agenda.
CONSULTATION ABOUT THE PROPOSED CHANGES

The Association was not involved in consultation prior to the publication of Commissioning a Patient-led NHS.

We are concerned at the process through which the changes were announced and the subsequent consultation process. It is understood that the consultation process by SHAs has varied across the country. However in general, strong concern has been expressed by many of our member authorities with regard to the timing of the process, which was over the summer, and the way in which they have or have not been engaged. It has led to a feeling that the changes were being rushed and that in some instances what was being proposed was a “fait accompli.” In some instances there was also concern about how much the views of the local authorities had been reported back to the SHA Board.

It is therefore important in considering the SHA proposals, the Department of Health and the External Panel, seek to ensure within the proposals that:

— there has been very clear consultation with local authorities, at all tiers;
— there is an indication of the views of the local authorities; and
— an indication of how the views were taken into consideration within the recommendations.

We would also expect extensive engagement of all local authorities in the forthcoming statutory consultation process.

LIKELY COSTS AND COST SAVINGS

There are concerns that the emphasis for the changes appear to be around the savings. It is recognised that there is a need to deliver savings but that this should be undertaken within the context of savings within the public sector, particularly given the Government cross sector approach to efficiencies. The approach described earlier in this submission should mean that delivery is more efficient and effective. Joint delivery may lead to back office functions and processes being shared and lead to synergy between different workforces.

In commenting on the savings element of the reconfiguration local authorities raised the following issues:

— concern that, with the speed at which proposals were developed, it was not clear how much work had been undertaken on risk assessment and detailed costings;
— delivering savings through changing management structures was too simplistic; and
— the savings generated within their local area may not be significant set against the larger deficits of PCTs.

Local Government Association
8 November 2005

Memorandum submitted by Macmillan Cancer Relief (PCT 39)

INTRODUCTION

1. Macmillan Cancer Relief helps people who are living with cancer. Every day around 740 people in the UK are told they have cancer. More than one million people in the UK today have had a cancer diagnosis, and more than one in three will be diagnosed at some time in their life.

2. Macmillan Cancer Relief works in partnership with others to improve cancer services and influence change. We work with a range of partners, including the voluntary and private sectors, hospices and local authorities, but our main partner is the NHS, with whom we’ve been working since the 1970s. In all of these scenarios, the partner organisations retain responsibility for staff employment.

3. Macmillan’s range of community based services include more than 2,800 nurses, 360 GPs as well as other doctors and health and social care professionals, cancer care centres, a range of cancer information services and centres, practical help at home, carer’s schemes, and benefit advice projects. We also contribute to the funding and development of cancer facilities.

4. The nature of cancer is changing. Treatments are more effective, survival rates are increasing and mortality rates are declining. The five-year relative survival rate for 21 major cancers increased by more than 10% between the period 1971–5 and 1986–90.25 The way cancer patients are treated is also changing. Four

out of five cancer patients now receive radiotherapy treatment as outpatients. While patients undergoing or recovering from cancer treatment, or else receiving palliative care, will predominantly be living at home, cancer services are still concentrated in the acute sector.

RECOMMENDATION: Macmillan believes that cancer should be seen as a major priority for the primary care and social care sectors, and not just an acute care, or end of life, issue.

MACMILLAN’S EVIDENCE
5. Macmillan Cancer Relief has invested heavily in developing better cancer services within the NHS over the last 30 years. Using our “pump-priming” model to initiate developments we have co-funded major NHS innovations with the Department of Health for England, notably the clinical nurse specialist, but also more recently Primary Care Cancer Leads, the Gold Standards Framework and cancer information centres. Our developmental model of funding has proven benefits and many of our innovations are reflected in the cancer service Improving Outcomes Guidance and the NICE Supportive and Palliative Care Guidance.

6. Macmillan Cancer Relief is therefore in the unusual position of being able to convey the views not only of its staff and people affected by cancer, but also of Macmillan postholders who are supported by Macmillan but employed by a partner organisation, mostly the NHS. This submission is based on an informal consultation exercise, specifically conducted for this purpose, with Macmillan staff and postholders.

MACMILLAN’S RESPONSE TO THE PROPOSALS
7. We welcome the suggestion that “as a general principle” PCTs will have a clear relationship with local authority boundaries. We hope this will make it easier to identify need and to secure the support of both health and social commissioners (and providers) of local services.

8. We also welcome the Government’s recognition that commissioning is a specialist skill and believe that “Commissioning a Patient-Led NHS” represents an opportunity to develop a clearer framework of strategic planning and management based on population needs and wants.

9. We do have some concerns about the current reform proposals. Sir Nigel Crisp’s letter (dated 28 July 2005) sets out a number of criteria against which SHAs’ proposals will be assessed. We have used these criteria as the basis for our submission.

RECOMMENDATION: We ask that the Committee recommends that the Government takes action to ensure that our concerns about the possible unintended consequences of “Commissioning a Patient-Led NHS” are fully assessed and addressed prior to implementation.

CRITERIA: PCTS’ ABILITY TO SECURE HIGH QUALITY, SAFE SERVICES
10. The current “postcode lottery” of care must not be made worse by cutting urgently needed services. We have evidence which suggests that sector uncertainty created by additional reform, in the context of current financial difficulties, is resulting in unwillingness by some PCTs to make long-term service commitments. For example, Macmillan regional services teams and postholders are telling us that specialist cancer and palliative care services, and specialist palliative care teams, including those supported by Macmillan, are being cut, fragmented and/or current vacancies are not being filled because PCTs will not commit to long-term funding.

11. Macmillan has made a huge investment into community palliative care services—all of which has been raised through public donations which we have a duty to protect. Over the past five years, in England, we have invested approximately £230 million in cancer services and created more than 3,000 posts. We are anxious to ensure that this investment is not jeopardised and to avoid significant impact on people affected by cancer and post-holders. Given our “pump-priming” funding model, the reforms present our organisation with a number of questions about the viability of our on-going funding strategy. Unless our considerable investment is safeguarded we may be forced to reconsider our funding strategy.

RECOMMENDATION: Macmillan asks the Committee to seek assurances from the Government that current and future funding for cancer services is guaranteed and that NICE Supportive & Palliative Care Guidance will be fully implemented. We also ask that assurances are sought that Macmillan’s significant investment in cancer and palliative care services will be safeguarded into the future.

CRITERIA: PCTS’ ABILITY TO IMPROVE HEALTH AND REDUCE INEQUALITIES
12. We are concerned that, in cutting primary care services, there will be a growing divide in importance and resources between primary and secondary care, with hospitals continuing to enjoy the “lion’s share”. If this happens, the NHS is at risk of undermining its policy to reduce unnecessary admissions to hospital and to improve care in the community. We believe there is a danger that this will, in turn, undermine Government attempts to improve primary care through the forthcoming integrated Health and Social Care White Paper.
13. The evidence described above also illustrates that specialist palliative care services in the community are at high risk. We are concerned that if reconfigured PCTs are not prepared to fund specialist palliative care posts this will undermine the Government’s policy objective of increasing choice in end of life care. Without access to 24-hour community-based specialist palliative care services it will be impossible to enable patients to die at home if this is their choice.

14. We are also concerned that the reorganisation of PCTs should not threaten the future of cancer networks. Sir Nigel Crisp’s letter makes no mention of the importance of cancer networks despite the National Audit Office recommendation that such networks should be strengthened. Strong cancer networks are essential to ensure that cancer services are well co-ordinated, that services are reconfigured in line with the NICE Improving Outcomes Guidance, and that commissioning of cancer services is not fragmented. However, unless the new PCTs are committed to funding the infrastructure (ie network management posts, user involvement facilitator posts, etc) these networks will be further weakened.

RECOMMENDATION: We ask the Committee to urge the Government to take action to ensure that PCTs recognise the value of specialist cancer and palliative care services and clinical networks in co-ordinating and planning cancer services.

15. Effective commissioning, planning and provision of services must be supported by good quality public health information. We believe there needs to be clear lines of responsibility for ensuring accurate intelligence about demographics and patient need. We are unclear where such responsibility will sit within reconfigured PCTs.

RECOMMENDATION: Macmillan asks the Committee to recommend that there is greater clarity over the responsibility for public health information to ensure future commissioning is based on demographics, prevalence and other trends.

CRITERIA: PCTs’ Ability to Improve the Engagement of GPs and Rollout of Practice-Based Commissioning with Demonstrable Practice Support

16. We note that the current version of the GMS contract places little emphasis on cancer. The current NHS Cancer Plan also focuses predominantly on improving access to secondary care.

RECOMMENDATION: Macmillan would like the Committee to seek assurances from the Government that Practice-Based Commissioning and the updated GMS Contract will give greater priority to improving cancer and palliative care in the community.

CRITERIA: PCTs’ Ability to Improve Public Involvement

17. While the Government has recently undertaken a considerable consultation exercise about the principles of patient-led care (“Your Health, Your Care, Your Say”), there has been little patient or public involvement in the actual proposals set out by Sir Nigel Crisp to reconfigure primary care structures. Macmillan Cancer Relief has been, and continues to be, a major charitable funder of NHS cancer services and we would very much welcome the opportunity to engage with Government on these vitally important reforms.

18. We believe user involvement posts and structures in cancer care at PCT and network levels must be maintained and that the current precarious and fragile funding for such posts needs to be resolved. It is vital that these structures remain and flourish if commissioning and provision of services is to be based on patients needs in the future.

RECOMMENDATION: We ask the Committee to recommend that voluntary organisations are more involved in the future development and implementation of proposals, that service users are fully consulted, and that funding for existing mechanisms for user involvement are guaranteed.

CRITERIA: PCTs’ Ability to Improve Commissioning and Effective use of Resources

19. We understand the policy intention behind “Commissioning a Patient-Led NHS” to increase contestability/the range of service providers and thereby increase choice for patients. However, people affected by cancer already experience lack of coordination, which in turn leads to inadequate care, and are confused about which services are available and from whom. A more mixed market of care may create more uncertainty and confusion for people affected by cancer, and may increase the risk of poor communication between the different professionals and agencies involved.

RECOMMENDATION: Macmillan asks the Committee to urge the Government to ensure that, in a mixed market of care, more emphasis is given to high quality patient information about available services, and that patients are supported and helped to interpret this information, so that they can make informed choices and decisions. We believe that cancer patients need a single key contact (a navigator) throughout the patient journey to help them navigate the maze of health and social care services.
CRITERIA: PCTs’ Ability to Manage Financial Balance and Risk, and Deliver at Least 15% Reduction in Management and Administrative Costs

20. We recognise the need to reduce costs. However, as outlined above, we are concerned that specialist care and roles will be cut as a consequence.

21. We are also concerned that the drive to reduce management costs will be passed on to providers which will have an impact on services commissioned from the voluntary sector who may not be in a position to absorb management costs.

RECOMMENDATION: Macmillan asks the Committee to recommend that the Government confirms its commitment to specialist services in primary care, including the role of the clinical nurse specialist in cancer and palliative care.

CRITERIA: PCTs’ Ability to Improve Coordination with Social Services Through Greater Congruence of PCT and Local Government Boundaries

22. While we welcome greater co-terminosity of health and local authorities, we do not think that co-terminosity alone will guarantee joined up services. Given the complexity of the cancer journey, we believe a whole patient pathway approach must be taken. We see the potential for fragmentation of existing services which work across organisational boundaries and are concerned that there is the potential for breakdown in communication between professionals. The benefits of collaborative work may then be dissipated. As we have emphasised earlier, cancer networks provide the key to ensuring that cancer services are commissioned according to need and are well-co-ordinated.

RECOMMENDATION: We recommend that the Committee seeks assurances that cancer networks will be sustained to ensure that care planning and management happens across whole patient pathways.

Macmillan Cancer Relief
7 November 2005

Memorandum submitted by the Multiple Sclerosis Society (PCT 21)

1. About the MS Society

1.1 The MS Society welcomes the opportunity to submit evidence to the Health Select Committee’s inquiry into changes to Primary Care Trusts.

1.2 MS is the most common disabling neurological disorder affecting young people in the UK with an estimated 85,000 affected by the disease. MS is a disease of the central nervous system where myelin, the protective sheath surrounding the nerve fibres of the central nervous system, is attacked and damaged. MS is unpredictable and can cause a wide variety of symptoms such as loss of mobility, pain, fatigue, vision problems, numbness, loss of balance, depression and cognitive problems. The disease may progress steadily or involve periods of active disease followed by periods of remission.

1.3 The MS Society was established in 1953, and is a UK-wide charity dedicated to supporting people who have MS, as well as providing help to those people’s families, friends, carers and colleagues. A significant number of our trustees, staff and volunteers either have MS or a personal connection with MS.

1.4 The Society provides care and support through services which include running a national information and helpline service, publications, a website that receives more than 40,000 visitors each month, welfare grants, funding research, funding MS specialist nurses and delivering respite care. Our annual budget is £26 million.

1.5 We are a democratic organisation of over 44,000 members. Our network of 340 branches delivers local improvements in service delivery to people with MS across the UK; they also play a vital role in our fundraising.

1.6 We aim to ensure that people affected by MS are involved in all decisions.

2. Terms of Reference—Rationale Behind the Changes

2.1 The recent political focus on improving health and social care services is welcome. Various recent initiatives and consultations have been launched by the Government with this aim.

2.2 A number of these key proposals established specific schedules—the NSF for Long-Term Conditions (NSF-LTC) outlined a 10 year strategy, the PMSU report Improving the Life-chances of Disabled People proposed improvements by 2020.
2.3 Many people felt that these proposed time-frames were too long, and that more needed to be achieved in the short-term. However, while the MS Society recognised this concern, we also felt that it was important that any developments and reforms were launched with deliberation, effectively consulted on, and based on coherent strategy.

2.4 When Sir Nigel Crisp published his intentions to reform PCTs, outlined in Commissioning a Patient Led NHS (hereafter CPLN), we were specifically concerned about the operational deadlines it contained.

2.5 We believe that such deadlines may not be able to effectively incorporate the findings of the Your Health, Your Care, Your Say consultation. Concerns were raised by MS Society members that the contents of the White Paper on health and social care had already been decided.

2.6 The Committee should note that recent reports in Health Service Journal stated that the majority of PCT chief executives were critical of the direction outlined in CPLN. Of those surveyed, 87% stated that the Department of Health’s approach was “rushed”. 65% felt that it was “political”.

2.7 The MS Society encourages the committee to investigate the legislative context in which CPLN was developed, and analyse the interrelationship between other proposed initiatives.

3. TERMS OF REFERENCE—LIKELY IMPACT ON COMMISSIONING OF SERVICES

3.1 Practice Based Commissioning

3.1.1 The MS Society is concerned about how specialist services for people with long-term conditions will be commissioned, following the implementation of the direction proposed in CPLN.

3.1.2 Many people affected by MS have expressed concern about the relatively limited understanding of MS shown by their GP and other primary care professionals.

3.1.3 However, given the relatively low number of people with MS on GPs lists, this is understandable.

3.1.4 For many people, their main contact with health professionals following diagnosis is with neurologists and specialist MS nurses. Many have expressed concern that accessing this expertise will be made more difficult by the direction established in CPLN—with services potentially being spread across a range of providers, people are concerned that it will be difficult to navigate where and who can provide them with the quality health care services they require.

3.1.5 We are concerned whether Practice Based Commissioning can effectively address the needs of people with MS; specifically, we question whether by the deadline of end 2006, the commissioning of specialist services using the proposals outlined in CPLN can be done in a framework which understands the complex and fluctuating conditions of people with MS.

3.2 PCT responsibility for placing or managing contracts

3.2.1 Traditionally, specialist services for people with MS and other long-term conditions have not been seen as a priority for PCTs.

3.2.2 The MS Society currently funds a number of specialist MS nurses across the country to ensure that people with MS are able to access the specialist services they require. This commitment was undertaken to address gaps in service provision for people with MS.

3.2.3 We are concerned that CPLN may have a detrimental effect on the recruitment and retention of quality specialist MS nurses and other specialist staff.

3.2.4 We strongly encourage the committee to investigate whether the proposed direction set out in CPLN will have a detrimental impact on the recruitment of specialist MS nurses and other specialist staff.

3.3 Implementation of the long-term conditions NSF

3.3.1 The NSF-LTC sets out a comprehensive strategy for delivering services across health and social care.

3.3.2 This strategy, and its specific neurological focus outlined in the 11 quality requirements it contains is welcome.

3.3.3 However, without clearly defined targets to be met, there has been concern that the 10 year implementation programme will not be effectively managed.

26 Health Service Journal, 8 September 2005.
27 In lieu of any Department of Health strategy to address this concern, the MS Society is developing a guide designed to improve GPs’ understanding of MS.
3.3.4 Similarly, without additional resources for implementation, we are also concerned about how effectively the NSF-LTC will be developed.

3.3.5 In the context of CPLN, the MS Society encourages the committee to investigate whether the strategy of the NHS will be undermined in the direction proposed.

4. TERMS OF REFERENCE—LIKELY IMPACT ON PROVISION OF LOCAL SERVICES

4.1 Integration

4.1.1 It has been clear from work conducted on previous consultations, and discussions with MS Society members, that a significant barrier to the provision of quality services for people with long-term conditions had been the lack of coherent integration between health and social care.

4.1.2 The legislative context had previously indicated that proposed changes to social care structures would lead to more legitimate integrated service delivery between health care and social care.

4.1.3 The MS Society welcomed this intention established in Independence, Well-being and Choice (IWC). This reflected the views of our members who had commented that quality delivery which met their total care needs was suffering from this lack of integration.

4.1.4 It was also stated that many people were not concerned about the complexities of commissioning and structural reform. They expected a more person-centred approach which offered flexibility in service delivery, and adequately recognised the complexity of fluctuating conditions. What structural changes that led to was felt to be less important to people using services than the desire to see such services implemented.

4.1.5 Commissioning a Patient Led NHS (CPLN) proposes a number of changes which will impact on the delivery of both health care and social care. The MS Society believes that it is important that the previous agenda which established an intention to provide more integrated care is not lost as a result of CPLN.

4.1.6 Similar concerns have been voiced that the potentially progressive suggestions which appeared in IWC may be lost not only as a result of CPLN, but also in the forthcoming white paper on “health outside hospitals”.

4.1.7 It is therefore vital that the Committee’s investigations explore the impact CPLN will have on improving integration between health and social care.

4.2 Coterminality between SHAs, larger PCTs and Local Authority Social Service Departments

4.2.1 We welcome the intention to make larger PCTs coterminal with Local Authority Social Service departments.

4.2.2 The MS Society believes this has the potential to release large management cost savings which we expect to be reinvested in service delivery.

4.2.3 We recommend that some of the problems highlighted earlier (para 3.3) with implementation of the NSF—particularly concerning resources—should be considered in the context of proposed coterminality.

4.2.4 We agree that SHAs should be reconfigured to be coterminal with Regional Government, and would welcome clarity from both the Department of Health and the Committee’s findings about how this structure will be developed.

4.3 Voluntary sector delivery

4.3.1 We encourage the Committee to investigate the scale of the expectation around voluntary sector delivery of specialist services.

4.3.2 Oftentimes, the voluntary sector will produce materials providing information and support for the people they represent—addressing specific areas of concern, or providing clarity on new initiatives which may impact their lives.

4.3.3 These services from the voluntary sector have been developed following an awareness that there aren’t similar resources developed elsewhere—the voluntary sector is addressing gaps in the delivery of information and support that was unmet by resources from the Government.

4.3.4 With greater emphasis being seemingly placed on using the voluntary sector, we urge the committee to investigate exactly how that relationship would work, with specific reference to funding, accountability, and autonomy.

4.3.5 We also encourage the committee to consider the role that the voluntary sector could have in being at the heart of the development of legislation. We believe this could utilise the expertise available in such organisations. It could also provide greater awareness of how legislation could be developed to more accurately meet the specific circumstances of people with long-term conditions.
5. TERMS OF REFERENCE—CONSULTATION ABOUT PROPOSED CHANGES

5.1 The MS Society is concerned that the current consultation exercise, Your Health, Your Care, Your Say (YHYCYS) will not be able to adequately contribute to the directions proposed in CPLN.

5.2 It is significant that this listening exercise should reflect the views of those who have responded—certainly proposed changes which arise from YHYCYS will have been significantly affected by the directions established in CPLN.

5.3 It is also vital that any consultations are undertaken as comprehensively as possible. We are concerned that the short time-frame established in CPLN.

5.4 However, many members of the MS Society feel that they have already responded to a significant number of consultations, which seek their views on how best to provide specialist services which will address their need.

5.5 For some people, further consultations may discourage them from believing that services are likely to meet the needs they have previously established.

5.6 The MS Society urges the committee to investigate how any associated consultations to CPLN are undertaken comprehensively, while reassuring people that quality service delivery will result from these changes.

6. TERMS OF REFERENCE—LIKELY COSTS AND LIKELY SAVINGS

6.1 As mentioned earlier in this document, we are concerned that inadequate resources are being committed to delivering these reforms.

6.2 Certainly, without adequate resources being allocated, or new funds being given for implementation of other key strategies (such as the NSF-LTC mentioned earlier), we are concerned that the proposed reforms are unrealistic.

6.3 Additionally, we urge the committee to investigate whether the cost saving proposals will provide the necessary funding for implementation. The MS Society are sceptical about whether this can be achieved.

KEY RECOMMENDATIONS

1. The MS Society encourages the committee to investigate the legislative context in which Commissioning a Patient-led NHS was developed, and analyse the interrelationship between other proposed initiatives.

2. We are concerned whether Practice Based Commissioning can effectively address the needs of people with MS; specifically, we question whether by the deadline of end 2006, the commissioning of specialist services using the proposals outlined in CPLN can be done in a framework which understands the complex and fluctuating conditions of people with MS.

3. We strongly encourage the committee to investigate whether the proposed direction set out in CPLN will have a detrimental impact on the recruitment of specialist MS nurses and other specialist staff.

4. It is vital that the Committee’s investigations explore the impact CPLN will have on improving integration between health and social care.

5. We agree that SHAs and larger PCTs should be reconfigured to be coterminus with Regional Government, and would welcome clarity from both the Department of Health and the Committee’s findings about how this structure will be developed.

6. With greater emphasis being seemingly placed on using the voluntary sector, we urge the committee to investigate exactly how that relationship would work, with specific reference to funding, accountability, and autonomy.

7. We encourage the committee to consider the role that the voluntary sector could have in being at the heart of the development of legislation. We believe this could utilise the expertise available in such organisations. It could also provide greater awareness of how legislation could be developed to more accurately meet the specific circumstances of people with long-term conditions.

8. The MS Society urges the committee to investigate how any associated consultations to CPLN are undertaken comprehensively, while reassuring people that quality service delivery will result from these changes.

9. The MS Society urges the committee to investigate whether the cost saving proposals will provide the necessary funding for implementation. The MS Society are sceptical about whether this can be achieved.

The Multiple Sclerosis Society

November 2005
Memorandum submitted by the National Council for Palliative Care (PCT 28)

1. **BACKGROUND**

The National Council for Palliative Care (NCPC) is the umbrella organisation for all those involved in providing, commissioning and using hospice and palliative care services across England, Wales and Northern Ireland. It promotes the extension and improvement of palliative care for all who need it across all sectors and in all settings.

The aims of the new arrangements announced by the NHS Chief Executive in July are:
- To ensure the commissioning of services that improve population health.
- To enable real patient choice.

The principal proposals are:
- To bring forward by two years the introduction of practice-based commissioning for all general practices.
- To reconfigure Primary Care Trusts to reflect the progressive transfer of major elements of the commissioning function to general practice level.

2. **LIKELY IMPACT ON THE COMMISSIONING OF SERVICES**

For palliative care the principal question arising from the proposals is whether they will lead to more effective commissioning than is possible within current arrangements. The Council’s present conclusion is that there is no evidence to suggest that they will.

2.1 The essential requirements for commissioning palliative care services are as follows:
- Population-based needs assessment involving analysis of the epidemiological, demographic and socio-economic factors that influence palliative care need.
- An understanding of all the potential domains of palliative care need in individual patients and their families.
- A knowledge of what models of service delivery are most effective in meeting palliative care need.
- A knowledge of how patients would wish to see services delivered.
- An understanding of the areas of care and support in which patients would wish to exercise choice eg over place of death.
- An assessment of the service volumes that may be needed to meet population needs and the exercise of patient choice.
- Development of service specifications that would guarantee delivery to good practice standards.
- Accreditation of providers who can deliver to such standards.
- An agreed price for service delivery.

2.2 All of these requirements are being met within the current arrangements for commissioning palliative care services.

1. Population-based needs assessment—This is being undertaken at Cancer Network and PCT levels in all 34 Cancer Networks using a nationally developed methodology.
2. Domains of patient and family need—The NICE Guidance on Supportive and Palliative Care Need published in March 2004 contains a comprehensive description of the potential domains of need. It was put together with the involvement of service users.
3. Effective models of service—The NICE Guidance sets out evidence-based recommendations for the essential core service components for any population.
4. How services should be delivered—User groups have been set up at Network level and more locally to capture patient and carer views.
5. Patient choice—Use of tools such as the Gold Standards Framework for Primary Care, the Liverpool Care Pathway for the Dying Patient, the Preferred Place of Care model and the development of common approaches to individual patient and carer assessment are all helping to identify and meet patient choice.
6. Service volumes—The methodology for needs assessment referred to above includes guidance on how to estimate service volumes.
7. Service specifications, accreditation of providers, national tariffs—A programme of work has been established for the introduction of Payment by Results for specialist palliative care services in both the NHS and the voluntary sector. It covers all these subject areas.

In general, palliative care providers in both the NHS and the voluntary sector are supportive of the current and developing arrangements for commissioning and would be concerned if they are disturbed by the new proposals.
2.3 The Importance of Managed Clinical Networks

Although Cancer Networks have no formal responsibility for commissioning services, they have taken the lead in assembling the information necessary for commissioners to carry out their function eg through needs assessment, establishment of user groups. Cancer Networks should continue to take that lead and we recommend their role should be strengthened for the future. Neither general practices nor individual PCTs (current or reconfigured) are well placed to take it over.

2.4 Commissioning Specialist Palliative Care Services

In order to function efficiently and effectively services need to be based on and organised for populations that are greater in size than most current PCT populations. As a result it is now common practice for two or more PCTs to be clustered to provide a population of appropriate size. Consequently the proposal to reduce the number of PCTs is to be welcomed. Also welcome is the proposal to align PCT and local authority boundaries which would facilitate enhanced integration of health and social services.

However, the proposal to transfer much of the commissioning function to general practice level is generating concern. The fear is that the current arrangements for commissioning that work well may be disturbed, that commissioning could become fragmented with the loss of collaboration and continuity between services.

Eve Richardson
Chief Executive, The National Council for Palliative Care
7 November 2005

Memorandum submitted by the National Infertility Awareness Campaign (PCT 45)

I am writing on behalf of the National Infertility Awareness Campaign (NIAC) with regard to the Health Select Committee’s inquiry into Changes to Primary Care Trusts.

NIAC is an umbrella organisation representing views from across the full range of organisations involved in the field of infertility, including patient groups, professional bodies and pharmaceutical companies. For over a decade it has been campaigning for fair and equal access for all to fertility services on the NHS and the eradication of the “postcode lottery” of treatment that currently exists.

It was therefore with great interest that we read the terms of reference for this inquiry, which clearly has implications for the future provision of these services. We have therefore taken the opportunity of submitting this brief memorandum setting out our comments on the proposed changes. The comments follow the order of the inquiry’s terms of reference.

RATIONALE BEHIND THE CHANGES

NIAC supports the rationale behind the need to review the way in which Primary Care Trusts (PCTs) operate, which is based on the recognition that services are not being provided effectively under their current configuration. In no area is this more evident than in the provision of infertility services.

Traditionally, infertile couples have faced huge inequities in access to treatment on the NHS, resulting in around 80% having to seek their treatment privately. NIAC therefore greatly welcomed the publication by the National Institute for Health and Clinical Excellence (NICE) of a clinical guideline on infertility in February 2004. The guideline set out the much-needed structure required to provide infertility services on the NHS to all those with an agreed clinical need regardless of where they lived.

However, despite it being the first piece of guidance in which the Government directly intervened by issuing an instruction on how it expected PCTs to implement it, progress in meeting NICE’s recommendations has been slow and very patchy. According to a recent report by the Audit Commission, this is mainly due to poor planning and financial management by PCTs.

NIAC therefore supports the need to reorganise PCTs to ensure that access to services are improved and patients’ needs are met. However, the process by which this is done requires careful management by Government to avoid creating even further delays to the provision of services. Some central coordination is essential: at present, plans for reorganisation are being drawn up by Strategic Health Authorities, which means that they may differ from one part of the country to another. This approach runs the risk of exacerbating the inconsistencies in services across the UK as a whole, to the detriment of patients.
Likely Impact on Commissioning of Services

Infertility treatment falls within the Specialised Services National Definitions Set because some assisted reproductive techniques, the most well-known of which is in-vitro fertilisation (IVF), are provided at a limited number of specialist clinics that tend to cover several PCTs. The arrangements for commissioning specialised services are based on PCTs working collaboratively according to local needs, but have to date raised significant concerns over their effectiveness.

NIAC shares these concerns and welcomes the Government’s decision to review these arrangements as part of the overall changes to PCTs. It seems clear that in some parts of the country PCTs face considerable financial pressures, but at the same time are failing to plan adequately for future services, leading to funding not being made available for some treatments. Historically, infertility services have always suffered from low prioritisation when it comes to funding, particularly if there is little or no expertise in commissioning this type of service. NIAC would therefore support a move that encouraged PCTs to improve their financial management and plan ahead to ensure that patients’ needs are met.

Likely Impact on Provision of Local Services

Given the low priority traditionally accorded to infertility services, NIAC would like to see any reorganisation of PCTs incorporate measures to increase the level of patient involvement in priority setting. This would help to ensure that specialised services, which fall outside mainstream commissioning, were not overlooked.

More importantly, there needs to be some direction from Government on access to these services in order to eliminate the inequalities that currently exist. A specific example of this would be the need for centrally set eligibility criteria for access to infertility services. At present, PCTs can set their own criteria, which vary considerably from one part of the country to another, essentially denying treatment to couples on the basis of where they live. Finally, we would like to see a robust system put in place for monitoring the effectiveness of specialised commissioning and for taking action against PCTs that fail to meet patients’ needs.

Likely Impact on other PCT Functions, including Public Health

NIAC agrees that a greater emphasis should be given to prevention, particularly with regard to health conditions that could be avoided through changes to lifestyle and diet. With regard to infertility, it is important that people are fully informed about the factors that can cause the condition and about they ways in which they can reduce the chances of becoming infertile.

Alongside this, it is essential that GPs also receive adequate information to be able to advise patients that are having problems conceiving, and that a clear pathway is developed from GP referral to treatment to ensure that those couples that go on to require assistance are investigated and treated as quickly as possible.

Consultation about Proposed Changes

NIAC support the Government’s plans to conduct a consultation on changes to PCTs and, in particular, would welcome a full consultation on any plans to change the current arrangements for the commissioning of specialised services.

Likely Costs and Cost Savings

The objectives of an effective commissioning structure are to ensure that patients are being offered the “right treatment by the right provider at the right time” (Department of Health, Review into Commissioning Specialised Services—background notes, July 2003). Ensuring access to the most appropriate treatment at the time of need not only benefits patients, but also saves the NHS money by reducing wastage from inappropriate interventions and increased costs of treating patients at a later stage.

This is particularly the case with infertility services, where ensuring that patients have access to a full range of treatments means that they are able to benefit from the treatment that is most appropriate for them. A review of commissioning, as part of the proposed changes to PCTs, should focus on addressing this point to ensure that arrangements are both clinically and cost effective.

I do hope these comments are taken up by the Committee and look forward to following the progress of its inquiry.

Clare Brown
Chair, National Infertility Awareness Campaign
10 November 2005
Memorandum submitted by the NHS Alliance

1. INTRODUCTION

1.1 The NHS Alliance is recognised as the principal independent representative organisation for primary care. Its membership includes both primary care organisations in the UK and GP practices while individual membership is fully multi-professional, including NHS managers, doctors, nurses, allied health professionals, pharmacists and other primary care professionals together with PCT board chairs and non-executives. In particular it reflects the critical partnership between lay people, managers and clinicians in planning, securing and evaluating efforts to improve the health of local populations.

1.2 Its 10 professional networks have a growing role in sharing good practice and informing strategy and policy. In additions, the NHS Alliance is unique in bringing together practices and primary care trusts in planning, securing and evaluating local health services.

1.3 The NHS Alliance is committed to values of fairness, equity and collaborative working within a structure that is mutually supportive and accountable. Both national and local organisations have an important role to play in delivering those values.

2. RATIONALE BEHIND THE CHANGES

2.1 Since their inception, Primary Care Trusts (PCTs) have been concerned to balance “local engagement” with “critical mass” in the discharge of their threefold responsibilities:

— Commissioning health care.
— Providing primary and community health care services.
— Improving health.

2.2 Commissioning a patient-led NHS demonstrates the Government’s commitment to the first of those core functions: commissioning high quality, modern, patient centred care. The NHS Alliance welcomes that commitment and supports the direction of policy. Nevertheless it is concerned that the top-down approach so far adopted in implementing Commissioning a patient-led NHS may not deliver the widespread improvements that government and health professionals wish to see. Organisational design that is the product of close working between SHAs and PCTs with front line clinicians and local communities is more likely to be successful. The Secretary of State for Health recently emphasised that this is to be regarded as fundamental in the assessment of reconfiguration proposals. The Alliance fully supports that approach.

2.3 A recent report commissioned by the NHS Alliance from the Health Services Management Centre: Reconfiguring PCTs—influences and options (April 2005) described the perception that many PCTs are struggling to fulfil their range of functions within current resources and management capacity. Criticism has focussed on the alleged failure of PCTs to have sufficient impact on secondary care provision. It is argued that individual PCTs possess too small a population base for effective commissioning of secondary care. In fact, the average population size of PCTs is now 175,000 while other factors are involved in weak commissioning, including: financial pressures, central targets, lack of contestability and pressure from Strategic Health Authorities (SHAs) to support Acute Trusts that are experiencing financial difficulties. The NHS Alliance is not aware what evidence exists to support the proposals from a number of SHAs for forced mergers giving 1:1 co-terminosity between PCTs and County Council boundaries, or in some cases large PCTs that cross several adjoining unitary authorities.

2.4 As a result of the factors described above, well before the publication of Commissioning a patient-led NHS many PCTs were already engaged in or considering forms of integration short of full merger. Amongst them are the Greater Manchester Association of 14 PCTs; Hampshire and the Isle of Wight where 10 PCTs work together in a confederate model, and joint arrangements in West Yorkshire where 15 PCTs—covering four health economies and five local authorities—have collaborated through a confederate model since 2001. There are a number of models around the country. All of these result from organic growth that encourages organisational design to be the product of close working between front line clinicians and local communities. They focus on pro-active solutions rather than the analysis of problems which too often leads to a “one-size-fits-all” approach.

2.5 That approach in preparing proposals for reconfiguration has led to particular concerns. In a recent NHS Alliance survey of PCT PEC chairs, 77% said that local circumstances and patient needs have not been given proper consideration in preparing proposals for the reconfiguration of PCT boundaries. Although some SHAs have carried out exemplary consultation in preparing proposals, a principal issue for many PCTs has been the lack of local clinical engagement in the process. This will be an important challenge for re-configured PCTs.

2.6 A further rationale for Commissioning a patient-led NHS is said to be the opportunity to save 15% in PCT management costs. This issue is addressed in detail under the heading “Likely costs and cost savings” below. However the NHS Alliance/Health Services Management Centre joint paper found that numerous studies have shown that mergers of health care organisations generally fail to deliver cost savings.
3. **Likely Impact on Commissioning of Services**

3.1 The term “commissioning” has sometimes been used in the narrow sense of describing how health services, particularly secondary care, are contracted and funded. This definition is incomplete and too narrow. It reinforces adversarial relationships and results in fragmented services secured through different mechanisms. From the patient’s point of view, this has meant disjointed and uncoordinated provision. Commissioning at its best is collaborative, encouraging integrated care and placing patient needs and population health improvement at the heart of the process. It involves a cycle of activities:

- Needs identification and assessment.
- Service planning.
- Securing services (through appropriate possibly different mechanisms).
- Monitoring.
- Evaluation, then leading back to a new round of needs identification and assessment.

3.2 Commissioning of primary, community and secondary care services will, in future, take place at two levels:

- Strategic commissioning, at PCT level.
- Practice based commissioning, at the level of individual GP practices or groups of practices.

3.3 In addition, each PCT will be responsible for blocked-back commissioning. This is direct commissioning carried out on behalf of those practices who do not wish to be actively involved in practice based commissioning, or who wish to commission a limited range of services. There are indications that a substantial number of practices may, initially at least, prefer this option.

3.4 Strong clinical leadership and engagement, already at the heart of the most effective Primary Care Trusts, is essential to the commissioning and provision of excellent health care. Local clinical engagement is also key to other planks of the health reform agenda, notably practice based commissioning, choose and book, payment by results and electronic prescribing.

3.5 Clinician leaders are concerned that the current implementation of *Commissioning a Patient-led NHS* may weaken clinical engagement. The recent NHS Alliance survey of PCT PEC chairs found that:

- 78% said that current proposals for PCT reconfiguration would weaken engagement with GPs (while 65% said it would “significantly weaken” engagement).
- 84% said reconfiguration would weaken engagement with other clinician groups such as nurses and allied health professionals (while 64% said it would “significantly weaken” engagement).

3.6 The NHS Alliance is fully supportive of Practice Based Commissioning, reflecting the Government’s intention of devolving decision making to front line clinicians working closely with the communities they serve. The Alliance has long promoted the view that PCTs and other primary care organisations should provide “umbrella support” and not “hierarchical oversight” to their constituent primary care practitioners. However, many PEC chairs—six out of 10 of those who responded to the recent NHS Alliance survey—fear that reconfiguration as currently proposed will disrupt the implementation of practice based commissioning.

3.7 Achievement of this policy objective will depend upon clear direction as to how clinical engagement and clinical decision-making will be formalised within new Primary Care Organisation structures. Many clinicians—GPs, nurses and allied health professionals—have been alarmed at the way PCT reconfigurations have been proposed without their input. They fear that current plans—including both restructuring and divestment of local management—will lead to weakened commissioning at both PCT and practice levels.

3.8 Two issues in particular were not discussed in Commissioning a patient-led NHS:

- The role of the PEC or any similar clinical forum in the reconfigured PCTs.
- The importance of engagement with clinical groups other than GPs, including nurses and other health professionals.

3.9 The NHS Alliance argued strongly in its recent paper: *Commissioning a patient-led NHS: fitness for purpose and clinical engagement*, for the retention of the PEC in the form of a clinical executive with satellite clinical forums at locality levels. Effective strategic commissioning and blocked-back commissioning are both dependent upon good clinical leadership at PCT level. As well as GPs, nurses and other clinician groups have a critical a role to play in strategic commissioning (and blocked back commissioning). Similar arrangements at regional and Department of Health levels would benefit NHS effectiveness and efficiency.

3.10 There are currently some 3,000 professional members of PCT PECs. The NHS Alliance would wish to see reconfiguration implemented in a way that does not discard this existing knowledge and expertise.
4. **Likely Impact on Provision of Local Services**

4.1 Typical services provided by PCTs are outlined in an appendix to this document.28

4.2 The NHS Alliance supports the principle of contestability in primary and community care. The key issue is the separation of decision making between commissioning and provision, so that the one is not prejudiced by the other. Divestment of the provider function is one way of achieving this, but not the only one. The NHS Alliance welcomes the Secretary of State’s recent clarification that divestment will not be required without the agreement of the PCT. In order to avoid damage to patient services, decisions on divestment should be made locally, with full consultation and discussed in public session. Policy should be agreed by the PCT and its stakeholders—including patients and the public—without interference or pressure from SHAs.

4.3 Primary and Community Care Services are hugely complex in their design and indivisible from Social Care provided by Local Authorities. They are also fashioned by the particular local character and culture of the environment in which they are delivered. In view of the experience of involving the private sector in the national Independent Sector Treatment Initiative the NHS Alliance would wish to see more evidence of modelling and piloting prior to limited private sector involvement.

4.4 Reconfiguration and re-structuring of PCTs will inevitably dissolve good local partnerships, trust and knowledge. That will impact upon health and social care partnerships, in particular the management of long term conditions and the Choosing Health agenda.

4.5 There are particular issues for the primary and community nurse workforce, where the demographics are such that, by 2008, as many as 25% could opt for retirement. Many nurses have expressed dismay at proposals for the divestment of the provider function and concern that fragmentation of services may compromise their professional roles. At the same time, there are particular anxieties about nurse training including the provision of adequate numbers and quality of clinical placements for student nurses, together with cost implications if this responsibility is transferred to alternative providers.

4.6 The breadth of services provided in primary and community care by PCTs has expanded substantially over the past five years, as the NHS Alliance publications *Can Do!* (2004) and *Fast Forward* (2005) illustrate. Primary and Community Care staff have already demonstrated their capacity to innovate change and champion the interest of patients. There is a strong case to support the wider national dissemination of best practice that exemplifies the founding principles of the NHS, in parallel with the modelling and piloting referred to above.

4.7 Ultimately, human services depend on constructive relationships, integrity and trust. (*Reconfiguring PCTs: influences and options*, NHS Alliance/Health Services Management Centre, April 2005) Evidence—as well as common sense—tells us that mergers are more likely to be successful where there is a focus on the human and cultural aspects of integration, actively gaining the support of staff as well as other stakeholders. The NHS Alliance would recommend this approach.

5. **Likely Impact on other PCT Functions, including Public Health**

5.1 The key challenges for the NHS over the next 20 years are:

— Improving the health of the population, addressing inequalities in health and promoting self-care.

— Delivering cost-effective services in the community and reducing demand for expensive hospital care.

— Improving information systems and our knowledge and understanding of effective public health interventions.

5.2 All of these require public health skills and we already know that there is a shortage of public health capacity. How *Commissioning a patient-led NHS* addresses the issue of public health and health improvement will be critical to success. The NHS Alliance is encouraged by the decision that all posts linked to Choosing Health will be protected in the planned re-organisation.

5.3 The NHS Alliance believes that public health has four key functions:

— Improving health and reducing inequalities.

— Developing partnerships, community involvement and joint approaches to community development with the local authority.

— Informing the commissioning of services (best practice, best value and evidence).

— Clinical governance—development and use of better information systems for disease surveillance and quality control of service delivery.

5.4 The Alliance believes that this broad range of functions can be divided into two components:

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28 Not printed here.
— A community focused public health function that needs to deliver reductions in inequalities and improvements in health through partnership and community involvement (the first two functions listed above).

— A narrower specialist public health function that encompasses the third and fourth functions.

5.5 The first of these functions is essential for delivery of the Wanless “fully engaged” scenario and ideally this function needs to operate through civic engagement with a single PCT operating in partnership with a single local authority. There is a risk that large PCTs with responsibility for commissioning expensive hospital services and covering more than one local authority will give pre-eminence to the narrower specialist function required to support commissioning and clinical governance at the expense of local public health advocacy and leadership.

5.6 Concerns have also been raised that emergency planning functions may be overlooked. Emergency planning requires strong relationships at the local (borough) level. Large PCTs, covering a large populations and several local authorities, may struggle to maintain the appropriate links at a senior level. Some PCTs are concerned about a lack of health protection expertise at the local level, a problem experienced in some areas after the last NHS reorganisation in 2001–02 and the creation of the Health Protection Agency, which removed specialist health protection staff from PCTs and located them in large Health Protection Units at a county level.

5.7 Commissioning a Patient led NHS also sets out plans for the transfer of existing provider services in PCTs, such as district nursing and health visiting, community based therapy services etc, to other organisations. This has caused much concern for PCTs because of fears that there would be difficulties in mobilising staff and resources in a separate organisation (or organisations) in the event of a pandemic, such as the predicted flu pandemic.

5.8 The NHS Alliance believes there is a need to clarify the public health and emergency planning responsibilities of the proposed new SHAs alongside the responsibilities of existing Regional Public Health teams linked to Government Offices in the regions.

5.9 Current arrangements for patient and public involvement need strengthening. Primary Care Trusts (and their predecessor organisations Primary Care Groups) were based on concepts of “natural communities” that would allow the promotion of community health and engagement of local stakeholders in decisions about priorities and resource allocation. Commissioning a patient-led NHS does not address how public and patient involvement will be taken forward.

6. Consultation about Proposed Changes

6.1 The NHS Alliance has already registered concern with Ministers about those proposals for reconfiguring PCTs that have been prepared with insufficient participation of Primary Care Trusts themselves, local clinicians and other local stakeholders. It is understood that these will be referred to an independent scrutiny panel. The Alliance is reassured by the Secretary of State’s statement of the criteria that proposals will need to meet before being allowed to proceed to the consultation stage. However, concerns remain about the proposed timing of the formal consultation and ability to engage local stakeholders.

6.2 In similar vein, the speed of implementation will make difficult any useful involvement by local people. It is not clear if Overview and Scrutiny Committees or Patient and Public Involvement Forums will be able to formally comment or influence the changes.

7. Likely Cost and Cost Savings

7.1 Evidence from both the public and private sectors illustrates that mergers consistently fail to deliver planned cost savings. The NHS Alliance believes that there is a great deal of scope to achieve further efficiency gains in the delivery of health and social care services apart from organisational change. It has published instances of these and more are coming to light as a result of the Your health, your care, your say exercise. At the same time, the Health Services Management Centre has suggested, in a presentation to the NHS Alliance 2004 annual conference, that mergers typically result in organisational paralysis for around six months. Given that reconfiguration is taking place at the same time as the implementation of other radical NHS reforms, that may lead to additional unanticipated costs.

7.2 According to Reconfiguring PCTs— influences and options, the NHS Alliance/Health Services Management Centre paper referred to above, there is little evidence for the positive effects claimed for increased size of primary care organisations. One recent review of more than 30 studies in the UK and USA found no evidence that increases in population generate costs savings or improvements to performance. Many studies have questioned whether mergers deliver cost reductions, economies of scale.


or improvements in efficiency. 31 The economic benefits of merger are typically modest 32 and these savings may be outweighed by a combination of unanticipated costs. These include the direct costs of merger and the unintended negative consequences such as loss of morale and productivity resulting from disrupted relationships and communication patterns. 33 Consequently the NHS Alliance welcomes the Secretary of State’s announcement that future PCTs may be small or large and that there is no national template for them.

7.3 Perhaps the most important issue to bring to the Health Committee’s attention is the need to avoid the potential disruption to patient care that some professionals see as a likely consequence of the wholesale changes proposed. That would require genuine consultation with local clinicians, NHS managers and populations. Ironically, the price of achieving short term savings in PCT management costs could be increased health care costs in the future.

NHS Alliance
November 2005

1 NHS Alliance networks:
   — The NHS Alliance national federation for practice based commissioning.
   — The leadership network (for PCT chief executives, Board chairs and PEC chairs).
   — The non-executive network (for PCT non-executive board members).
   — The PEC chairs network.
   — The modernisation and commissioning leads network (with clinician-manager pairs representing most PCTs).
   — The nurse network (for nurses working in primary care, including district and community nurses, health visitors, school nurses, practice nurses, etc).
   — The practice managers network (for GP practice managers).
   — The allied health professional and primary care professionals network (for physiotherapists, occupational therapists, speech & language therapists, etc, together with pharmacists and other primary care professionals).
   — The health network (for all those with an interest in public health, including but not limited to public health professionals).
   — The clinical governance network (for clinicians with a clinical governance role).
   — The specialists in primary care network (for consultants and specialist doctors employed in primary care; examples include community paediatrics, geriatric medicine, diabetes medicine, dermatology, genito-urinary medicine, and more).

Memorandum submitted by the NHS Confederation (PCT 22)

INTRODUCTION

1. The NHS Confederation welcomes the inquiry on the impact of the proposed changes outlined in Commissioning a Patient Led NHS (28 July 2005); the subsequent clarifying letter from John Bacon dated 26 August 2005 on the configuration and future roles of Primary Care Trusts (PCTs); and the recent statement by Rt Hon Patricia Hewitt MP, Secretary of State for Health on the changes to PCT provider function dated 25 October 2005.

2. The NHS Confederation is a membership body that represents over 93% of all statutory NHS organisations across the UK, including 90% of Primary Care Trusts (PCTs) and 100% of Strategic Health Authorities (SHAs). Our role is to provide a voice for the management and leadership of the NHS and represent the interests of NHS organisations. We are independent of the UK Government although, of course, we work closely with the Department of Health and the devolved administrations.

3. Our evidence sets out our general views, based on feedback from a cross section of our member forums, on the current situation regarding the implementation of the proposed changes. Where appropriate, we have also included more specific comments on the questions asked.

32 Goddard and Ferguson, 1996.
33 Fulop et al, 2002.
OVERVIEW

4. The NHS Confederation is supportive of the general direction of Commissioning a Patient Led NHS. We support strengthening the commissioning functions of PCTs, the development and full implementation of practice based commissioning, and increasing the choices available to patients through an extension in the range of providers delivering community and primary care services.

5. The Confederation believes that the proposed changes to PCTs must be seen in the context of the overall reform of the NHS and the drive to ensure that the healthcare system is increasingly focused on the delivery of personalised care through efficient, effective and universally high quality services.

6. Any discussion on the future of PCTs must however recognise their many achievements since their inception in 2001. They have played a crucial part in the delivery of many key NHS targets. In particular they have worked closely with local authorities, other local strategic partners, the voluntary and community sector and with patient and public groups to deliver more home based services, closer integration with social services and new approaches to health promotion. This is demonstrated by the very positive comments of many local authorities on the current NHS structure.

7. It should also be noted that clinical engagement with primary care contractors eg GPs, Pharmacists etc has shown significant progress in many areas although there is still room for further improvement in increasing engagement. Many PCTs developed and implemented approaches to engaging clinicians in commissioning prior to the introduction of the current policy.

8. Many PCTs have also recognised the need to reduce back office functions and a significant number are already sharing management teams across more than one PCT. Others have been experimenting with shared commissioning models which have allowed them to obtain greater leverage with the hospital sector and make best use of scarce expertise without the need for structural change. An example is the Association of Greater Manchester PCT’s joint approach to commissioning across the conurbation.

9. It is within this context that the NHS Confederation will now address the specific questions posed by the inquiry.

RATIONALE BEHIND THE CHANGES

10. The NHS Confederation supports the continued importance of commissioning, assuring the provision of high quality services and of health improvement as the three core functions of PCTs in line with the direction set out in Shifting the Balance of Power (2001) and re-affirmed in Commissioning a Patient Led NHS. Indeed we stressed the importance of commissioning during discussions on Foundation Trusts as we believed it is a necessary but neglected component of the current reforms.

11. We welcome the commitment to develop the commissioning function within PCTs and see this as essential for the reformed health system which requires a dynamic balance between strong commissioners, capable of actively managing the healthcare system and an extended and more flexible range of providers.

12. The proposed organisational development and fitness for purpose process will be of paramount importance in ensuring that commissioning structures and expertise are strengthened. We strongly support this initiative and believe it will facilitate the development of strong corporate Boards, with high levels of expertise in both executive and non-executive members. We also believe that, in view of the hard choices that face commissioners, these Boards must be well connected to their local populations and to local clinicians and that OD processes will need to support the development of robust mechanisms to achieve this.

13. We believe that the Improving Health and Social Care White Paper, due to be published in late 2005 is an extremely important document focusing for the first time on the whole range of services delivered outside hospitals. It could have wide-scale implications for the future organisation and functions of community services, the degree of plurality developed and the level of integration with social care. These issues may impact on the future functions of PCTs. Management theory suggests that organisational form should follow the clear definition of function.

14. We are concerned therefore that, as the new organisational boundaries of PCTs will be agreed and consulted upon before the future functions of the organisations are clarified, there is the possible risk of further changes being needed once the functions are finally confirmed. The Confederation believes that, if this were the case, it would be detrimental to the stability of PCTs, staff morale and clinical engagement in the short to medium term. This is particularly concerning as significant numbers of clinical staff in PCTs are over 50 years of age and the service would be hard hit if uncertainty prompted an increase in early retirement. In view of this, NHS Employers, part of the NHS Confederation, is working closely with government and Unions.

15. Nevertheless, we recognise that there is a difficult set of judgements to be made about the appropriate pace of change. Once a potential restructuring is announced in an NHS which has experienced many previous changes, it is very difficult to focus attention on the purpose of the change and the potential benefits to patients whilst individuals are uncertain about their personal futures. Our members have split views about whether the best action now is to proceed with the commissioning changes as rapidly as possible or whether a slower pace is desirable. The announced changes to the time-scale for the review of provision and the devolution of this responsibility to the new PCTs has been seen as helpful by a majority.
16. The NHS Confederation believes that much of what has been gained over the past five years has been by finding local solutions to local issues, increasingly through partnerships with social care, housing and the voluntary and independent sectors. We believe that this approach offers the best opportunity to develop the range of community services which will allow an increase in the proportion of care delivered outside hospital. We would argue therefore that in determining the configuration of PCTs, co-terminosity with these local strategic partnerships should be given high priority and we welcome the emphasis placed on this in both Creating a patient led NHS and Commissioning a patient-led NHS. We recognise however that this will deliver new PCTs which vary greatly in size and scale.

17. A second key function is the development and support of practice based Commissioning Groups. This will require PCTs to work at smaller neighbourhood levels with groups of GP practices. There is a conundrum here: organisations that are co-terminous at a large County Council level will need strong locality structures which are adequately resourced whilst PCTs co-terminous with small Unitary Authorities will need to share functions with other similar organisations or to cover more than one Unitary Authority.

18. Acute and Mental Health members also support the need for enhanced commissioning and have been critical of fragmented commissioning when carried out by small PCTs without strong co-ordinating mechanisms. They are, in general, supportive of the move to larger geographical units and some acute Trusts have argued that these should be co-terminous with the catchment populations of hospitals. This would disrupt relationships with local government and, although it might strengthen secondary commissioning, the benefits of closer integration of community services would be lost.

19. This means, in our view that there is no simple or single solution for configuration. Every case must be determined on its merits and tested on whether locality arrangements are sufficient for large PCTs and whether collaborative mechanisms are robust for small PCTs. We welcome the appointment of an independent review panel which will ensure that these vital questions are given appropriate priority. We conclude however that reconfiguration should only be considered where functions, including strengthened commissioning arrangements, would be better delivered as a result of the changes. The key test must be whether better service will be delivered for patients.

20. Although a major consideration for change is the proposed savings of £250 million, including a requirement outlined in Commissioning a Patient Led NHS for 15% saving in management and other costs by PCTs, reconfiguration will not of itself necessarily save money when taken net of staff and infrastructure costs. There is evidence that re-organisation does not usually produce savings (The process and impact of NHS trust mergers: a qualitative study and management cost analysis (Fulop et al, 2001)).

21. The necessity of developing strong, appropriately resourced locality structures in the larger PCTs may also reduce the potential benefits of fewer organisations. We have not seen the detailed modelling of the costs of the new structures and cannot therefore comment in more detail. We are however not convinced that the proposed savings can be released purely through the savings from reducing the number of organisations and believe that wider sources of savings will be needed.

**Likely Impact on Commissioning of Services**

22. There is general agreement that commissioning has been the area where some PCTs have been weakest. The reasons for this have been explored in a recent NHS Confederation briefing and can be summarised as:

- The need to analyse and understand the difficulties of and lessons from commissioning in health authorities.
- Lack of investment in a range of tools, techniques and expertise required to create a more professional approach to commissioning.
- Lack of bargaining power due to fragmentation of commissioning.
- Disengagement of clinicians when local PCT priority setting was pre-empted by centrally directed targets.
- The use of line management techniques and performance management which were frequently confused with commissioning.
- The lack of any real status in commissioning as an area of managerial expertise at PCT level.

23. These findings support the strengthening of the commissioning function within PCTs. We did not however find unequivocal evidence for the thesis that provision of services has distracted the PCTs from their commissioning responsibilities. In a recent survey, PCT Chief Executive members were almost equally split between those who believed that divesting provision would be beneficial to commissioning and those who believed it would not. Some argued strongly that being able to provide allowed them to respond rapidly to develop more appropriate patterns of non-hospital care which strengthened their negotiating position with the acute sector. This group believe that losing the ability to provide will actually weaken commissioning. It is therefore unproven in our opinion whether the wholesale divestment of provided services by PCTs will, of itself, improve these commissioning functions.

24. Some of our non PCT members, including Foundation Trusts, believe that PCTs should divest the provision function to allow them to focus more effectively on commissioning.
25. Strengthening of the commissioning functions will, we believe, also require increased investment to ensure that new skills and enhanced commissioning functions are incorporated into the new organisations.

26. The NHS Confederation, therefore, welcomes the emphasis on commissioning within the new PCT structures but does not believe that this, in itself, will ensure fitness for purpose or deliver the savings sought within Commissioning a Patient Led NHS.

**Likely Impact on Provision of Local Services**

27. As discussed above, many of our members argue that allowing PCTs to provide services is a strong lever to drive the shift of services from secondary care to primary care, enabling as it does rapid introduction and development of new or improved services. With increased plurality, the skills to develop and manage new services would allow new services to be developed where there was no current external expertise. Finally, it is envisaged that the new PCTs will become providers of last resort. To do this requires some operational skills to be available.

28. In general, we support increased plurality within the health service and believe that it offers the opportunity to develop new and imaginative services for patients. There are many good examples already of services provided for hard to reach groups by the voluntary sector and some very imaginative new services for example home telemetry, provided by the private sector. Indeed plurality is already common in services for older people and for those with mental health problems. However, we believe that it is also the case that many community services are not necessarily either of a size or nature where contestability would be advantageous to the patient. Rural proofing of potential service configurations may also be necessary.

29. In addition whilst small services could be subject to competition, the potential benefits would have to be balanced against the increased transactional costs, potential fragmentation of care and lost economies of scope and scale. The NHS Confederation, therefore, believes that the key test for divestment of provision should be that contestability offers demonstrable patient benefit and service improvement. This argues for case by case assessment against a clear understanding of which services need improvement rather than a simple requirement to divest provision.

30. Therefore, we strongly welcome the recent statement by the Secretary of State which clarifies the flexibility available to PCTs. We do, however, accept that there needs to be a robust separation of commissioning and provision within the PCT as to ensure probity. Most PCTs already work in this way.

31. There is significant interest in our broader membership in becoming providers of community and primary care services. We have supported a network of organisations interested in the use of APMS (Alternative Personal Medical Services) as a tool for delivering better services. A number of acute Trusts also believe they could offer new and improved services that deliver better integration along care pathways. We believe that there are real benefits to be had from some of these new models and that PCTs should be encouraged to explore these where they are appropriate to local circumstances.

32. We are most concerned about the anxiety that the current uncertainty is causing for clinical staff in PCTs. They are often very proud of working for the NHS and this needs to be recognised. We hope that the Secretary of State recent announcement will help give reassurance to this vital group of staff. As employers we are committed to ensuring that they are treated fairly and given the appropriate safeguards. NHS Employers is committed to taking a key role in this aspect of the work.

**Likely Impact on other PCT Functions, including Public Health**

33. Whilst the greatest debate has been about the split of provision and commissioning, we are pleased that health improvement will remain a function of the new PCTs. In most cases, these activities are best undertaken in conjunction with other local stakeholders eg local authorities, voluntary and community sector through partnership arrangements such as Local Strategic Partnerships and Local Area Agreements.

34. Successful partnership working depends to a great extent on the development of robust relationships which foster trust and enable challenge and innovation at various levels in the organisations concerned. This is further support for our belief that the configuration of the new PCTs should enable the maintenance of co-terminosity with Local Strategic Partnership groupings at top tier local authority level. This will help ensure that, wherever possible, the learning from and good practice examples of partnership are not lost in continuing the development of services targeted at reducing health inequalities.

35. The NHS Confederation recognises and agrees that there are efficiencies to be gained from rationalisation of back office functions such as human resources and financial services either by cross organisational working between NHS organisations at local level or between health and local authority partners. We support initiatives to ensure that as high a proportion of resources as possible is invested in direct patient care.

36. However, we do believe that good services require good management. We are aware of the comments of external inspectors such as the Healthcare Commission and the Audit Commission that the service is under-managed. We believe therefore that the new structures must be properly resourced for their functions...
and be given sufficient time to bed down and deliver the required reforms. Structural change, however effectively managed, runs the risk of diverting attention from the real challenge of delivering improved services for patients.

**Consultation about Proposed Changes**

37. The timescales outlined in *Commissioning a Patient Led NHS* have constrained the extent to which the pre submission proposals have been subject to full local consultation. This has caused concerns in some areas. We believe it is important therefore that formal consultation should be extensive and robust to ensure that all stakeholders have the opportunity to explore the implications of the structural changes proposed locally. Where appropriate, this should include local overview and scrutiny committees as strong relationships with local government will be essential to the success of the new organisations.

**Likely Costs and Cost Savings**

38. Any reconfiguration will have costs associated with it, particularly those relating to recruitment, redundancy, contract and asset transfer, dissolution of old organisations, establishment of new organisations and staff development and re-deployment costs. The new larger PCTs may also need a further infrastructure, with its own costs, to ensure local responsiveness and engagement with practice based commissioners. Alternative structures may be necessary to take account rurality and other local differences. Exact values are difficult to estimate until the final configuration of organisations is agreed.

39. The NHS Confederation understands that any cost savings will need to be net of these costs. A recent survey of PCT Chief Executives found that, whilst there was overwhelming agreement that financial targets would be met in 2005–06, some organisations would struggle to reach balance. The number estimating that achieving financial balance would be difficult increased when asked about 2006–07. Reconfiguration costs were felt to be a major pressure in forward plans.

40. We have not seen the detailed financial models of the changes so cannot comment in detail. We do however believe that the costing model should be a major part of the assessment process for each of the structural proposals together with an assessment of the benefits that will be delivered to the health and social care community. This may change the decision if the costs of restructuring outweigh the costs of other methods of strengthening the commissioning functions of PCTs. We believe that it is important that the benefits of the changes to patients are made explicit together with the costs and savings. This will help ensure that there is support from the public as well as key stakeholders including NHS staff and organisations and local government.

**Conclusion**

41. The NHS Confederation is broadly supportive of the changes to PCTs outlined in *Commissioning a Patient Led NHS*.

42. We welcome the commitment to strengthen the commissioning functions of PCTs and the continued commitment to health improvement.

43. We believe however, that reconfiguration proposals and the divestment of provision both need to be considered carefully at local level to ensure that they will deliver the intended benefits for patients and that the risks of change can be effectively managed.

44. Finally, the NHS Confederation welcomes this inquiry and the opportunities it raises to further refine the process already underway across England to change the role and functions of PCTs. We are pleased to have been asked to give evidence.

*NHS Confederation*

*October 2005*

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Memorandum submitted by Norwich Union Healthcare (PCT 7)

1. Summary

1.1 Norwich Union Healthcare (NUHC) is delighted to submit written evidence to this inquiry and welcomes the investigation into this area of reform in the NHS.

1.2 NUHC recognises that good commissioning is the lynchpin of NHS reforms, yet is underdeveloped and hindering the delivery of value for money from the considerable increases in NHS funding.
1.3 NUHC therefore recently commissioned NERA Economic Consulting to conduct a report on the issues surrounding commissioning NHS services in a rapidly changing environment. This report—Commissioning in the NHS: Challenges and Opportunities—was undertaken in association with the NHS Confederation and Professor Chris Ham of the University of Birmingham. The full report is available at http://www.nera.com/Publication.asp?p_ID=2517.

1.4 The report concluded that Practice Based Commissioning, although to be welcomed, will not be a panacea. The current and future roles of Practices and PCTs in commissioning under the new NHS structure were examined, with the report highlighting the need for “Strategic Commissioners”. Strategic Commissioners would deliver functions that are underdeveloped in the NHS and which need to be aggregated above Practice Based Commissioning. As “enabling bodies”, Strategic Commissioners could be developed either within the NHS, or outside, drawing on private expertise.

1.5 This memorandum seeks to draw the relevant lessons from the Report for the Health Select Committee’s Inquiry into Changes to Primary Care Trusts. It also summarises the key areas that Practice Based Commissioning will have difficulty delivering and the role that a strategic commissioner could play.

2. Introduction to Norwich Union Healthcare (NUHC) and NERA Economic Consulting

2.1 NUHC was founded in 1990 as the healthcare arm of Norwich Union and now provides a range of income protection and private medical insurance products and occupational health services that cover over 800,000 lives. It is one of the largest providers of income protection and private medical insurance in the UK.

2.2 NERA Economic Consulting is an international firm of economists which provides economic analysis and advice to corporations, governments, law firms, regulatory agencies, trade associations and international agencies. The global team of more than 500 professionals operates in 19 offices across North and South America, Europe, Asia and Australia. NERA Economic Consulting was founded in 1961 as National Economic Research Associates and is a subsidiary of Mercer Inc, a Marsh & McLennan company.

3. Summary of NERA Report

3.1 The importance of good commissioning has long been acknowledged. However, there have been difficulties in securing the skills and putting in place the incentives to make it happen effectively. Anticipated reforms should be welcomed because they offer the opportunity to:

3.1.1 correct this historic imbalance; and

3.1.2 respond to changing commissioning needs given other reforms to the NHS.

3.2 In order to make the most of this opportunity, reforms need to address the issues that underlie the development of more effective commissioning in the new policy environment. Questions about the numbers of PCTs are of course relevant. But they are less important than getting the right skills, powers and incentives to commission effectively in place, regardless of the exact identity or size of the commissioner.

4. Rationale for Reform

4.1 Apart from the general desire to harness improved commissioning skills, changes in the NHS environment make now a good time to revisit commissioning structures.

4.2 Important developments in the NHS include Practice Based Commissioning (PBC). This offers significant potential to improve incentives and actively engage clinicians in ensuring that services respond to the local needs of the population. PBC needs to be considered in the light of other key reforms particularly Choice, and Payment by Results (PBR). In particular, by standardising the price and to some extent the terms on which providers are paid for treating NHS patients, and offering patients choice of provider, commissioners will lose control over some of the ways they manage resources, demand and the market.

4.3 Despite the likely benefits of PBC, it should not be regarded as a panacea, and there are a number of specific areas where it will be difficult for PBC to provide complete solutions. These relate to a range of commissioning functions which can not sensibly be delivered at an extremely local level for a variety of reasons, including:

4.3.1 administrative economies of scale in commissioning. In some cases it may be inefficient to deliver functions such as procurement at a very local level. This is particularly the case where there is a need to rely on specialist skills, eg legal or actuarial expertise.

4.3.2 substantive economies of scale in commissioning. For example, it may be easier to manage financial risks associated with high cost low incidence conditions at larger population levels. It may also be more appropriate for a provider of certain services (eg public health, screening, chronic disease management) to manage risks across an entire population of a certain size.

4.3.3 inherent tension between competition and co-operation. Commissioners need to co-operate with providers (including providers such as Foundation Trusts who are likely to be large and have strong incentives to develop services to their own priorities), while also maintaining an element of competitive
tension and negotiating strength (eg to ensure that commissioners have an appropriate voice in service redesign). There is a risk that the views of small commissioners will be swept aside by those of large providers.

4.4 An example is Chronic Disease Management. The potential for chronic disease management to improve health outcomes and avoid the need for unnecessary hospitalisation is being increasingly recognised. This is the case in both seriously ill patients at risk of multiple admission and at the earlier stages of disease. PBC may offer an opportunity to localise some such services, but to be delivered efficiently they may need to be delivered across many neighbouring practices. Services also need to be appropriately integrated with hospital care, without a local acute provider being in sole control of the pathway once a patient has reached an acute setting, which is a risk with small commissioners especially given the incentives of PBR.

4.5 Equally, there may be difficulties in undertaking functions such as contract management at a very local level, where the necessary skills may not exist. In addition, contract management can benefit from analysis of larger samples of data and some elements of contract management can generate confrontation between the parties—for example, auditing invoices when there are doubts about clinical coding. When organisations also need to co-operate in important ways to deliver a good overall service, there are risks associated with this, so it could be better to locate such functions with another organisation.

4.6 It is also the case that, in the past, part of the problem with commissioning has been the pressures that commissioners face to respond to demand, rather than need, in other words, the pressure to deal with short term demand at the expense of planning for the long term. Providers come under quite understandable pressure to deal with cases which present. However, in the face of resource constraints there is a risk that commissioners will underinvest in preventive care or spotting undiagnosed illness.

4.7 In fact, innovative and proactive steps in this area may offer better return in terms of health benefit as well as saving future acute care costs. The approach of health demand mapping to identify undiagnosed diabetes patients being piloted in Slough (Commissioning in the NHS: Challenges and Opportunities—Ch3, 3.4, Box 2) offers an example of an innovative approach to commissioning for the long term. The major reforms discussed by the Department of Health do not in themselves enhance incentives to take this kind of long term view.

5. Implications for PCT Numbers and Functions

5.1 There are clear benefits from reviewing commissioning structures. However, current discussion appears to focus on reviewing the numbers and functions of PCTs, and other health service bodies. Our view is that it is misleading to look at the issues in such a narrow light. Instead, a more considered and fundamental view of how different elements of commissioning would best be organised in the NHS is needed. While there is clearly a “scale” issue with regard to many commissioning functions, there are skills, power and incentives issues, which also need to be considered.

5.2 A framework for encouraging a strategic focus on commissioning and incentivising long-term efficiency could be created by making an organisation explicitly responsible for these areas and incentivising it accordingly. There are a range of models of varying ambition through which this could be achieved. Collectively they could be termed “strategic commissioning”. The table in appendix 1 outlines the potential responsibilities of a “strategic commissioner”, and the rationale for the aggregation of these responsibilities.

5.3 The expertise to deliver effective commissioning across the piece is spread across a range of locations, including the NHS and private sector. Considering the scope to bring in commissioning expertise—whether for narrow or broad tasks—from external sources as well as current NHS bodies offers substantial potential for improving NHS services. The table in appendix 1 outlines some of the skills that could be provided by the private sector, and the report itself outlines structures for introducing those skills.

6. Conclusions and Recommendations

6.1 This submission does not seek to make recommendations about the future number or size of the PCTs. It does however seek to raise the broader questions of skills, function and form that are needed if effective commissioning in the NHS is to be developed.

6.2 The Report clearly highlighted a lack of expertise, skills, powers and incentives to deliver all aspects of effective commissioning under the new NHS structure. We believe the identification, or creation, of “Strategic Commissioners” would help to address this current weakness and ensure patients receive the highest level of care in the NHS.

Norwich Union Healthcare

31 October 2005
Memorandum submitted by Oxfordshire PFI Alert Group (PCT 8)

This group was formed five years ago to raise public awareness and understanding of the issues surrounding the use of the Private Finance Initiative in the NHS. A public debate was held on the subject. Since then the scope has been enlarged to cover other controversial policies including Foundation Trusts, Independent Sector Treatment Centres, Payment by Results and the changes now proposed for primary care. Membership includes representatives of professional bodies, trades unions and community groups concerned with health matters.

1. RATIONALE BEHIND THE CHANGES

Commissioning a patient led NHS appears to increase the speed and extent of the internal market. The development of the purchaser/provider split, Foundation Trusts programme, the introduction of Payment by Results and the requirement to purchase 15% of NHS care in the private sector are already realities. We believe these to be unnecessary, divisive and wasteful of resources.

The longest established, the Purchaser/Provider split, was shown after its introduction in the early 90s to have doubled administrative costs. Early assessment of the first wave of foundation trusts presented a mixed picture but fell far short of being a ringing endorsement.

The National Audit office has already indicated that its early assessment of Payment by Results will lead to increased de-stabilisation for the NHS and in particular for provider units. Attempts to extend the principle to the more long term management of chronic conditions are likely to consume a great deal of resource and professional time.

It would appear to us relevant to question the existence of any evidence in support of these policies.

In Oxfordshire Thames Valley Strategic Health Authority wishes to go a step further by tendering out the leadership and management function of the future PCT. Tenders will be sought from NHS bodies, the voluntary and private sectors. This appears to us to be a major extension of the market and potentially the private sector, into the commissioning of health-care with no proposed consultation, no detail on governance or costs.

This proposal has the unique distinction of uniting all Oxfordshire’s MPs in opposition to it, together with most councillors of all parties. Many non-executive directors of NHS trusts have also expressed dismay.

2. LIKELY IMPACT ON COMMISSIONING OF SERVICES

Reduction in the number of PCTs (from five to one in Oxfordshire) will lead to a diminution in the local knowledge applied to the process and may reduce the frequency and ease of direct contact between primary care and hospital staff.

Commissioning will therefore tend to be based more on economic and managerial decisions than on debate and co-operation between clinicians, at least until practice based commissioning is fully operational. We are concerned that the implementation of both initiatives, at the same time, is going to lead to confusion and difficulties between commissioners and providers and may cause major fragmentation in service provision as well as commissioning.

3. LIKELY IMPACT ON PROVISION OF LOCAL SERVICES

There is lack of clarity on the intentions regarding the provider function of PCTs. “Commissioning a patient-led NHS” refers to decisions on which services a PCT should no longer provide but makes provision for those where it continues to do so. Nigel Crisp’s letter of 28 July states that PCTs should totally shed their provider role by 2008. However, Patricia Hewitt has recently hinted, but not confirmed, that this will be optional rather than mandatory.

There is already an impact on the staff providing these community services in that their future employment is unclear. If it is confirmed that they will no longer be employed by the PCT the uncertainty will remain, with likely effect on recruitment and retention.

The effect of the multiple provider situation beyond 2008 can only be estimated but the instability already being caused by parallel changes in the hospital sector is not reassuring.

4. LIKELY IMPACT ON OTHER PCT FUNCTIONS, INCLUDING PUBLIC HEALTH

Commissioning, rather than purchasing, is based on the rationale of starting from assessing the needs of the population served and then forming a plan of which services and changes are required in order to meet those needs. It is not clear from the proposed changes in Oxfordshire where the public health function of PCTs will sit. Public Health has been an important part of the management and leadership of all of the PCTs. We question where it will sit within a private or voluntary sector team. If they are within the team—will they be answerable to the company they work for? If they are not within the team how will they be able to ensure...
that the commissioning decisions that are made are based on the long-term health needs of the population and not on the need for short-term profits? This may lead to a major increase in inequalities in the health of our population.

5. Consultation about Proposed Changes

In stage 1, para 2 it is stated that any merger changes will be subject to local consultation. In fact the only option being offered for consultation is the move of five PCTs into !. No other option is offered. Thames Valley SHA does not intend to hold any consultation with the public about the major changes in how the PCT will be managed and lead. We are told this is because it is not a change in service provision. However, given the potential consequences of such a change we feel it is essential that public consultation takes place, before the changes happen.

When the future of services currently provided by PCTs has been clarified there must also be clarification of local consultation on proposed changes.

6. Likely Costs and Savings

There will clearly be ongoing savings following the reduction in the number of PCTs but against this has to be set any redundancy payments or compensation for contracts terminated.

In addition there will be the costs of advertising and recruiting to new posts and, no doubt, of new logos and stationery.

The support services needed for practices involved in commissioning should also be taken into account.

The whole question of savings needs to be looked at in the context of recent history.

Since 1997 there has been in primary care—

The abolition of fundholding.

The establishment of PCGs with the initial intention that they should move, at their own pace, through four stages, the final one being becoming a PCT.

2001—the conversion of PCGs to PCTs, the abolition of Health Authorities and Regional offices and the development of SHAs.

2005—recognition that there were too many PCTs and SHAs and drive to amalgamation

By 2006—change to practice based commissioning

By 2008—partial or complete removal of provider role for PCTs

Whatever may be the merits of any of the changes, none has been cost neutral. The changes in provider trusts have also to be taken into account. It is not unreasonable to question how long the current changes will remain in place before once again undergoing substantial modification.

7. Private Management for PCT

Although for obvious reasons this did not appear in the document under consideration, it is of such fundamental significance that it should form part of the Health Committee’s investigation of potential changes to PCTs.

In mid October the Thames Valley Strategic Health Authority suddenly announced that it intended to seek bidders from the private sector for the management function of the new single PCT for Oxfordshire to be formed by amalgamating the current five.

The time table is that the plan has been submitted to the DOH, advertisements will be placed in the EU Journal in November, a list of bids published in February and the successful firm takes over at the beginning of April 2006.

There is to be no public consultation.

The rationale is explained on the basis that the single PCT will be a very large organisation needing unusual management expertise. In fact it will be the size of the former Oxfordshire Health Authority. The argument of size is in any case undermined by the indication from the SHA and the DOH that it is being seen as a pilot for other, smaller, PCTs.

The concept of handing over responsibility for the allocation of a large proportion of the health budget for Oxfordshire to what seems likely to be a foreign based, for profit organisation cannot be allowed to proceed unquestioned by the public or their elected representatives. We believe that the current return for private companies involved in health care is 10%. With a budget of £575 million, this potentially means £57.5 million of tax payers money being handed to share holders. We are already being asked to make £35 million in savings this year. This will mean major reductions in services to Oxfordshire residents.
8. **Recommendations for Government**

8.1 Reject the application by Thames Valley SHA to tender out management function of the future Oxfordshire PCT.

8.2 If the application is not rejected, as suggested in 8.1, a full period of public consultation on the changes proposed for commissioning should occur.

8.3 If the application is not rejected, then explicit guidance on the governance of any tender process and on how the PCT will be managed is required before the process can proceed.

*Mark Ladbrooke*  
Chair, **UNISON Oxfordshire Health Branch**

*Dr Helen Groom*  
General Practitioner and member of PEC, **Oxford City PCT**

*Peter Fisher*  
President, **NHS Consultants’ Association**

*October 2005*

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**Memorandum submitted by the Parkinson’s Disease Society (PCT 36)**

1. **The Parkinson’s Disease Society**

1.1 The PDS was established in 1969 and now has 55,000 members and supporters and over 300 local branches and support groups throughout the UK. The Society provides support, advice and information to people with Parkinson’s, their carers, families and friends, and information and professional development opportunities to health and social services professionals involved in their management and care.

1.2 In 2004, the Society spent more than £2 million on funding research into the cause, cure and prevention of Parkinson’s, and improvements in available treatments. The Society also develops models of good practice in service provision, such as Parkinson’s Disease Nurse Specialists, community support, and campaigns for changes that will improve the lives of people affected by Parkinson’s.

2. **Introduction**

The Parkinson’s Disease Society (PDS) welcomes the Select Committee’s decision to hold an inquiry into the changes to the configuration of Primary Care Trusts and their commissioning role. We are grateful for the opportunity to input into the inquiry to raise our concerns for the provision of a high quality of care and treatment for people with Parkinson’s within the framework of fewer PCTs and Practice Based Commissioning.

3. **The Changes to Primary Care Trusts**

3.1 The Society believes it is of key importance that any change to PCTs and commissioning should be managed in a way that does not undermine the standards of treatment and care outlined in the newly published National Service Framework for Long Term Conditions and in the draft NICE guidelines on Parkinson’s disease.

3.2 In particular we seek reassurance that NICE draft recommendations such as:

- Access to a specialist within six weeks of a suspected case of early Parkinson’s.
- Access to a specialist within two weeks for new referrals in the later stages of the disease with more complex problems.
- All people with Parkinson’s should have regular access to specialist nursing care to provide monitoring and adjustment of medication, a point of contact for support including home visits and a reliable source of information about clinical and social matters relevant to Parkinson’s disease.

3.3 The Society seeks reassurance that the Quality Requirements within the NSF are also properly addressed—particularly the development of personalised care plans for every patient, tailored to their needs. This is crucial for people with Parkinson’s as the condition varies from person to person, fluctuates throughout the day and week to week and changes as their Parkinson’s progresses.

3.4 In addition enhanced medicines management is a critical factor in the ongoing treatment of Parkinson’s. In order to effectively control their symptoms people with Parkinson’s have to take a range of different medications at specific times throughout the day. It is vital that this is recognised and each patient receives the necessary support from trained health and social care staff.
3.5 Palliative care is also a crucial aspect of care for those in the advanced stages of Parkinson’s. A focus on expanding and improving this type of provision such as more beds in hospices is an important step forward. Recent research from the Parkinson’s Disease Society highlights the fragmented and inaccessible services and poor quality care that are too often experienced by people with advanced stage Parkinson’s and their carers.

3.6 The Society believes that the NSF and the NICE Guideline on Parkinson’s, though the latter is in draft, are major steps forward in the drive to ensure that everyone with Parkinson’s is able to access high quality integrated care, tailored to their needs.

It is vital that in the new structures these standards are driven through and that the Department of Health and the Healthcare Commission ensure that this is the case. The Society is concerned that this progress is not lost in the restructuring and that managing long-term conditions effectively is at the forefront of local plans.

3.7 Much of the implementation of the NSF can be supported by the role of the Parkinson’s Disease Nurse Specialist and this is a service that is reported by people with Parkinson’s to be extremely valuable to them in managing their condition successfully. However the current confusion over the proposed changes in provision and commissioning of this service and how the provision of community services such as specialist nurses will be developed is of concern to the Society.

4. Conclusion

While we recognise that local consultations on services will take place, we would very much welcome the opportunity to comment on the changes before they go to local consultation, particularly on the proposals for charity and voluntary sector organisations to take on the provision of services in the community. We would therefore support the Committee in calling on the Government to consult on these proposals so that organisations such as the Society have a full and proper opportunity to input into the reconfiguration of PCTs and the development of Practice Based Commissioning.

Parkinson’s Disease Society
9 November 2005

Memorandum submitted by the Royal College of Nursing (PCT 37)

EXECUTIVE SUMMARY

0.1 The Royal College of Nursing has a membership of over 380,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets. The organisation is the voice of nursing across the United Kingdom and the largest professional union of nursing staff in the world. The RCN promotes quality patient care and nursing interests on a wide range of issues by working closely with government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

0.2 The RCN supports and is working to develop strong commissioning at PCT & practice level. As such we recognise the need to separate commissioning and provision of services in some cases.

0.3 Essential to this is a system of robust and effective clinical leadership and engagement at practice, PCT and SHA level. This should encourage innovation, inform the reform agenda and support practitioners in the delivery of high quality, patient centred services.

0.4 Good health and social care services are based on a strong workforce that is engaged, consulted and which receives proper investment and fair reward.

0.5 The public are entitled to receive seamless services and should not be aware of artificial boundaries between those services. RCN supports a health economy which is characterised by shared good practice, cooperation and collaboration to achieve shared health goals and consists of a broad range of integrated services, freely available at the point of delivery regardless of race, ethnicity, faith, culture, sexuality, gender, age, personal wealth, mobility or social status.

0.6 RCN supports the continued development of a strategically planned, properly funded, effectively delivered, and joined up public health service. This is key to improving the health of the nation, enhancing productivity and promoting social cohesion.

0.7 RCN believes that vulnerable people and services should be protected from the worst excesses of the market and that there should be in place a clear framework of regulation, inspection and protection. This would be concerned with controlling entry and exit to the market; protection of services and staff in the event of market failure; and the promotion of the provision of a broad range of high quality services, universally accessible and relevant to local needs.
1. RATIONALE BEHIND THE CHANGES

1.1 The document *Commissioning a Patient Led NHS* follows on from the policy outlined in CPLNHS which was launched in early 2005. It has also been widely seen as a precursor to the forthcoming White Paper “Healthcare outside hospital”.

1.2 The stated rationale for the contents of the “Commissioning a patient-led NHS” document is as follows;

- Strengthen the function of commissioning through larger strategic Primary Care Trusts (PCTs) and more localised practice based commissioning structures.
- Separate the commissioning and provider functions.
- Make £250 million financial savings by reducing management costs achieved through mergers and organisational reconfiguration.
- Ensure closer working between PCTs and local authorities.
- Develop more pluralistic models of primary care provision, by inviting alternative, non NHS organisations to provide services. PCTs are to remove their provider function, by 2008 unless there are no other suitable providers.

1.3 While the RCN supports any action aimed at improving public health and patient care we are concerned to see that the imposed pace and nature of change has caused uncertainty within PCTs and other parts of the NHS. This is neither in the interest of the public or the staff employed by the NHS. The timescales set by the letter from Sir Nigel Crisp do not allow for meaningful consultation or intelligent, measured and reasoned thinking.

1.4 In summary, the letter from Sir Nigel Crisp (DH gateway reference number: 5312) calls for:

- Practice based commissioning (PBC) to have 100% coverage by December 2006.
- PCTs to only provide services where a case cannot be made for them to be provided by another agency (independent, voluntary sectors and local government). Where PCTs continue to provide services, there will need to be a split within the organisation to ensure that commissioning and service provision are separated so that any conflict of interest is prevented (However the RCN wishes to point out that within practice based commissioning both provision and commissioning will be taking place).
- Contestability is to be introduced into the system, with the aim of improving quality and enabling a level of choice within primary care.
- PCT’s and Strategic Health Authorities (SHAs) to be reconfigured and aligned with government office boundaries.
- All Acute trusts are required to achieve Foundation Trust status by the end of 2008.

1.5 Since the publication of the Nigel Crisp letter the RCN has been made acutely aware of the uncertainty felt by nurses who strive to provide the best possible care in often difficult circumstances. The suggestion that NHS Primary Care services should basically be put out to tender has raised alarm among many community nurses. This anxiety and uncertainty will inevitably distract staff attention away from their core business serving the public good in primary care.

1.6 The announcement of CPLNHS has caused numerous nurses to contact the RCN and voice their grave concerns over the future of community services. We support the widely held view that the significant challenge of implementing CPLNHS will ultimately impact upon Primary Care teams’ ability to deliver upon other significant and challenging Primary Care initiatives such as improving public health (via the choosing health delivery plan); reducing health inequalities; improving the management of long term conditions; developing integrated health and social care teams; improving access to services; and delivering the various elements of the GMS contract.  

2. LIKELY IMPACT ON COMMISSIONING OF SERVICES

2.1 The RCN fully supports the development of strong commissioning, in the knowledge that effective commissioning aims to ensure that all services address local health needs, diminish health inequalities, promote health and improve patient care.

“Commissioning is a strategic activity concerned with the development of new look services to meet the identified health and health care needs of local populations”  

2.2 Where effective commissioning is achieved, the public should expect:

- Improved health experience.
- Solutions to their local community health problems.

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— Quicker and easier access to services regardless of their age, ethnicity, ability, social class, gender, race or health status.
— Their complex care needs to be met by the most appropriate people.
— Seamless and co-ordinated care from the multi disciplinary team. The patient will be unaware of organisational structures and false boundaries.
— The opportunity to influence the provision of local services—people need to be listened to and their views respected.

2.3 In order for commissioning to be effective, nurses need to be involved at all levels—PCT, PBC and SHA and contribute to the following essential functions:
— Providing strategic leadership on the new PCT and SHA boards through strong professional networks and provision of evidence-based clinical advice.
— Having clear clinical leadership roles in the commissioning process especially in developing care pathways across traditional boundaries (community, general practice, hospital, local authority (LA), independent and voluntary sectors).
— Contributing to contract specifications, monitoring and the evaluation of services.
— Ensuring partnership working between all relevant agencies.
— Making certain that front line nurses are actively engaged with practice based commissioning and that they hold budgets for nurse led initiatives and specific services for patients and community groups.
— Ensuring that explicit governance arrangements are in place so that clear relationships are defined for SHA, PCT, LA and general practice personnel.
— Facilitate cohesive working between PCT commissioners and those involved in practice based commissioning.

2.4 For many years the RCN has called for more effective commissioning and for the process to focus on improved community health as much as the contracting of secondary care services. Historically primary care services have been financially marginalised in order for acute hospital activity to be funded to meet increasing demand for in-patient services. It is not uncommon for provider budgets in primary care services to be “raided” so that the cost of increased activity at the local acute hospital can be paid for. In this sense we can support the separation of the provision and commissioning of services.

2.5 The RCN supports the Department of Health view on practice based commissioning, which, if executed properly, will enable greater patient choice over services and allow patients with long-term conditions to have access to better and more effective support than previously and thus prevent unnecessary hospital admission.

2.6 Unfortunately the current instability within PCTs could result in nurses and other clinicians not being well placed or have the enthusiasm necessary to fully engage with the new commissioning structures. To put it simply, this could hamper the aspirations of CPLNHS from being achieved.

2.7 The RCN has published much literature on commissioning and run numerous workshops on commissioning with the intention of equipping front line nurses and nurse managers with the skills and knowledge necessary to be effective. We plan to continue this work.

3. **Likely Impact on Provision of Local Services**

3.1 Community services are difficult to understand without the experience of working within the community. They can be complex and on appearance, disconnected and disorganised, often because people live chaotic and marginalised lives requiring services from a number of agencies. The needs of patients being cared for in the community can be far more complicated than their disease or condition would suggest, on account of their personal relationships and living conditions. One justified fear of the recent reforms is that community services are in danger of becoming more fragmented, thus posing genuine danger to people who are ill, needy and living in socially excluded communities.

3.2 Sound and co-operative partnership working between agencies is key to successful community services, making it essential for all reform to focus on improvement in this area not potential compromise.

3.3 Responsible health reform must reflect demographic trends, the need to prevent illness and improve public health, manage long-term conditions better and diminish the need for hospitalisation. This can only be achieved through the development of comprehensive community services which are well resourced and able to employ properly trained, educated and supported staff. It is difficult to see how a variety of small alternative providers can meet this challenging agenda.

3.4 The RCN is currently exploring the issues around contestability so that we have the opportunity to identify what checks and balances may be needed to prevent any potentially inadequate provider of community services being allowed access to the market.
3.5 While the RCN welcomes all efforts to improve innovation within communities, it is essential for commissioners to understand the needs of the people they are there to serve and concentrate particularly on the needs of the most vulnerable people living within their boundaries. One main concern is that provider plurality and market pressures may lead to competitive tensions which do not foster a sense of shared innovation, collaboration and partnership. In this sense, community services, under pressure to compete, will not “join up”.

3.6 Frontline community nurses work closely with the public, community groups and individual patients and are therefore well placed to influence the shape and design of local services. For some years now it has been noted by many NHS managers and policy makers that, for the main part, it has been nurses who have taken the lead in helping to redesign services and, in doing so, have improved access to services and the quality of care for patients. The joint RCN/Department of Health document, “Maxi Nurse” offers many examples on how nurses have expanded their roles and reshaped services to better meet patient needs and wishes.

3.7 Despite the obvious benefits of nurse led services highlighted in the above publication, the RCN has genuine concerns regarding the impact that CPLNHS will have on patient care and how, in the near future, some nurse led and specialist services could be further diminished.

3.8 It has been reported to the RCN that many community nurses who are near to retirement are so dismayed at the prospect of community services being damaged that they will choose to go for early retirement, rather then being forced to work outside the NHS.

4. Likely Impact on other PCT Functions, including Public Health

4.1 The RCN welcomed the “Orford letter” which clearly set out how Public Health functions should be protected from the financial cuts described in Sir Nigel’s letter and further expressing the need to develop, rather than diminish the public health function. Many community nurses, such as health visitors and school nurses have a public health function within their roles which needs to be expanded if choosing health is to have the impact we all wish to see.

4.2 There are a number of statutory functions, such as public health, child protection, prescribing, workforce planning and development which need serious consideration during this time of major reconfiguration and uncertainty.

4.3 There is still ambiguity around the level of risk sharing in public health between SHA, PCT and Practices. Our concern is that market type mechanisms have in the past failed to act to coordinate public health initiatives or contribute to joined-up strategies for health improvement. We would welcome a more robust debate around how public health needs might be address in a mixed market economy (assuming of course that it is agreed that a mixed market approach to health delivery is appropriate and evidence based).

4.4 In terms of future workforce planning, it will be very difficult to develop a “fit for purpose” health care workforce unless the community is able to provide high quality clinical and learning placements. Fragmenting community services could, the RCN believes, seriously damage workforce planning and the development of a future workforce which is able to function with competence and knowledge in the community.

4.5 PCTs currently employ community nurses and provide an important Human Resources function. Nurses have begun to question the value of Agenda for Change and Improving Working Lives in the light of the government call to put community services out to tender. We are already aware from several comments made by the Department of Health that they are unwilling to set commissioning standards for pay, terms and conditions for staff who may work for independent sector providers, even if those staff are engaged in delivering NHS services. This raises a very real concern about this policy acting to undermine the investment and hard work undertaken to create an equal and transparent system of pay, terms and conditions (Agenda for Change). This risks creating differing standards of employment across the health economy, to the detriment of recruitment and retention and strategic workforce planning.

4.6 Evidence and experience tell us that organisations which provide the best possible HR, governance and clinical governance engender staff with high motivation and morale, while at the same time providing high quality patient services.

4.7 PCTs provide community services which are highly valued by people who live better and healthier lives because of them. They can be difficult to define and harder to measure, but nevertheless lie at the heart of health and social care and often enable people to enjoy a reasonable quality of life and sometimes, when inevitable, die well at home. Community services can be invisible to the majority and therefore all too easily forgotten by those who develop policy and those who hold the budgets.

36 This is a view reported widely by our members through the discussion zones and regional contacts, but has also been picked up in some consultation papers from Strategic Health Authorities such as West Yorkshire SHA (W Yorkshire SHA—CPLNHS “The Way Forward”).

4.8 The RCN is anxious to support reforms which patently aim to enhance and expand community services and address health inequalities. But we cannot support reforms which are not supported by empirical evidence and appear to fragment and diminish services.

4.9 Much of the evidence around the use of market-based services points to the inevitable outcome that there are always “winners and losers” in such market-based system unless there are a series of robust checks and balances.\(^{38,39}\)—these checks and balances, if indeed they exist in the proposed UK model, have not been debated or disclosed in CPLNHS.

4.9.1 Whilst there are a range of models of mixed market health economies to learn from which aim to prevent the excesses of the market,\(^ {40}\) our concern is that CPLNHS represents a rushed experiment with the “marketisation” of primary care in England which may result in the neglect of people who are not in a position to demand, shout or complain.\(^ {41}\)

4.9.2 The Government’s current policy position of driving reform through the generation of economic instability and the assumption of consumerist values in the delivery of healthcare, whilst having some merits in certain circumstances, has not been supported in the main through empirical research and public debate. We would want to draw the Committee’s attention to the fundamental difference between “consumers” of goods and services and “patients”. Consumers enter markets with economic power and are able to make choices over services and goods.

4.9.3 Patients however do not generally seek to be ill or to receive health services and in that sense there is a need for health services rather than a desire, and those needs are unpredictable in the main. Public health poses particular challenges in this respect in that health needs are often unknown so the desire or need to enter the market for services is dependent on access to information, health advice, mobility and peer support. Information supplied and required by both sides of the exchange is often imperfect in health care, solutions are often high cost and markets can be dependent on any number of externalities which may distort clinical priorities. This may result in selection bias (cream skimming), inequity of provision and moral hazard.\(^ {42}\)

4.9.4 In their study of US Chronic Disease Management, the Kings Fund found that where there was competition between MCOs (Managed Care Organisations), it could lead to a focus on attracting young healthy enrolees at the expense of people with chronic disease. They also noted a distinct lack of focus on social care and wider public health issues.\(^ {35}\)

5. Consultation about Proposed Changes

5.1 The RCN has issued an application to be granted permission to apply for a judicial review of the Government’s failure to carry out a public consultation on the proposed changes to the role of Primary Care Trusts in England.

5.2 The consultation that has occurred has been about how to implement the change not on the merits of the policy shift itself. The government proposals, outlined in CPLNHS, stated that PCTs’ role in provision of services will be:

“…reduced to a minimum and that primary care trusts will act as the provider of services only where it is not possible to have separate providers.”

5.3 The RCN believes the implications of the document could fundamentally change the nature of the NHS. No longer will it be a provider of service and employer of staff but instead a commissioning agent behind an NHS logo.

5.4 The significance of the document issued by Sir Nigel Crisp, is that, by stating that PCT’s will only have a “minimum” provider role, it appears to dramatically redistribute the balance between public and private services in favour of the latter.

5.5 The Secretary of State, Patricia Hewitt said on October 25:\(^ {44}\)

“District nurses, health visitors and other staff delivering clinical services will continue to be employed by their PCTs unless and until the PCTs decide otherwise. The terms and conditions of staff will of course be protected.”


\(^ {40}\) See for example in the Netherlands and Sweden where provider plurality exists in a framework of legal restraints on competition; contractual and service protection for patients and staff against market failure; and effective national collective bargaining with local flexibility.


\(^ {42}\) op cit.


\(^ {44}\) Hansard 25 October 2005.
5.6 The problem here is that people making these local decisions have already had a very clear instruction on 28 July to reduce their provider role to a minimum and the initial reconfiguration plans to facilitate this were to be submitted to the Department of Health by the 15 October, 2005. We know from our members that there is a great deal of anxiety about the lack of consultation around these proposals and indeed about the future of primary care services.

5.7 For these reasons, we feel that we have to challenge the government’s policy in court. A judicial review is not something we take lightly. The RCN is not against reform and never has been. However, we believe the Government has to undertake genuine consultation on its proposed reforms.

6. **Likely Cost and Cost Savings**

6.1 The NHS is already facing unprecedented financial challenge as a result of several factors in combination:

- Increase in staffing costs related to overspend on Consultant and GP contracts. There have also been net increases in staff numbers in certain areas to meet demand/increased activity—estimated to have cost around £2 billion. There has been an increase of approximately 89,000 more clinical staff employed in the NHS since 1999; 67,880 of which are nurses/midwives/health visitors.\(^4\) That some of these are likely to lose their jobs or not be able to find employment on qualification is a tragedy and a waste of public money.

- Drug costs—these continue to rise and are up 5.6% on last year; by 46% since 2000.\(^4\)

- IM&T—total costs for IM&T have increased to £6.2 billion over 10 years.\(^4\) Overspends in meeting the technical challenge of linking up thousands of different organisations from SHAs to Hospitals to GP surgeries are commonly reported.

- Payment by Results—this averaging out of costs undertaken in drawing up the NHS tariff has left some Trusts with up to 20% less income than they would normally receive for the same or increased levels of activity. There are also some Trusts who have benefited from the same process.

6.2 In addition to the challenges brought about by the above, the demand to make rapid savings of £250 million is a challenging one and is already having a negative impact on front line services and relationships between PCTs and Acute Trusts. Frontline clinical and nursing posts have been frozen, nursing redundancies have been made and newly qualified nurses are finding it difficult to find jobs.

6.3 The RCN recently announced the findings of an exhaustive survey of PCT and Acute Trust Board financial reports and recovery plans in which we discovered a predicted NHS wide deficit of around £1 billion and the loss of around 3,000 posts. We also know from previous experience that mergers and reconfiguration rarely achieve the desired savings to the extent planned—the fact that many large deficits reported by individual Trusts have a significant historical element supports this view.

6.4 Whilst there is some evidence to suggest that limited competition promotes efficiency and cost reduction in some services, there is little evidence that supports this in primary care in the UK setting. If anything there are a number of studies which point to slight deterioration in the quality of services under previous approaches to a market based system.

6.5 Developing a competitive market in primary care is going to require significant investment; careful planning in terms of distribution of services and entry into the market; and robust, patient centred regulation to ensure services remain focused on local needs. This whole system approach needs to be underpinned by a wide spread consensus on the direction of travel and proper evaluation of each stage of the process to ensure that patient outcomes and the principles of the NHS are maintained. Any efficiency or cost savings delivered through a competitive healthcare market must be derived from innovation and creativity in service design and delivery and not through downward pressure on quality or on the terms and conditions of the staff delivering the services in the NHS.

*Royal College of Nursing*

*9 November 2005*

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\(^4\) NHS Confederation, 2005. “*Money in the NHS: the facts*”.

\(^4\) Department of Health, 2005. “*Investment in IM&T in the NHS*”.
Memorandum submitted by UNISON (PCT 35)

INTRODUCTION
UNISON is the UK’s largest trade union with over 1.3 million members, all of whom are users of the health service. We represent over 60,000 NHS staff working in Primary Care Trusts, across a range of occupational groups including occupational therapy, nursing, healthcare assistants, health visitors, admin and clerical, cleaning and catering, health service management, finance, and chiropody. In addition, we have growing numbers of members delivering primary and community care services for the voluntary sector, and as part of new integrated models of working such as Section 31 Partnerships, Care Trusts and Children’s Trusts. Finally, we represent staff working in a range of functions in Strategic Health Authorities.

UNISON welcomes the opportunity to submit evidence to the Health Select Committee’s inquiry into the important and far-reaching potential changes to primary care trusts’ functions and numbers arising from the Department of Health’s document Commissioning a Patient-Led NHS. We have structured our submission around the headings listed in the terms of reference, and have added a final section specifically on the staffing aspects of the changes to reflect our particular interests and concerns in this area. We would welcome the opportunity to give further, oral evidence.

GENERAL
UNISON is strongly opposed to the moves outlined in Commissioning a Patient Led NHS to transfer the provision of community services away from PCTs to alternative providers, and to the objective of introducing more contestability into the provision of primary care. We oppose too the reconfiguration exercise announced by Commissioning a Patient Led NHS, on the grounds that it is being rushed through in order to achieve centrally imposed efficiency targets, and seems unlikely to deliver the high-quality, locally sensitive commissioning arrangements that are needed. While this submission focuses on the changes in Commissioning a Patient Led NHS that relate to primary care, we also oppose the policy changes that Commissioning a Patient Led NHS contains in relation to acute and ambulance trusts, in particular the proposal that Ambulance Trusts should be able to apply for Foundation status.

RATIONALE BEHIND THE CHANGES
It is difficult to discern any coherent rationale behind the changes announced in Commissioning a Patient Led NHS. This is in large part because these changes pre-empted both the Government’s consultation exercise Your Health, Your Care, Your Say, and the White Paper on Health and Social Care expected in December 2005. As a result, the Government has not yet given a systematic account of either the issues and challenges in primary care that it believes need to be addressed, nor of its vision of how primary care should work in future.

Despite this, it is however possible to identify a number of likely policy goals underlying the changes in Commissioning a Patient Led NHS. These are as follows:

Strengthening PCT commissioning capacity
The Government appears to believe that many PCTs have been weak at carrying out their commissioning responsibilities, citing for instance inadequate progress in redesigning services, failure to properly hold providers to account, and failure to ensure that money is directed toward the areas of greatest need. Such problems, the Government argues, are due in part to PCTs being distracted from their commissioning functions by their role in direct service provision.48

UNISON accepts that there is room for PCTs to improve the way in which they commission services. However, we believe that the Government is underestimating the positive progress that is being made within the current framework in order to develop PCTs’ commissioning performance and to tackle existing weaknesses. While the Commission for Health Improvement’s 2004 report on PCTs was critical of a number of aspects of their commissioning performance, it also stated that “having seen some notable commissioning practices, we remain cautiously optimistic that PCTs can make progress in future.” 82% of PCTs have already redesigned one or more care pathway at the primary/secondary care boundary,49 and funding inequalities are being addressed through measures such as the new General Medical Services contract and the implementation of the new PCT resource allocation formula.

Furthermore, there is little evidence linking weaknesses in PCTs’ commissioning performance to their role as service providers. Instead, where problems have occurred, these tend to be related to other constraints. A recent Audit Commission study on service redesign49 found that only 7% of PCTs feel that they have sufficient staff in order to drive service redesign projects; that PCTs whose health economies are in deficit

48 See for example Patricia Hewitt’s speech to NHS Chairs, 20 September 2005.
50 Ibid.
can find it harder to invest in alternative services; and that the influence of national targets can have a negative impact on clinician engagement. Similarly, the ability of some PCTs to carry out their commissioning responsibilities has been hampered by a shortage of skilled financial managers—according to the Audit Commission, in 2002–03 auditors expressed concerns about inadequate staffing and management capacity in relation to finance in 34% of PCTs.51

**Introducing contestability and diversity of provision**

Commissioning a patient led NHS sets out a policy goal of increasing contestability in primary care by putting in place arrangements to secure community based services from a range of different providers. In addition, it stipulates that the role of PCTs in direct service provision should be reduced to a minimum, and that where PCTs do continue to manage services, decision-making on commissioning and on provision should be separated in order to enhance contestability. These changes are intended to deliver a “greater variety of service offerings and responsiveness to patient needs”, and would appear to be driven by a view that PCTs are not currently doing enough in order to drive up standards and improve access in primary care.

It is undoubtedly the case that there is more work to do in order to make primary care services more convenient and accessible to patients, and to better reflect the diversity of patient needs—indeed these are some of the themes that have emerged from the listening events being mounted by the Department of Health as part of its Your Health, Your Care, Your Say consultation. However, UNISON considers that PCTs are already successfully undertaking numerous activities that are delivering on these goals, and we reject as unsupported by any evidence the notion that provider competition will result in additional improvements. Examples of the positive progress being made include:

- Implementation by PCTs of a range of strategies to improve access to General Practice, such as extending opening hours and improving the structure of practice services, and directly employing GPs in order to attract them into underdoctored areas.52
- Development of new community outreach services and the raising and monitoring of GP standards through the quality and outcomes framework.
- Increasing numbers of professionals prescribing medicines in the community, for example practice nurses running immunisation sessions, and pharmacists providing emergency contraception.

**Cost control and the efficiency agenda**

The Government has committed the NHS to saving at least £250 million per year in overhead and administration costs, as part of its drive to achieve its Gershon target of £6.5 billion in annual savings in the NHS by 2007–08. This is directly reflected in the criteria set out by Commissioning a Patient Led NHS for the assessment of proposals for PCT and SHA reconfiguration, according to which PCTs should be able to demonstrate their ability to deliver at least a 15% reduction in management and administrative costs, and SHAs will also be expected to deliver “significant reductions.” Indeed, it seems probable that the desire to achieve cost savings through the merger of financial and administrative functions is the principal driver behind the Government launch of the current reconfiguration exercise.

Cost control and the efficiency agenda are also one of the primary motivations behind the accelerated roll-out of practice-based commissioning announced in Commissioning a Patient Led NHS. With the introduction of an activity based payment system in the form of payment by results, Primary Care Trusts will no longer be able to control their expenditure as they have in the past by allocating blocks of funding to providers based on what is affordable. As a result, if the volume of referrals increases by more than the increase in funding available, PCTs could face serious financial deficits. Practice-based commissioning represents an attempt to curtail this risk by transmitting these financial pressures down to the level of the clinicians making referral decisions, giving them the responsibility for balancing budgets, and encouraging them to redesign services to make them more cost effective.

Although cost control and the achievement of efficiency savings are clearly one of the objectives of Commissioning a Patient Led NHS, there are real questions about whether these benefits will be realised in practice. This is explored below under “Likely costs and cost savings.”

**Likely Impact on the Commissioning of Services**

UNISON is not opposed to the reconfiguration of PCT and SHA boundaries where this is part of a locally initiated and organically developed strategy to strengthen commissioning arrangements—for example to facilitate better partnership working by delivering greater coterminosity with local authority boundaries.

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52 What CHI has found in primary care trusts, Commission for Health Improvement, 2004.
However, we are gravely concerned that the current review of commissioning arrangements has been driven by a Department of Health cost cutting agenda, and has operated to a timescale that has made it impossible for PCTs and SHA s to formulate well thought through proposals that have the support of local partners and stakeholders. As a result, UNISON considers that the reconfiguration exercise risks weakening the future development of PCTs’ commissioning performance in the following ways:

— By leading to more unwanted structural reorganisation. According to the Audit Commission, the level of structural reform in the NHS in recent years has had a significant adverse impact on the quality of its financial management, diverting managers’ attention and making it more difficult to undertake accurate financial forecasting.\(^53\) In addition, the Audit Commission recently reported that those PCTs that had had the greatest level of stability in senior management positions were most likely to have a comprehensive commissioning strategy, this being a more important predictive factor than the size or age of the PCT.\(^54\) Such evidence suggests that the structural reorganisation and instability that would be generated by a widespread round of PCT mergers would be more likely to harm rather than to benefit PCTs’ ability to successfully respond to the commissioning challenges of the next few years.

— By undermining the involvement of primary care staff and local communities in the commissioning process, where reconfiguration leads to PCTs covering larger geographical areas. Larger PCTs are likely to be more remote from their local communities, and will have more primary care staff working across a larger number of different sites. As a result, engaging members of the public and primary care staff in commissioning will be more difficult.

— By undermining links with local authorities, where reconfiguration results in PCTs that are currently coterminous with local authority boundaries being merged.

— By disrupting existing joint commissioning arrangements, for instance with local authorities and other PCTs.

Another measure contained in Commissioning a Patient Led NHS which UNISON considers may have a detrimental impact on commissioning is the universal roll-out of practice based commissioning by December 2006. While UNISON strongly supports the principle that primary care staff should be fully involved in the commissioning process, we are concerned that practice based commissioning may undermine PCTs’ ability to ensure that services are commissioned for their local population in a coherent and planned way and that inequalities in patient access are addressed. This is because, under the Department of Health’s practice-based commissioning guidance,\(^55\) the only sanction that appears to be available to the PCT is if a practice fails to balance its budget over a three year period, in which case the PCT may revoke the right to hold an indicative budget. However, it is unclear whether and how PCTs can, for example, compel practices to co-operate together in the planning of certain areas of service provision. If practice based commissioning is not to lead to the emergence of weak and chaotic commissioning in instances where practices are unwilling to exchange information and plan together, it is vital that this issue is resolved as soon as possible.

Finally, UNISON wishes to highlight to the Committee our opposition to the Thames Valley Strategic Health Authority’s decision to put out to tender to NHS, voluntary sector, and private sector bidders, the management of PCT commissioning functions across Oxfordshire.\(^56\) This is a significant policy development which goes beyond anything announced by the Government, yet we understand that, despite this, the Department of Health is intending to allow Thames Valley SHA to go ahead with it. UNISON is particularly concerned that the SHA may be tempted to award the contract on the basis of which bidder can offer the greatest efficiency savings, shifting the focus away from commissioning quality services to meet the health needs of the local population; and that, if the contract is awarded to a private sector organisation that is also a commercial healthcare provider, this could create major conflicts of interest. We therefore recommend that the Government should act immediately in order to halt the proposed tendering process, until there has been an opportunity for it to be subject to full public debate and scrutiny, including consideration of alternative approaches.

**Likely Impact on the Provision of Services**

One of the problems with Commissioning a Patient Led NHS has been that, while it stated that services should be provided by alternative providers, no details were given of who it was envisaged these providers might be. This lack of information has made it substantially more difficult to properly assess the likely impact of the Government’s proposed changes on the provision of services, as well as exacerbating anxiety amongst staff.


\(^{56}\) See Thames Valley Strategic Health Authority Board Paper 62/05, October 2005.
Some clarification on the proposed options for alternative provision was subsequently provided in a letter to UNISON from Patricia Hewitt dated 22 September, which set out the following options:

- Some services may be managed by GPs or collections of GPs.
- Some may become stand-alone NHS Trusts, Children’s Trusts, Care of the Elderly Trusts etc.
- Some may be managed by acute hospitals or local authorities.
- Some may be managed by the not-for-profit or voluntary sectors; including staff or community-led social enterprises or co-operatives.
- Some may continue to be run by PCTs, so long as there is a clear separation between the purchasing and providing functions.
- Some may be run by private providers.

UNISON believes that PCTs provide excellent, highly valued services, and that there is absolutely no reason for provision of these to be transferred to external providers. We consider that the position adopted by Commissioning a Patient Led NHS that the role of PCTs as providers of services should be reduced to a minimum is illogical when viewed alongside the continuing role proposed for PCTs as providers of other services, such as out of hours services, and also as employer to an increasing number of GPs. Furthermore, we consider it to be inconsistent with the Government’s policy stance towards GP practices, which are to take over responsibility for commissioning under practice-based commissioning, but yet will remain responsible for the provision of general medical services. In UNISON’s view, the principal constraint on innovation and expansion of primary and community care services remains the shortage of appropriately skilled staff—for instance, the number of district nurses and health visitors has fallen in recent years. If diversity of provision and contestability are introduced into primary and community care services, we believe that the most likely result is that the new providers will seek to poach existing staff, destabilising current services, whilst adding no new capacity.

UNISON is also extremely concerned about the potential impact of the introduction of contestability and diversity of provision on equity of patient access to primary healthcare services, and on the quality of the services that patients receive. Primary and community health services depend critically on communication and joint working between different groups of professionals, both within the health service, and in other services such as social services and housing. In addition, the number of district nurses and health visitors has fallen in recent years. If diversity of provision and contestability are introduced into primary and community care services, we believe that the most likely result is that the new providers will seek to poach existing staff, destabilising current services, whilst adding no new capacity.

We acknowledge and welcome the recent statement by Patricia Hewitt that district nurses, health visitors and other staff delivering clinical services will continue to be employed by their PCT unless and until the PCT decides otherwise. However, we remain concerned that PCTs may be forced to make decisions on provision in accordance with criteria that are weighted in favour of external provision, and look to the Department of Health to provide us with reassurance on this point. In addition, we would regard it as unacceptable for the provision of new or additional services to be ringfenced in any way for the voluntary or private sectors. Instead, we recommend that, new or additional community health services should be commissioned from PCTs or other public sector bodies, unless it can be convincingly shown that they do not have the capability to deliver the services required.

Finally, we wish to highlight the importance of the payment system that is adopted if the Government does allow the creation of a competitive market in the provision of primary care services. Under the Government’s new payment by results system, procedures must be charged to PCTs at a fixed national tariff price. However, it is unclear whether the Government is intending to extend this system to the provision of primary and community care services. UNISON has concerns about the payment by results system, which we believe creates perverse incentives and acts as an engine for damaging competition. However, if greater contestability is introduced into the provision of primary and community healthcare services, we believe that it would be vital to ensure that a mechanism was in place in order to ensure that providers were not able to compete against each other on the basis of price. All our experience of the operation of markets in other areas of the public services suggests that, if providers are allowed to compete on price, they will respond by driving down costs at the expense of service users and the workforce, for example by reducing staff numbers and investment in staff training.

**Likely Impact on Other PCT Functions Including Public Health**

It is unclear whether Commissioning a Patient Led NHS envisages that the PCT provided services that may be externalised include public health services such as stop smoking and screening services. This needs to be clarified. UNISON considers that, if PCT reconfiguration results in larger PCTs covering several local authorities, this may reduce PCTs’ sensitivity to local public health needs. In addition, such an outcome

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would be likely to reduce PCTs’ effectiveness in working in partnership with local authorities to tackle cross-cutting public health issues through mechanisms such as Local Strategic Partnerships and Local Area Agreements.

**Consultation about Proposed Changes**

UNISON considers that the consultation surrounding the changes announced in *Commissioning a Patient Led NHS* has been extremely poor. A meeting of the Department of Health’s Social Partnership Forum was held just a week prior to the publication of *Commissioning a Patient Led NHS*, yet the Department of Health made no mention of it, and the document was released at a time when many people were away and with no covering press release from the Department of Health. Furthermore, under the timescale set out in *Commissioning a Patient Led NHS*, the time period allowed to SHAs and PCTs to consult with local authorities, MPs, patient bodies and other local stakeholders was so short as to make any meaningful consultation process all but impossible. Finally, while we welcome the Government’s establishment of an external panel to advise the Secretary of State on whether SHAs’ proposals for reconfiguration meet the criteria set out by the Department of Health, we believe that it is deeply regrettable that the membership of this fails to include any trade union representation.

As alluded to above, UNISON is also of the opinion that the changes announced in *Commissioning a Patient Led NHS* unhelpfully pre-empt the conclusions of both the Government’s *Your Health, Your Care, Your Say* consultation, and also December’s expected Health and Social Care White Paper. This has not only made it impossible to evaluate the changes contained in *Commissioning a Patient Led NHS* in the light of the Government’s broader policy objectives for primary care, but has also meant that SHAs and PCTs have been forced to develop their proposals on reconfiguration without knowing how policy on primary care will develop over the coming months.

**Likely Costs and Cost Savings**

UNISON considers that any cost savings from PCT reconfiguration as a result of the creation of fewer, larger PCTs, are likely to be outweighed over the short to medium term by the costs of PCT restructuring, including redundancy costs and the costs of developing new harmonised systems, for example in finance and IT.

We are also concerned about the potential administrative and management costs of the move towards practice-based commissioning. Experience under GP fundholding showed that the management costs incurred were higher than the commissioning savings achieved. Although practice-based commissioning will not work to exactly the same model as GP fundholding, with the administration of contracts continuing to be undertaken by PCTs, it is still likely to absorb significant amounts of staff and management time, and to generate substantial additional administration for GP practices.

**Staffing Issues**

If major reconfiguration of SHA and PCT boundaries takes place, this will lead to significant levels of job insecurity and instability for staff working in these organisations, in particular for senior managers but also potentially for other groups such as admin and clerical staff. UNISON and the other NHS trade unions are currently in discussion with the NHS Employers’ organisation with a view to agreeing an HR Framework in order to manage the workforce implications of the reconfiguration of PCTs and SHAs. It is vital that these discussions are concluded as soon as possible, so that there is an agreed framework ready for when the Government’s decisions on reconfiguration are announced.

A second issue is the staffing implications of the potential transfer of PCT provided services to private or voluntary sector providers. Many of the staff in PCT provided services are nearing retirement, and there is a danger that if services are transferred, these staff may choose not to continue working in them, opting instead to seek more stable and secure employment in other parts of the NHS. To date the Government has said that normal legal protections will apply to staff in PCT provided services who are transferred across to new external providers, but no discussion has taken place regarding the terms and conditions on which new starters would be employed. This is clearly an important issue given the Government’s commitment to eliminate the two-tier workforce.

UNISON is also concerned about the impact that the reconfiguration of SHAs will have on workforce planning and development, both in PCTs and also in acute trusts. Currently, SHAs are responsible for a number of crucially important workforce related functions, including workforce planning, recruitment and

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58 Changes to primary care trusts and strategic health authorities, DoH Press release, 18 October 2005.
Ev 164  Health Committee: Evidence

Retention initiatives such as Return to Practice, and oversight of the implementation of Agenda for Change and of the Improving Working Lives standard. In addition, together with Workforce Development Confederations, SHAs hold the training budget for non-professionally qualified staff. It is vital that the reconfiguration of SHAs does not impede their ability to undertake these roles, and that the staff training budgets which they hold continue to be ringfenced for training purpose and are not diverted to meet other costs, such as those of restructuring.

8 November 2005

Memorandum submitted by Martin Avis

I have just read the memorandum from Jane Hanna and wish to support its factual content and details regarding the ophthalmic centre saga in SW Oxfordshire. The manner in which this process was conducted was a sad failure of the process of national and local decision making in the NHS. I raised the question as to the individual PCT’s responsibility to take decisions on the basis of the evidence presented to them at two meetings of the Chairman of NHS Trusts in the Thames Valley SHA. Nick Relph and Jane Betts, Chief Executive and Chair, were present on both occasions, the second being in September 2003. It was understood and accepted by all that it was the individual Boards decision and to be taken in the interests of their population unless directed in writing concerning overriding national interests. However, subsequent discussions with individual Chairs indicated that if advised verbally by the TVSHA that their jobs were at risk they would ensure their Board voted the way they were told. Two had been told they had to get their Boards approval of the Ophthalmic centre proposal or their jobs would be lost. I was never directly threatened regarding my job until after my Boards rejection of the ophthalmic proposal in November 2003. The “inability” of the TVSHA or the top NHS officials to put in writing that the SW Board must vote in favour of the ophthalmic centre proposal in the national interest meant the non-executives present rightly opposed the proposal on the evidence before them. It did not demonstrate a benefit to our population and did not deal satisfactorily with substantial potential risks, which have subsequently become real financial burdens to an area already exceeding its budget. The Chairman of Cherwell Vale PCT and myself requested, in December 2003, an internal review of the lessons to be learned from the process that led to the no vote at SW PCT and a fraught lead up to the yes vote at Cherwell Vale PCT. This request was directed to John Reid. No review ever took place. I am sure that what happened to myself and the SW Oxfordshire PCT non-executives has weakened local decision making and ensured the TVSHA continues as an outpost of the Department of Health. Local Trust Boards will tend to rubber stamp decisions recommended by their executives rather than risk their jobs in upholding local interests. I am concerned about the difficulty for Chairs and non-executives in holding their executives to account when these executives careers and interests lie in conforming to political and civil service pressure applied in covert ways.

Martin Avis
Emeritus Professor Oxford Brookes University
Manager Oxfordshire Carers Forum
Ex Chairman of SW Oxfordshire PCT

Please use this memorandum in support of the Jane Hanna submission

24 November 2005

Memorandum submitted by Jane Betts

I am writing following a conversation with Jane Hanna who alerted me to your committee’s important work. I was chairman of the Thames Valley Strategic Health Authority at the time of the treatment centre debacle and resigned because of it. I now chair the CAB in the south east of England and am vice chairman of the Gangmasters’ Licensing Authority as well as being chief executive (part time) of the Comparative Clinical Science Foundation (chaired by Lord Salisbury) established to promote integrated medicine for humans and man—particularly apposite as we wait the arrival of avian flu!

It became clear to me that, on the issue of the treatment centres, my role and that of my board and the executives had been completely subsumed to the will of Richmond House. This placed my staff in a position of great stress and made my board impotent. We became a conduit for communication rather than being
able to handle the issue ourselves. I seem to remember that even the chief executive of the NHS Nigel Crisp who at one point said that it was a local decision (on R4) then had to retract this embarrassingly 24 hours later.

Jane Betts
24 November 2005

Memorandum submitted by Professor Peter Bradshaw, University of Huddersfield (PCT 9)

As one engaged professionally in the local health economy and more importantly as a person with daily contact with PCT staff I offer the following observations:

The proposed changes to primary care need to be considered *inter alia* with the plethora of other NHS changes that include notably, *Choose and Book, Payment by Results and Commissioning a patient-led NHS.*

Funding—The fairest way of funding health services is through general taxation and the alternatives are inefficient economically and threaten what the NHS can proudly claim to be the near universality of services. The funding alternatives disintegrate the notion of pooled risk on which the NHS depends. This allows purchasers to determine arbitrarily who gets treated according to their ability to pay and other concerns for profitability that override the quality of outcomes for patients. These factors should provide a focus for stringent analysis whenever the NHS is made to look too expensive to afford.

Delivery—The NHS embodies a unique set of equity principles regarding access to care based on clinical need. Traditional ways of predicting health need and providing services based on local epidemiological evidence took a knock with the creation of the current PCTs. Yet with time and patience the position is being retrieved in that population specific approaches to meeting health needs are recovering from the abandonment of Health Authorities in the last reorganisation. The proposed new PCTs, unlike their predecessors have no such remit despite the Secretary of State’s minor retraction on the provider role of PCTs. Prioritising decisions about financial entitlement and giving them precedence over clinical decisions violates the principles on which the NHS exists. In terms of the proposed models for PCTs that are to be solely purchasers of care and treatment, the predictable outcomes are:

— Fragmented and inconsistent staff training, services and treatment outcomes.
— The delivery of poor continuity of care with gross geographical inequities. This has all the potential to undo so much good and to make the inequities of postcode lottery in prescribing look a very minor matter by comparison.
— The subjugation of public health improvements to the more pressing matter of buying treatments as cheaply as possible.

Private Provision—Two interrelated concepts arise:

1. Firstly the NHS has had a long flirtation with private solutions to the provision of mainly non-clinical services and latterly for a restricted range of clinical services. The rationale for this is that the NHS is capable of genuine free market behaviour on the basis that contestability (this means competition to Tory members!) enhances choice. The evidence is that the NHS is only a very poor substitute for what Adam Smith had in mind and the analogy that a free market in health services can mimic commercial markets is a naïve and false analogy.

2. The second and related premise is that the activities identified in 1 above produce superior economic efficiency and better quality services. This is a similarly invalid assumption.

The welter of empirical evidence from the USA and the limited data on Independent Treatment Centres in the UK reinforce the conclusion that the current proposals are an absolute threat to universal access to services that is the hallmark of the NHS. No privatised health system anywhere in the world has been proven to deliver equity. There is similarly no assurance that independent providers actually deliver value to the taxpayer or that they are interested in only cherry picking the most manageable and profitable patients leave those with more complex pathologies to the NHS.

Despite the inefficiencies in the NHS that have resulted from repeated unevaluated reorganisations, the service still delivers a lot of care and treatment for a modest outlay and this fact is the best indicator of value for public money that we have.

Professor P L Bradshaw
Professor in Health Care Studies, University of Huddersfield
31 October 2005
Memorandum submitted by Colin Carritt (PCT 46)

I learn with alarm that the Thames Valley Health Authority has taken a decision to invite private bids for the administration of the Oxfordshire Primary Care Trust. I further understand that this decision was made without any consultation with the public or with staff within the NHS.

I have to say that this situation beggars belief. As the purchasing authority the effect of privatising the PCT will be for the private sector to control, regulate and fund the health services in the region. Since many of these services are themselves contracted out, it would seem that there is a danger of the private sector regulating itself.

I understand that the decision can now only be reversed by the Secretary of State, Patricia Hewitt, to whom I will also be writing. However, as your committee will be looking into the changing role of the PCTs I thought it would be appropriate and, I hope, helpful, for you to hear my concerns.

Colin Carritt
14 November 2005

Memorandum submitted by Liz Haggard (PCT 2)

I was for eight years chief executive of a community health services trust which provided services for a population of half a million people. Our staff included district nurses, health visitors, chiropodists, occupational therapists, speech therapists, pain specialists, learning disability specialists and Macmillan nurses who provided services in home and community for older people with health problems, people with long term physical and mental health needs, patients discharged from acute hospitals, people who wished to die at home, children at risk, children with health problems and physical and learning disabilities. Our patients were people with multiple problems, many of them finding it difficult to manage financially and practically, many of them from ethnic minorities. They depended on our services being reliable and knew that we worked alongside their general practitioner so that our staff knew their doctors. Patients knew they could contact us because we worked with their general practice.

It is extraordinary to suggest that “contestability” and staff employed by a range of separate organisations would bring these patients any advantages which would outweigh those that come from staff employed to work as members of the primary care team. Primary Care Trusts are large enough to provide staff who cover patients at home 24 hours a day, seven days a week; large enough to provide varieties of work, flexibility and opportunities for development for staff, large enough to manage staff so that someone is accountable if a nurse fails to visit or a mistake is made, centralised enough to be contactable and to set up and run good systems with acute services, and yet local because the staff they employ work with general practices.

The current consultation has not given the public the one choice which survey after survey shows is the one they prefer. The results are clear. The public say: continue with the model of general practice we have and trust, which includes the services provided by the staff like district nurses and health visitors who work with our doctors; make improvements in general practice—we like the better premises, the improved access and the longer consultation times, but we don’t want radical changes in this vital part of the health service. Listen to what we say and read the surveys please—they tell you that we trust our general practice and we want to keep it pretty much the way it is. Of course if you ask us questions like, “Would you like more information” we are likely to say yes, but you cannot assume that in any way that means you will have our support in dismantling our general practice services.

Liz Haggard
28 October 2005

Memorandum submitted by James Halsey (PCT 25)

1. I am a lay person and do not feel confident about responding to the terms of reference, but would like to make the following comments.

2. I struggle with the title Commissioning a Patient-Led NHS, as having read as much as I can about this initiative, I cannot see the Patient as a priority.

3. I may be way off beam, but as a lay person involved in the NHS in a number of areas, I think this is all about money and under any other name appears to be the stealth privatisation of the NHS. Once you commission instead of provide services, one important consideration for any independent provider must be cost.

4. In the majority of cases, public consultation appears to be a tick box exercise and I question as to whether or not there is any hard evidence that confirms that not only is the public listened to, but their views change Government thinking.
5. This initiative, coupled with “Agenda for Change”, has left many NHS staff uncertain about their future, which must affect morale. Despite all of this they continue to try and deliver high quality care to patients, against a backdrop of a target driven and ever-changing NHS.

6. I always try and adopt a positive attitude about any initiative but really question whether this initiative is truly about patients.

James Halsey
5 November 2005

Memorandum submitted by Jane Hanna (PCT 48)

I am writing to ask whether the Health Select Committee will receive further evidence concerning the issue of the democracy and the role of the Non-Executive Director? I noted the concern raised in the Health Select Committee on Thursday 10 November regarding the potential democratic deficit arising as a result of a significant reduction in the number of Non-Executive Directors. It concerns me greatly that accountability for the acceleration of outsourcing of NHS services including possible contracting out of Commissioning is to rest with Primary Care Trusts as I believe there is an existing serious democratic deficit which is likely to worsen with the proposed merger of PCTs.

My interest in this matter is as a former Non-Executive Director of South-West Oxfordshire Primary Care Trust (2001–04) and Non-Executive Director of the Oxford Radcliffe Infirmary NHS Trust (1993–97); as a Tutor in Constitutional and Administrative law at Keble College, Oxford and as a District Councillor for the Vale of the White Horse. I became committed to public and patient involvement in the NHS following the sudden unexpected death of my partner in 1990, which also led to my founding a health charity, Epilepsy Bereaved and working as a member of the Joint Epilepsy Council.

I believe that South-West Oxfordshire PCT was the only PCT in England where the Non-Executive Directors and the Board voted in 2004 against the contracting out of cataract operations to Netcare. Our experience described in summary below represents a test case of the effectiveness of Non-Executive Directors in ensuring accountable and locally responsive decision making particularly in the context of the outsourcing of public services.

As Non-Executives we were categorically told by managers from TVSHA that if we did not vote in favour of the Netcare contract we would be liable to a personal surcharge. Subsequent to our decision not to contract with Netcare, we were criticised by TVSHA in the Oxfordshire press and substantial inappropriate pressure was brought to bear on Board members leading to a reversal of our Board decision in an emergency meeting held within a week of our original decision (four Non-Executives did not alter their original position). Local Oxfordshire MPs including David Cameron, Evan Harris and Tony Baldry were kept fully briefed of the facts of this affair at the time and gave what support they could at the time to the Non-Executives.

Our Chair, Martin Avis was the only Chair in Oxford not to have his position renewed by the NHS Appointments Commission and he told us that the reason given to him was the vote on the Netcare contract. The Chair of the Strategic Health Authority subsequently resigned and went public about her concerns about the lack of independent and accountable decision making.

File on Four reported serious allegations of political interference with the PCT, but no independent or internal inquiry was ever held despite the request of our Chair. An Independent Review of eye services in Thames Valley commission by TVSHA found that the Netcare contract posed risks to Thames Valley eye services in Oxfordshire where extra capacity was not needed. There has been no accountability for the Netcare contract decision, not for the interference with the South-West Oxfordshire Board. In subsequent outsourcing decisions such as contract with Capio we were told repeatedly in no uncertain terms that not only did the non-executives have no option but to agree to all outsourcing proposals but also that we must present these decisions as local decisions.

I resigned as a Non-Executive Director in June 2004 because of a number of issues including my experience on the Netcare contract decision. I considered that it would not be possible for me to fulfil my statutory governance responsibilities. These were described by Lord Warner in evidence to your committee as last week:

“Non-executive directors in the new PCTs will be in exactly the same position in discharging their non-executive functions as the non-executive directors in the current PCTs. They will be in the majority, they will discharge the same functions, they will hold the chief executive and other members of the executive board to account. I though this was rather elegantly explained by Mr McIvor to you last week.”
I am enclosing a set of some of the supporting papers relating to this matter including the following:  
Letter from Non-Executives to John Reid, Secretary of State for Health (requested by our Chair, on the day following our Board decision, on the instruction of TVSHA but never sent by TVSHA).
Statement of Reasons by South-West Oxfordshire PCT Non-Executive Directors.
Notes of an emergency meeting of South-West Oxfordshire PCT Non-Executive Directors.
Although these events happened in 2004 I am aware of one Non-Executive Director in Oxfordshire who allegedly has received ongoing threats of discipline which he believes are due to the fact that he continues to challenge decisions and another Non-Executive in Oxfordshire who has recently resigned in order to speak to the media about his public interest concerns.

I appreciate there are serious allegations contained in this letter and have contemporaneous records available to produce a more detailed memorandum should the Committee consider this helpful.

Jane Hanna
12 November 2005

Further memorandum submitted by Jane Hanna (PCT 48A)
This statement is made by Jane Hanna, former non-executive director of South-West Oxfordshire Primary Care Trust (PCT). The Health Select Committee received evidence on Thursday 10 November 2005 regarding the potential democratic deficit arising as a result of a significant reduction in the number of Non-Executive Directors in the planned changes to primary care. This evidence concerns the issue of an existing democratic deficit in Primary Care Trust Boards particularly in the context of the contracting out of services to the private sector.

My interest in this matter is as a former non-executive Director of South-West Oxfordshire Primary Care Trust (2001–04) and non-executive Director of the Oxford Radcliffe Infirmary NHS Trust (1993–97): as a tutor in constitutional and administrative law at Keble College, Oxford and as a district councillor for the Vale of the White Horse, Oxfordshire. I became committed to public and patient involvement in the NHS following the sudden unexpected death of my partner in 1990, which also led to my founding a health charity, Epilepsy Bereaved and working as a member of the Joint Epilepsy Council. This statement includes a summary of the Netcare Contract and the decision-making of the PCT and a more detailed statement of evidence supporting this summary.

The Statement below is has been produced using evidence from a file of written papers and on a written and contemporaneous record kept of events as they developed.

SUMMARY OF THE NETCARE CONTRACT AND DECISION-MAKING OF THE PCT

The experience of South-West Oxfordshire PCT in relation to the contract with Netcare represents a test case of the effectiveness of Non-Executive Directors in ensuring proper stewardship of public funds, proper governance, accountability, openness and locally responsive decision-making. I believe that South-West Oxfordshire PCT was the only PCT board in England to vote against the contracting out of cataract operations to Netcare. The decision of South-West Oxfordshire PCT was necessary to authorize the signing of the contract with Netcare. This was because there was no national legislation or national directive from the Secretary of State for Health overriding the devolved decision to the PCT. The decision was an important test case of Shifting the Balance of Power and the roles and responsibilities of a Primary Care Trust Board.

The SW PCT Board voted not to approve the private cataracts unit because it was against the local public interest. Board members, including non-executives were subjected to bullying tactics in the months leading up to the decision and subsequent to this decision. Non-Executives also experienced serious delays and barriers to accessing available information relating to the decision and had to correct minutes of the public board meetings on key aspects of the PCT Board’s position on at least four separate public board meetings between January 2003 and January 2004. Exceptional pressures were placed on the non-executive directors of the Board and we observed the effects of greater pressure on the executive members of the Board. In the immediate aftermath the PCT was prevented from sending out a press release giving the reasons for the decision and instead the Thames Valley Strategic Health Authority (TVSHA) issued a press release which was critical of the decision of the Board. The non-executives were pressured into meeting in emergency session over the weekend immediately following the decision of the Board and following our decision not to change our decision, the Chair was pressured into calling an emergency meeting of the PCT. The TVSHA agreed to underwrite the financial risks to the PCT. The PCT Board approved the contract with Netcare at this meeting, although all the original non-executives (apart from the Chair) voted against this reversal because of continued concerns of financial impact on the Oxfordshire system as a whole and the impact on clinical services.

59 Not printed.
In January 2005 the PCT Board Chair was not renewed and the Chair of the Thames Valley Strategic Health Authority (TVSHA) resigned. In an emergency meeting of non-executives in January 2005 we discussed how fundamental relationships of trust within the Board; between the Board and the TVSHA and the NHS Appointments Commission had been seriously damaged and the need for an inquiry into events. I resigned in June 2005 after experiencing other decisions where the PCT was required to rubberstamp national policy but required to present decisions as local decisions. I also resigned in the end because despite a request by the non-executives of South-West Oxfordshire PCT in January 2005 for an investigation into events there was no internal or public inquiry.

Subsequent to the decision, the TVSHA commissioned an independent report into eye services in Thames Valley. The Finnemore report was published in September 2005 and concluded that local NHS services were on target to meet government waiting lists for cataracts some as early as the summer of 2004 and that there was excess capacity in Oxfordshire and highlights the need for urgency in addressing risks to local eye services.

The National Audit Office also investigated the netcare contract from a remit of best value, but this did not include investigating allegations of political interference with the PCT.

A public board paper for the meeting of South-West PCT on 24 November 2005 includes a six month review of the NETCARE contract. Netcare are currently contracted to provide 800 cataracts a year in North and South Oxfordshire from April 2005 for four years. South Oxfordshire is contracted to take on average 456 cataracts and 593 pre-operative assessments per year. The Board Paper shows that in the first six months of the contract £255,000 has been paid to Netcare to carry out assessments and operations although only £40,000 of work has been carried out.

A six month review in November 2005 found that only 50 of 323 available pre-operative assessments have been booked and only 43 operations have been done out of 249 theatre slots available. The tariff cost is £72 for preoperative assessments and £824.34 for a cataract operation, but the cost is six times the national tariff as the NHS has to pay for all contracted procedures, regardless of whether they are performed. The set up costs of the mobile units and project management are not mentioned in the review but have to be paid for by the NHS.

The review concludes that “the uptake of slots for Netcare has been slow. The population commonly requiring cataract surgery is elderly, and the Oxford Radcliffe Hospitals have a strong reputation and short waiting lists”. The review notes that in relation to the general surgery chain run by CAPIO referrals have also been slow and concludes “The concept of Independent Treatment Centres has been show to catch on”.

**Detailed Evidence on Events Leading up to the Original Board Decision on 27 November 2003**

Board members of South-West Oxfordshire PCT were first made aware of initiatives on treatment centres in January 2003 but the Board had concerns even at this stage about the lack of information and transparency about the initiatives. The minutes of the Board meeting on 27 February 2003 (after correcting at the Public Board meeting on the 24 April 2003 state:

“The Board accepted the next steps. It was noted that the PCT needed clarity on the timescale and additionally at what point the PCT would need to make a decision to commit or pull out”.

It was always the understanding of the PCT Board that the board was required to take a decision to approve each Treatment Centre after reviewing the outline and full business case, and that legally the signature of the PCT Board was needed. We also understood that the Secretary of State has power to make a formal direction to the PCT.

Board members considered an initial proposal for an ophthalmic treatment centre at a private meeting in July 2003 and a decision was made unanimously at this stage not to proceed because it was not in the interests of Oxfordshire’s population. This was because the NHS ophthalmic service was on target to meet waiting lists and had Beacon status as a centre of excellence and that funding a private unit would not be cost-effective and would expose the existing system to serious risk. Two other Primary Care Trusts locally did the same and a letter was sent by the Board to the Thames Valley Strategic Health Authority requesting withdrawal from the scheme.

The Chief Executive of the PCT received a letter on 21 August from Celia Cohen at TVSHA stating that after detailed discussions with the operations directorate of the Department of Health at the highest level the request of the PCT had been refused and that “we must remain a committed participant within the procurement process”. The PCT Board, however, had never made any decision to commit to the ophthalmic Treatment Centre (Ophthalmic ISDTC).

Leaked papers from an anonymous source on 21 August 2003 included an update from the national team to PCTs (Richard Audley) stating that a meeting will be arranged with the bidder and that:

“this is a pro-active meeting and not to question if anybody agrees of disagrees with the ISDTC”.
Under the section of the paper “Programme Forward”, the update continues:

“we only have until 19 September to resolve all outstanding issues . . . The buy in and signature on the contract of the PCTs is your responsibility. If you need any support with engaging them or keeping them on board do not hesitate to ask the NIT OC Team. We will provide assistance in any way we can, and if required will call on that provided by Sir Nigel Crisp and John Bacon to remind PCTs of their commitments and responsibilities to this programme”.

A leaked email on 27 August from Tony Hickson at TVSHA stated:

“The OC chain has based their figures on the Cataracts, PLUS other ophthalmic procedures, which I know is flawed, however these figures have been out in the tender document by the NIT (National Implementation Team) and cannot be changed”.

Leaked anonymised emails on 28 August 2003 between managers in Oxfordshire state the view of one manager:

“I think we must keep any local noise to zero”.

Executive members of the Board met with TVSHA and national team in September and reported that they had negotiated a reduction in the numbers of the cataracts. Non-executives express concern in private and public sessions of the PCT of the lack of information on the initiative including financial risk and impact on clinical services.

The South-West Oxfordshire PCT Board decides in a public board meeting on 25 September to proceed to consider the full business case for the ophthalmic ISTDC but only on condition that the business case ensures that the treatment centre meets the needs of the local population; is affordable; that workforce issues are sustainable and integration with local services is achievable. The PCT also agreed to consult the public on the Treatment Centre at the September meeting (minuted as a correction to the September Board meeting minutes at the PCT Board meeting of 27 November). A letter is sent to TVSHA from the PCT to inform them of the PCT Board’s position.

The Oxford Radcliffe Hospitals NHS Trust produced an impact assessment on the eye hospital concluding that the:

“the current plan is drastic on the Oxford eye Hospital”.

On the 13 October the Chair of the Local Optometric Committee wrote to ask the Chief Executives to put their views before any Board was made. The Committee:

“We feel strongly that the DTC locally is unnecessary to meet the NHS targets for Cataract Surgery in Oxfordshire, but risks seriously undermining the quality of training, and therefore in the long term the standard of Clinical expertise”

Neither the full impact statement from the ORH or the letter from the Chair of the Local Optometric Committee were circulated to non-executive board members at this time or indeed at any time before the decision of the PCT Board on 27 November.

Executive directors were under intense pressure from August onwards and on 5 November the Finance Director sought the support from Martin Avis, the Chair of PCT and Jane Hanna, non-executive in an emergency meeting with Cherwell Vale PCT representatives; members of the national team and the TVSHA. A written note of the pre-meeting between South-West Oxfordshire representatives and Cherwell Vale representatives states the understanding between South-West Oxfordshire PCT and Cherwell Vale PCT:

“SHA is pushing for early approval to the OTC ahead of the December Public Board meeting. All present agreed serious reservations regarding the process and merits of the OTC which needed to be progressed with the TVSHA.”

At the meeting with TVSHA and the national team, the PCT representatives from both boards stated that there was a serious risk that PCT boards might not approve the full business case given the speed of decision-making; the gaps in information and full evidence and the of lack of patient and public involvement or consultation. A TVSHA representative said

“that the PCT did not have an option. The Boards would be surcharged”.

When the basis of a surcharge was challenged, the representative stated

“ . . . this was new territory”.

When the TVSHA were asked to put the liability to surcharge in writing another TVSHA representative present said the

“the TVSHA would never put a threat in writing”.

It was agreed that the PCTs would consider the full business case at a meeting in November, but would not guarantee approval.

At a private meeting of South-West and South-East Primary Care Trusts the Board, Martin Avis explained that he and other Chairs had been verbally threatened since August. Martin told the meeting that another local PCT Chair had been told she would lose her job if the contract was not approved. Subsequently I have learnt from the person involved that it was the Chair of Cherwell Vale PCT.
At an emergency private session on Tuesday 25 November between senior managers of South-West Oxfordshire PCT and Martin Avis, Jane Hanna and Catherine Kirby (Non-Executive), the Finance Director, Caroline Kenny became distressed after realising non-executives might vote against the treatment centre and made a statement “but what about my career”. It was understood by everyone present that all that senior managers has been under extreme pressure regarding their personal futures.

The Non-Executives had made it clear to the Chair on many occasions and he had told the non-executives that he had communicated to TVSHA that we were happy for the Secretary of State to override our decision in the national interest as he has powers to do, but that we were not prepared to agree to a contract except on the objective merits of the scheme.

THE VOTE ON 27 NOVEMBER

The Non-Executives were very worried by the intense pressure and the lack of full information needed to make the decision. On the night before the meeting we were emailed at 5.40 pm with a 40 page document on the clinical practice of Netcare and we only received the actual completed Full Business Case one hour before our meeting on 27th. Prior to this we had received very scrappy papers with key information missing on local affordability and about local risk. The full business case was very much a national document and did not put the local case. A summary paper by our executive putting a local case was lacking in evidence regarding the impact of the decision and on key financial risks.

After a very robust debate of some two hours a vote was taken at the Public Board meeting. The vote was four (Execs and Chair): four (Non-Execs). Jean Bradlow, the Public Health Director abstained in the vote. All the non-Executives (apart from the Chair) stated that they were unconvinced by the evidence.

The impasse in the vote was resolved by the Chair. He asked the non-executives to repeat their reasons for voting against. Jane Hanna summarized the concerns which were minuted. Martin Avis, Chair then voted with the non-executive members.

In the aftermath of the decision. The executive members of the PCT were very distressed. Jean Bradlow told Jane Hanna that the decision would effect her job and Mary Wicks, the Chief Executive was visibly upset.

The non-executive directors were congratulated by representatives from Cherwell Vale PCT that were present in the audience and by some of the managers in South-West.

The Chief Executive, Communications manager, the two Chairs of the PCTs and Jane Hanna and Catherine Kirby agreed key messages for a press statement.

IMMEDIATE EVENTS FOLLOWING THE BOARD DECISION ON 27 NOVEMBER

A press release was produced that afternoon from the PCT explaining the reasons for the decision, but we were told that TVSHA had forbidden the issuing of the press release. Jane Perry, Communications manager of the TVSHA issued a press statement

“We know that treatment centers are very beneficial for patients so we are surprised and disappointed by the decision by the South-West Oxfordshire PCT Board not to progress their plans for a local treatment centre”

The non-executives were then exposed to negative publicity in the local press on the Friday. Senior executives from the PCT and the Chair of the PCT were summoned to TVSHA. All the non-executives were rung on Friday 28th by the Chair of Trust and told that he had been instructed that the Secretary of State for Health wanted a letter on his desk reversing the decision by Monday at 12 noon. Martin also told us that he had been told by Jane Betts at the TVSHA that she was on her way to the Appointments Commission and that the “tumbrels were turning”—we understood this to mean a phrase used during the French revolution and the guillotine!

Martin Avis called an emergency meeting on Sunday 29 with non-executives, the Chair of the Professional Executive Committee and the Chair of the Patient and Public Involvement Group of the PCT. It was explained that everyone’s positions on the Board were under threat from our decision. Non-executives told the Chair of Trust and the Chair of PEC that they would need to meet alone to decide what to do. The meeting lasted from 11am until 7pm. We carefully wrote a letter saying that they were already prepared to consider new evidence that a national scheme was in the local interest but that we could only do this at a properly constituted Board meeting as required under our standing orders. The letter was proposed to Martin Avis by email that evening and he agreed he would send the letter the next day.

On Monday 1 December the Chair rang me to say TVSHA would not allow us to send a letter to the Minister unless it was sent by Mary Wicks, the Chief Executive as well as the Chair on behalf of the non-executives. The Chair indicated he was very concerned about Mary Wicks. We agreed to write instead to Jane Betts, Chair of Strategic Health Authority.
Nigel Crisp said on the Today programme in December that the PCT could decide not to approve the treatment centre, but we would need to give our reasons. John Reid stated in Parliament that it was our decision so long as we gave reasons. We produced two pages of reasons after the meeting of the 27th but we also clearly understood from our Chair and from the executive team that we had been told that these reasons were not sufficient and that the PCT had to reverse the decision.

On 4 December the TVSHA agreed that the financial risk to the PCT would be underwritten. Nick Relph, Chief Executive of Thames Valley Strategic Health Authority wrote:

“The SHA commits that should this number (400 cataracts) be shown to be too high either by the ophthalmology review or from experience once the programme has commenced we shall ensure that the PCT’s financial position is not adversely affected. This will be achieved by reducing the numbers in the contract and brokering this activity elsewhere . . . I understand that the precise level of establishment costs is still subject to agreement but would expect either the NIT and/or the SHA to ensure that your financial position is not prejudiced . . . regarding project management costs we are working with the NUT to ensure that adequate funding is made available for project management costs”

Martin Avis emailed all non-executives on 5 December to state that

“There is now no financial risk in the brokerage, set-up costs . . . The excessive amount of precious executive (and non-executive) time this agreement, for some 450 cataract operations per annum, has and is consuming should cease . . . it is unfortunate that the Board has become split by this incident”

We also received emails from Tony Williams, Chair of South-East PCT (which shared the same executive directors as the South-West) expressing his serious concern about the pressures on Mary Wicks, the Chief executive.

Catherine Kirby wrote a detailed email on behalf of the non-executives on 7 December that in the interests of greater clarity and the integrity of the Board a large number of questions that remained unclear or without evidence or information still needed to be answered—these were listed in detail in the email. In particular, this concerned the financial risks on the Oxfordshire system as a whole; clinical risks to our population as well as the failure to adequately involve or consult local stakeholders and the public.

Nick Relph, Chief Executive of TVSHA wrote to Martin Avis on 10 December that the Treatment Centre did not require formal public consultation.

“It would not normally be necessary to consult when the change relates to a new, additional, service for local residents”

In Parliament, David Cameron MP asked the Secretary of State in a parliamentary question on 9 December

“Will he give me an assurance that, if a primary care trust votes against a diagnostic and treatment centre because it believes it is not in the interests of local people, it will not be subject to improper pressure from the Department of Health or the Strategic Health Authority to change its mind? Can he assure me that that has not happened, and will not happen, in the case of South-West Oxfordshire primary care trust”

Dr Reid responded

“I will be prepared to accept them and all reasonable people will accept that local primary care trusts have to make their own decisions, but the public will want to be sure that those decisions are based on the interests of local patients, and are not unduly influenced by the interests of local providers and producers, especially consultants. It is essential that, in all these, decisions, the interests of the patients are put first”

**EMERGENCY MEETING 11 DECEMBER**

The Chair called an emergency meeting for the 11 December 2003. The Board members present was different from the original first meeting on the 27th. For example, Mike Russell was present as a non-executive, but had been away in the immediate lead up to and the original board decision. The Board approved the OTC.

The non-executives who voted against at the first Board meeting did not alter their position. The reasons given were that the non-executives were concerned that 800,000 pounds was being transferred from the local eye hospital and that patients who needed eye care of a more serious kind such as patients with diabetes and glaucoma would lose vital high quality services for the sake of a private mobile cataracts unit that was not needed. We also were very concerned that even if TVSHA took the financial risk that this was a risk that remained on the Oxfordshire NHS and that, based on our experience, the PCT would inevitably be caught up in resolving financial risk to the whole system. We also considered that it was wrong to proceed with such haste without public involvement and consultation. There were also some concerns about price because the local NHS provider was quoting a lower price than netcare and when we were assured that netcare would
be 12% under National tariff we could never get a clear answer as to what the national tariff was—the national tariff figure changed from meeting to meeting or were not given at all. We gave our reasons in writing again after the meeting of the 11th.

**Aftermath**

Lesley Legge, Chair of the Oxfordshire Health Scrutiny and Overview Committee wrote to Dr Reid on 18 December seeking an explanation why decision-making was so rushed and uninformed and why there had been inadequate involvement of local people or indeed adequate information to the Health Scrutiny Committee. She questioned how there could be any meaningful public involvement and protection of local interests when these interests could be suspended as a matter of national expediency.

Following the decision, the non-executives were emailed by the Chair with information about their duties to act in a corporate manner.

Martin, Chair of Trust was only the Chair in Oxfordshire not to be renewed in January. *The Guardian* reported in June 2004 that he had been verbally threatened since August and the “The Chairs of other PCTs were, but they won’t talk”. He told the non-executives of the PCT that he had been verbally informed by Bernard Williams, Chair of the Appointments Commission that he was not renewed because of the Treatment Centre decision.

Non-executives met in January in emergency session to review what had occurred. It was agreed that there had been a serious breakdown of trust as a result of what had occurred in relation to the treatment centre decision. The relationships of trust which were discussed included within the PCT, between the PCT and the NHS system as a whole including the NHS Appointment Commission.

During February Martin Avis and executive board members told non-executives in private board sessions that it had been made very clear that we had no choice but to agree to all the other treatment centres, but that the board was also instructed to present these national initiatives as local decisions of the PCTs.

Jane Betts Chair of TVSHA resigned at the end of March concluding that the SHA was quoted in the Guardian as saying the TVSHA was

“local office of the NHS”

She was quoted as admitting the bullying tactics from TVSHA and that TVSHA was:

“the jam in the sandwich” because it was under heavy pressure from the Department of Health to deliver a deal that the prime minister had set his heart on. The contract was “on the top 10 list of things the prime minister wanted to see done . . . someone was playing political hardball with the people of south-west oxfordshire”

A New Chair, Fred Hucker was appointed to South-West Oxfordshire PCT in April 2004. He was formerly a non-executive at the TVSHA. There were only two applicants interviewed for the job—Paul Wesson, non-executive Director of South-West Oxfordshire PCT, was the other candidate. Bernard Williams was a member of the appointments panel.

After Fred Hucker was appointed all the Non-Executives were sent a letter from Sir William Wells, Chair of the Appointments Commission informing us that our new Chair would be making recommendations about our performance at the end of 12 months and that our appointment might be terminated before the end of our office term. It stated that this letter was sent to all non-executives of PCTs with new Chairs. The non-executives interpreted this letter as a threatening letter given the situation we were in and given we had not been placed on probation in the first twelve months after our original appointment.

Jane Hanna resigned on Thursday 27 May some six months later because no attempt had been made to learn lessons and instead the Board has continued to make other decisions under centralised pressure and without openness or consultation with local patients and the public.

File on 4 on 2 June reported on a detailed investigation into the events surrounding the cataracts decision and other examples from across the country. Nigel Crisp was interviewed about the allegations of bullying and why he had said on the Today programme in December 2003 that local Boards could make decisions on Treatment Centres. He said that it was in fact that the treatment centre decisions were in fact many people’s decision including the private provider before cutting short the interview.

In December 2003 TVSHA had commissioned an independent review of eye services in Thames Valley. In June 2004 a draft final report was leaked and reported in the local press. The report was extremely critical about the financial and clinical risks that threatened eye services in Thames valley as a result of the Netcare contract.

The Finnemore report was finally made public in September 2004. The final Report differs not in terms of facts but in the interpretation of the facts. The detail of the final report still concludes that local NHS services have a high reputation and are on target to meet government waiting lists for cataracts some as early as summer 2004 and that there is excess capacity in Oxfordshire; it includes reports from hospitals of clinical priorities being distorted by focus on cataracts at expense of patients with more serious eye conditions; and highlights the need for urgency in addressing risks Whilst the draft report concluded that the eye unit was being put in the wrong place and that there was a significant risk of destabilising the Oxford eye hospital,
the final report now says that the excess capacity will be helpful in managing need from elsewhere in Thames Valley and perhaps as far a field as Scotland and Wales. In terms of risk the detail of the report continues to highlight that the risks are urgent in terms of long term viability and quality of patient services.

A public board paper on a review of the treatment centre, 24 November 2005 finds that only 50 of 323 available pre-operative assessments have been booked and only 43 operations have been done out of 249 theatre slots available. The tariff cost is £72 for preoperative assessments and £824.34 for a cataract operation, but the cost is six times the national tariff as the NHS has to pay for all contracted procedures, regardless of whether they are performed. The set up costs of the mobile units and project management are not mentioned in the review but have to be paid for by the NHS. Finally, the paper mentioned negotiations by TVSHA regarding the underwriting of the financial risk, but does not mention the written agreement from TVSHA to the South-West PCT Board that all financial risks will be underwritten by TVSHA.

Jane Hanna
23 November 2005

Annex 1

INDEPENDENT SECTOR TREATMENT CENTRE SIX MONTH REVIEW

1. Introduction

Netcare Cataract Treatment Centre, which is part of the National programme of Independent Sector Provision, has been visiting Wantage, Mably Way practice since April 2005. The Netcare resource is made up of mobile units that visit on a monthly basis as a rotation throughout the country. There are three resources which are staffed specifically to the patients needs, pre-operative, operative (or theatre unit) and postoperative. Alongside the units Netcare provides a 24 hour telephone help line for patients undergoing surgery. Netcare also provide this service in Bicester and Reading.

When a patient has been diagnosed with requiring cataract surgery they are offered a choice of provider. Depending on the individuals clinical requirements, this is made up of Netcare and the locale acute hospital depending on the patients location within the county. The choice offer is provided by a call centre located at the Radcliffe infirmary. A script is used when contacting the patient to provide the patient with relevant and unbiased information about all providers, (as per DOH requirements).

Although the purpose of this paper is to identify the progress of the Netcare contract, the PCT is currently engaged with several other independent Sector Treatment Centre schemes: GC4-Capio, GSUPP and wave 2 diagnostics. A brief summary of this activity is identified under point 8.

2. Marketing

The uptake of slots for netcare has been slow. Various marketing strategies have been employed to encourage the uptake of the service. These have included, advertising on the local radio stations, open days/evenings for patients and patient groups, talks and presentations to local groups, presentations and open evenings to GPs and ophthalmologists. Information has been produced and displayed in GP practices. Marketing is ongoing.

All take up of Netcare has relied heavily on patient’s choice. In addition, the PCT are unable to commercially advertise one service over another. The population commonly requiring cataract surgery is elderly, and the Oxford Radcliffe Hospitals have a strong reputation and short waiting lists.

3. Attendance

Attendance to the Netcare service has been disappointing. The supporting table identifies the uptake against capacity. Patients requiring second eye surgery have been provided with a choice and all have re attended Netcare for the surgery. Second eyes make up another six cases for the coming months. The second eye waiting list is monitored and managed by the PCT.

<table>
<thead>
<tr>
<th>Date</th>
<th>Type of Clinic</th>
<th>South Oxfordshire Activity Allocated</th>
<th>Activity Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2005</td>
<td>Pre-operative</td>
<td>65 (104)</td>
<td>13</td>
</tr>
<tr>
<td>* May 2005</td>
<td>Theatre</td>
<td>42 (80)</td>
<td>11</td>
</tr>
<tr>
<td>June 2005</td>
<td>Pre-operative</td>
<td>40</td>
<td>13</td>
</tr>
<tr>
<td>July 2005</td>
<td>Theatre</td>
<td>40</td>
<td>12 (1 DNA)</td>
</tr>
<tr>
<td>August 2005</td>
<td>Pre-operative</td>
<td>136</td>
<td>11</td>
</tr>
<tr>
<td>August 2005</td>
<td>Theatre</td>
<td>104</td>
<td>9</td>
</tr>
<tr>
<td>October 2005</td>
<td>Pre-operative</td>
<td>82</td>
<td>13</td>
</tr>
<tr>
<td>October 2005</td>
<td>Theatre</td>
<td>63</td>
<td>11</td>
</tr>
</tbody>
</table>
No of Pre-operative clinic slots available = 323  used = 50
No of Theatre slots available = 249  used = 43

* The initial activity for these dates originally equated to 104 pre-operative slots and 80 theatre slots. A percentage of this activity was brokered to Kent and Medway.

4. **FINANCIAL IMPLICATIONS/RISK MANAGEMENT**

The financial implications mirror the constraints that have been identified. A paper was presented to the financial sub committee identifying the ongoing financial implications of the Netcare commitments.

Financial risk from the outset of the programme has been monitored. The tariff for pre-operative appointments is £72.00 and theatre slots £824.34, post-operative appointments are not charged. To date the South East and South West PCT have received invoices for the following activity:

<table>
<thead>
<tr>
<th>Month</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>£4,504</td>
</tr>
<tr>
<td>May</td>
<td>£62,649</td>
</tr>
<tr>
<td>July</td>
<td>£3,744</td>
</tr>
<tr>
<td>July</td>
<td>£32,149</td>
</tr>
<tr>
<td>August</td>
<td>£25,124</td>
</tr>
<tr>
<td>September</td>
<td>£69,244</td>
</tr>
<tr>
<td>October</td>
<td>£57,837</td>
</tr>
</tbody>
</table>

These account for pre-operative and theatre activity, on the basis of whether the procedures were allocated or not.

The financial risk associate with the under utilisation of the Netcare Activity has been identified on a pan-Oxfordshire basis to Thames Valley Health Authority. They have recognised this risk and are currently negotiating directly with the department of Health on Oxfordshire’s behalf to have this underwritten. For this reason, Thames Valley Health Authority have accepted the financial pressure not to be shown in forecasts at this point. However the PCT have recognised the need to continue with local action to fill treatment centre capacity where possible.

5. **CLINICAL QUALITY**

Clinical quality of Netcare is monitored under the contract by the DOH. All consultants are specialist and are registered by the GMC. Netcare adhere to guidelines for cataract surgery as recommended by the Royal College of Ophthalmology (2001).

To date there have been no clinical complaints or incidents.

6. **CARE PATHWAYS**

Clinical care pathways where set up in partnership with Netcare, local GPs, ophthalmologists and the Oxfordshire PCTs. These have been continuously reviewed against safety, ease of access, clinical audit and governance. The current care pathway is documented at each stage to provide a paper trail of the patient’s experience, and information to relevant parties, complying to Caldecott governance requirements.

At the post-operative clinical the need for second eye surgery is identified the patient is then contacted at an agreed time post surgery to offer the choice of where they would prefer to have their second eye treated.

7. **COMPLAINTS/COMMENDATIONS**

To date the South East and South West Oxfordshire PCT have not received any formal complaints or commendations about Netcare.

8. **FURTHER INDEPENDENT TREATMENT CENTRE ACTIVITY**

8.1 **General Surgery Chain GC4—Capio**

Capio is an independent sector provider that provides a range of inpatient and day case procedures, for example lower genital tract, upper genital tract, prostrate etc. Patients have been referred to Capio Reading since April 2005.

Referrals have been slow, however progress is being made. To support referrals through to Capio West Berkshire referral hub has been engaged. Promotion of Capio with clinicians is ongoing.
8.2 General Supplementary Activity

This contract is to provide orthopaedic capacity, with the aim to achieve the six month maximum waiting time for December 2005. This contract was awarded to BUPA, BMI and Nuffield. This capacity has been used to treat patients requiring joint replacements transferred from current lists.

8.3 Wave 2 Diagnostics

Wave 2 diagnostics is an independent treatment sector procurement to provide further diagnostics, with the aim to reduce diagnostic waits. Work is ongoing to identify capacity required and suitability of sites with the PCT area.

9. Conclusion

Uptake of Netcare activity has been disappointing, the ongoing demand and financial risk is being monitored. A modelling exercise has been completed for planning the ongoing Netcare requirements alongside that of North Oxfordshire partnerships.

Options for the future use of Netcare activity are currently being appraised by the Oxfordshire PCTs, Netcare and Thames Valley Health Authority.

The concept of Independent Treatment Centres has been slow to catch on. Continuous engagement with all stakeholders is imperative to gain the benefits from this activity.

Memorandum submitted by Bruce Laurence (PCT 30)

I write in a private capacity and not on behalf of any organisation but I am a director of public health of a PCT in the Midlands. I am writing this to express my concern at some aspects of the current direction of NHS policy, some crucial elements of which are covered by the remit of your committee.

I would like to take a public health perspective, but to do this it is necessary to start from a more general one.

I would first like to say that there are many policies that I welcome, in particular the current emphasis on Public Health stimulated by Choosing Health, but also National Service Frameworks, Connecting for Health and others.

The current thrust of a number of the most important developments is without doubt to diminish, or even dismantle the NHS as an integrated and predominantly public sector organisation. I do not believe that the public is really aware of the far-reaching and irreversible nature of these policies. Such consultations as there are do not make explicit how the market is being brought in at all levels and how this is already fragmenting the service. PCTs of whatever size will have very little hope of holding together effective care pathways or funding treatments through a needs-based approach. Above all PCTs will struggle to protect the interests of those who need services that do not serve the profit motive or the interests of those with social and economic power in the country as a whole and in the NHS in particular.

This process is happening from both within and without the organisation. We are seeing every encouragement for the private sector to take over all manner of roles within the service. Commissioning organisations are being forced to invest substantial sums in the private sector. There will certainly be some benefits from the engagement of private enterprise, though the process will inevitably involve some degree of cherry picking. More worrying is the way in which NHS providers under the demands of payment by results, and the freedoms of Foundation Trust status have to act as quasi-private institutions. Though FTs are not technically private or profit making organisations, if they are to thrive in the system that is being developed they are almost bound to act in ways that are little different to those of technically private institutions. It is no secret at all that for foundation hospitals the need to attract business and make money has rapidly become the prime mover and that competition has begun to drive out co-operation. Equally the need for PCTs (large or small) to minimise expenditure in secondary care will become a major driver whether logical or not in terms of patient experience.

One of the most concerning elements of this is that the ability to create sensible and effective care pathways for patients becomes almost impossible when competition drives providers to seek to maximise their own activity and income. I could give many examples, but I will give three from my own experience.

1. Clinical networks, such as cancer networks, which operate across a number of commissioners and acute providers, are finding it increasingly difficult to deliver integrated care pathways. Where patient care would benefit from moving specialised services from one trust to another, this is hindered by the need for those trusts to retain as much activity as possible. One recent example that I am aware of concerns the establishment of local home chemotherapy services.

2. I have heard reliably of a specific instance when one provider refused to share good practice in reducing waiting times with a “competitor”.
3. I am involved with a major review of children’s and maternity services where logical restructuring is being threatened by the potential of reduced services in key specialties to damage the financial viability of certain providers.

This problem results from unintended consequences of a number of policies. These include payment by results, foundation trust policy, and the policy of choice which, while laudable in its own right, does have some unfortunate side-effects.

Equity across the system is also threatened. As the market takes hold, those with no power will see their interests squeezed by the demands of those with power, including both the elite consumers and the big provider organisations whose ability to focus on what is profitable will only increase year by year. The central safeguards, such as Monitor, and the Healthcare Commission will be very unlikely to have enough power to prevent a drift in this direction, while there is already published evidence that the local stakeholder boards attached to foundation trusts are becoming frustrated at their inability to challenge the executives.

Once the system has been opened up to the market the clock cannot be turned back. For this reason this set of policy changes seem much more fundamental than previous structural changes.

What relevance has this to the reconfiguration of PCTs?

Firstly I would say that there are certainly some good reasons to amalgamate PCTs into larger units and that the policy is in principle a reasonable one. But there is a choice between complete re-organisation, and encouraging PCTs to form larger functional units through partnership and networking. The financial and other costs of total reorganisation are huge.

Also the reconfiguration of PCTs entails a major drive to split commissioner and provider functions which has several additional risks. My cautions that follow relate to both these aspects.

Firstly the “health services market” is a false market. It is false because none of the fundamental principles of a market applies to the health service, at least not one that has as its overriding goal good universal provision to the whole population. The market will fail most in rural areas and in protecting the interests of more deprived individuals and social groups. It is only wishful thinking that larger PCTs will be able to manage this market any better than the current PCTs.

I will not comment much on the savings that are going to be made from amalgamating organisations, but would ask the committee to consider whether from a budget of over £100 billion, the saving of a possible £250 million justifies the huge real costs of another root and branch reorganisation. Expenditures such as that on new premises, administrative time to TUPE staff and redundancies will bite deeply into any savings, and even relatively trivial matters like new stationary and signs will mount up. The costs inherent in loss of momentum in delivering clinical improvement and reduced staff morale are also very great, if less quantifiable.

Secondly, if PCTs have to relinquish their provider functions this is likely lead to the weakening of both the PCTs themselves and also the community services and community hospitals that have made up their traditional provision arms. PCTs will be weakened because having no capacity of their own will diminish their bargaining power with providers. Community services will be weakened because to a great extent they do not lend themselves to easy profits. These services are likely to fare badly as practice-based commissioners, acute trusts and private providers seek out the most profitable activities and shy away from the hard slog of providing for the poor and socially excluded, young, elderly and mentally ill. How many private providers and PBC plans involve the care of the elderly mentally ill or the homeless, for example?

It is a public sector NHS with a public sector ethos that has maintained such equity as there is in the health service up till now.

It is of great interest to me how the American organisation Kaiser Permanante was so trumpeted in the NHS a few years ago because of the way that it owned and integrated the primary and secondary care facilities. Now, we seem to have gone in exactly the opposite direction towards a model where the key to improvement seems to be specifically not owning or controlling any services at all.

Thirdly, practice based commissioning will soon become a major factor in the overall picture. Its success needs to be built on the local engagement that has taken three years of hard work to establish. This could be swept away as PCT managers take on new roles and GPs have to adapt to yet another organisation. (Incidentally why are GPs, who have been independent small businesses for decades deemed to be immune from the conflict of interest inherent in purchaser-provider organisations?)

Fourthly PCTs have spearheaded partnerships with other local institutions such as local government and the voluntary sector. In areas such as the largely rural, and not particularly deprived area where I work, it was only with the advent of a PCT with its own board that any attention was given to the small, but significant pockets of rural and urban deprivation that exist. While there may be certain advantages in efficiency of partnerships in scaling up PCTs it will be difficult to maintain this fine-grained appreciation of local needs.

Fifthly, we seem to be under the management of policy makers who are unaware of the realities of organisational change. There seems to be almost no appreciation of the amount of work and cost that a re-organisation entails; how expensive it is in money, time and morale.
The current crop of PCTs are implementing a stack of policies so high and so challenging that it is astonishing that there seems to be no understanding of how another wholesale reorganisation (from top to bottom of the service this time) will make it impossible to push these forward in a considered way. Here are the policies that I can think of in a two minute brainstorm.

Choose and book
Practice based commissioning
Choosing health
Connecting for Health
Agenda for change
Knowledge and Skills Framework
Winning ways
The Civil Contingencies Act
Local delivery plans and ISIP still in parallel
Local Area Agreements
Several National Service frameworks (approximately 10)
The cancer plan and Improving Outcomes Guidance for specific cancers
NICE policies
Pandemic Flu planning
All the various waiting time initiatives
Payment by results
At least three new screening programmes
Every child matters
And Improving working lives

plus now PCT reconfiguration and managing the purchaser provider split itself.

Finally improvements in PCT commissioning performance could come just as well from developing active networks, such as we have been developing in the area where I work, as from complete reorganisation.

PUBLIC HEALTH

As a director of public health my most specific concerns are about equity, the reduction of health inequalities, partnership work, the promotion of healthy lifestyles and the protection of the public. There are opportunities and risks inherent in PCT reorganisation which affect all of these.

Equity is threatened if practice based commissioning leads to gaps between well and poorly managed consortia. On average (and with many acknowledged exceptions) it is easier to recruit good GPs to wealthier areas than deprived ones, so without a lot of external support to weaker practices this policy is quite likely to increase inequality. Restructuring PCTs will set clinical engagement back and the new PCTs will take a long time to influence this process sufficiently well to ensure good performance across all practices. I have already discussed at length how equity is also threatened by the conjunction of other policies, notably PBR, commissioning-only PCTs and choice.

Health inequalities have not reduced despite many laudable attempts over the past few years. It is consistently established that the inverse care law operates most effectively in market based health services and so current policies may be expected to magnify inequalities. The policy of increased choice will have potentially beneficial effects in some areas, but not in that of decreasing health inequalities. The likely impact of the reconfiguration of PCTs on inequalities is uncertain. Experience where I work suggests that there is a danger of losing the local focus, and the small-scale calculation of resource allocation that has allowed relatively fine tuning for local variation in needs to be made. However it is also possible that pooling resources over a larger area can bring some benefits from larger scale flexibility. Of course many consider that reducing health inequalities will require very much more fundamental social and economic changes than the NHS can provide, but that is probably outside the remit of this hearing. What I would say is that the public health teams in the NHS are, in general, the torch-bearers for the reduction in health inequalities, and it is essential that the public health profession keeps very firm roots in the NHS commissioning organisations while building equally strong links into local government departments. While the document “Creating a Patient-led NHS” and the later commissioning counterpart are explicit about the importance of health improvement role of new PCTs, most of the policy discussion that is now going on is very much about PCTs’ commissioning roles, leading me to wonder whether the balance is going to be rather one-sided.

Partnerships are threatened by the dismantling of locally based organisations and their replacement with new ones covering up to a million people. To some extent the skilful development of localities within larger units can mitigate against this. But there is no doubt that PCTs have advanced local needs that were never before picked up on the radar of larger organisations. While decreasing the number of PCTs will, in some
cases improve coterminosity with the upper tier of local government this could also be achieved through networking arrangements with less disruption. The issue of partnership also illustrates the diverse needs of PCTs covering unitary and two tier authorities.

Health promotion is threatened by the separation of the provider services from the commissioning organisations. New health promotion services will have to compete, and as with clinical services there are those that are profitable and easy and others that are not. Quasi-private health promotion provider services in a competitive environment will be unable and unwilling to subsidise the less profitable activities from the proceeds of their cash-cows. We might expect to see services for the poor and excluded sacrificed to the much easier provision of slimming clubs and exercise facilities for the middle classes who know how to make their demands felt. Also it should be noted that patient demand for health promotion is always far below that for acute medical services so such services will already be under pressure in a market led system.

Public health and health promotion do not naturally or usefully split along a neat commissioner/provider fault line. Success in health promotion in PCTs has often come from the productive interaction of “public health entrepreneurs” amongst PCT core staff who saw new needs and opportunities and the health promotion units in those PCTs, and voluntary sector partners which could quickly develop appropriate services on the back of their core services.

Finally health protection will be threatened by the atomisation of the service. I am actively engaged in the planning for pandemic flu. Though there is good local will to work together, how will it be possible to ensure that independent GPs and foundation trusts, for example, will be willing to make the compromises and sacrifices that may be part of a rational plan?

It may sound from the above that I am against all current policies, but as I have said this is not the case. What I am against above all is the seemingly absolute fixity of the belief that a fragmented free market system must be better than the current public system. With this goes a determination to turn the NHS from an organisation into a sort of brand. While bigger PCTs may indeed be able to manage the market better, this is a leap of faith and I am sceptical that they will be able to remove all policy contradictions, hold the ring between so many conflicting interests and ensure that every need is met. I am scared that when all the commissioners and providers act logically from their own positions the outcome will be very illogical for the system as a whole and for patients with complex needs or for a society seeking to protect the interests of its vulnerable members. I believe is that health is a public good and that the promotion and protection of the public’s health is one of the highest duties of any society and government. I also believe that though a market system has many superficial attractions and temporary advantages, it cannot compete with a thriving public sector based health service in the universal provision of good health care and the promotion of good health.

I am also against a pace of change that takes insufficient account of the fact that NHS workers are real human beings. Both capability and commitment within the service is very great, but it is not endless. Because of what I have seen of the extraordinary dedication and professionalism of my colleagues I am not about to say that the whole system is facing collapse. I know that by hook or by crook the show will go on. But many will suffer and policies, whether good or ill, will not be implemented successfully at such speed.

I hope that the committee finds some interest in my remarks. I joined the NHS about seven years ago after spending 10 years working for medical relief organisations in Africa, Asia and Europe. I was somewhat surprised, and very gratified to find that the culture of public service in the health service is just as strong as it was in the very hard-driving NGO world. There is something extraordinary here that is worth protecting, and this is my motivation for writing this submission.

Bruce Laurence
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