

KING'S FUND RESPONSE TO: CHANGES TO PRIMARY CARE TRUSTS A HEALTH SELECT COMMITTEE CONSULTATION NOVEMBER 2005

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 June. 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. 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.

This represents 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 patient choice and payment by results, are placing on the service and the last thing we should be doing is diverting the attention of managers and health professionals from this demanding agenda, as well as from improving services to patients. There is a clear danger that patient care will suffer as a result.

3. Despite these concerns, we believe there is much of merit in the proposed changes. There is merit in the idea of strengthening the commissioning function in the NHS. Commissioners need to up their game if they are to counter the power of incentives applying to hospitals - we face distinct danger 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.

4. We believe that practice-based commissioning 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 our work in this area has shown that much stronger incentives are required if this to be a reality. In particular, practices that operate in areas that are already financially challenged will face few incentives to take a budget.

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.

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.
- 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 (e.g. 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. We are pleased that the Secretary of

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 reorganisation 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 (Fullop, BMJ, 2004).

Will the changes improve commissioning?

10. *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 through 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. However, the Department of Health will need to support this process as it's unlikely to happen on its own.

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 £76Billion 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.

King's Fund
November 2005

