

**Primary Care Trust Network response to the White Paper
Equity and Excellence: Liberating the NHS**

Summary

This paper sets out the Primary Care Trust Network's response to the White Paper *Equity and Excellence: Liberating the NHS*. It supplements the wider NHS Confederation response to the White Paper and the four associated consultation documents to which we have contributed.

The primary challenge facing the NHS over the next few years will be improving productivity to deliver an estimated £15-20bn efficiency requirement while maintaining or improving quality of care. The White Paper proposals must be considered in the light of this challenge, which is one of the greatest ever faced by the NHS.

There is strong evidence that Primary Care Trusts (PCTs) have made good progress in improving their capability and impact as commissioners, within the context of the previous Government's policy framework. We welcome the focus on further developing and strengthening commissioning which we believe is an essential component of a tax-funded healthcare system. Strong commissioning is even more essential given the economic constraints facing the NHS in the coming years.

We fully support the principles set out in the White Paper to ensure that we always put patients and carers first, we improve clinical outcomes and we empower clinicians. We believe that PCTs across the country have already established strong local frameworks from which this can be achieved.

Staff in PCTs are fully committed to working with the Coalition Government to deliver a successful National Health Service that produces excellent outcomes for patients and value for money for tax-payers.

However we feel that there remain a large number of unanswered questions in relation to the proposals which urgently need to be resolved before the plans can be taken forward, including:

- The role, function, accountability and governance of GP consortia
- The investment in management required to support the successful implementation of the vision
- Resolution to managing the conflicts of interest of GPs as both commissioners and providers
- The motivation and capacity for GPs to take on the new commissioning responsibilities
- The capacity of the NHS Commissioning Board to effectively deliver its responsibilities, including the commissioning of primary care
- The lack of clarity on the role of local government in the new system
- The consequences of moving to a more market orientated system and concerns about the new role for Monitor
- The risks of supply-side dominance as a result of reorganisation of the commissioning structures
- The risks of fragmenting the commissioning of complex services

We also have concerns about the significant risks to both quality of care and financial balance during the transition period, which are not sufficiently considered in the White Paper. There is an urgent need for a clear implementation plan to be put in place.

People working in PCTs have significant expertise and a wealth of experience that can be used to help address these issues and to design and implement effective reform of the commissioning system. The PCT Network is keen to work with the Coalition Government, the Department of Health and other stakeholders to resolve these concerns to ensure a successful future for the NHS.

1. Introduction

The PCT Network within the NHS Confederation represents over 90% of Primary Care Trusts in England. This response to the White Paper *Equity and Excellence: Liberating the NHS* from the PCT Network supplements the wider NHS Confederation response to the White Paper and the four associated consultation documents to which we have contributed.

The primary challenge facing the NHS over the next few years will be improving productivity to deliver an estimated £15-20bn efficiency requirement while maintaining or improving quality of care. The White Paper proposals must be considered in the light of this challenge.

There is strong evidence that PCTs have made good progress in improving their capability and impact as commissioners, within the constraints of the previous Government's policy framework. We welcome the focus on further developing and strengthening commissioning which we believe is an essential component of a tax-funded healthcare system. Strong commissioning is even more essential given the economic constraints facing the NHS in the coming years.

We fully support the principles set out in the White Paper to further empower patients and clinicians, and believe that PCTs across the country have already established strong local frameworks from which this can be taken forward.

Our members are fully committed to ensuring that the NHS delivers excellent services to patients as efficiently as possible, and continues to improve health outcomes. We believe this can be achieved despite the challenging economic situation and we will continue to work with the Coalition Government to help the NHS deliver these objectives.

The White Paper sets out radical proposals for the future direction of the NHS, but as the associated consultation papers make clear there are many important details which have yet to be determined. We believe there are some issues which are critical to the viability of the proposals, which we will highlight in this response.

Full support for the proposals in the White Paper for many in the NHS will be contingent on the Coalition Government addressing these issues.

Prior to publication of the White Paper, PCTs were facing a significant challenge: that of leading local delivery of the major productivity improvement and service

reconfiguration that is necessary to deal with slowing growth in NHS resources over the next few years, while significantly reducing their own management capacity and costs. They now face a further substantial task of supporting the transition to the proposed new commissioning structures.

Despite the challenges, staff in PCTs remain fully committed to working with the Coalition Government to deliver a successful National Health Service that produces excellent outcomes for patients and tax-payers. Our response to this consultation is intended as a constructive contribution to the debate over how the white paper proposals can be taken forward in a way that ensures this is achieved.

We believe that the government has set out a powerful long term vision but that there are real and substantial risks for the NHS during this transition period. We are concerned that the White Paper and the associated consultation documents do not address the risks of transition and that we lack an implementation plan.

PCTs have significant experience and expertise – including that contributed by both staff and non-executive directors - which can help resolve these issues. The PCT Network is keen to work with the Coalition Government, the Department of Health and other stakeholders to resolve these concerns to ensure a successful future for the NHS.

We have structured our response to the White Paper around its main themes rather than the separate consultation papers, as many of the issues are cross-cutting.

2. GP Commissioning Consortia

We agree that there are real benefits in aligning clinical and financial decision-making, and that GPs and other members of primary healthcare teams are well placed to review the overall shape of local health services, make high level assessments of their quality and impact, identify opportunities for improvement, and make commissioning decisions on this basis. Most PCTs have worked hard to develop effective clinical leadership for commissioning and in many places Practice based Commissioning (PbC) has been effective in delivering improvement.

We do recognise that progress with PbC has been mixed and agree that we need radically better and more systematic ways of locking GPs into the commissioning process so that they take responsibility for the financial and efficiency consequences of their clinical decisions and are effectively held to account for this. However we believe this could be achieved more rapidly than the proposals set out in the White Paper by building on the current approach rather than undertaking whole scale reorganisation.

Many of the frustrations expressed by GPs in relation to PbC relate to the cumbersome nature of decision-making in the NHS. Much of this derives from the procurement and consultation rules which PCTs have operated under. We would advise a thorough review of these rules to ensure they are fit for purpose for the future.

PCTs have also championed localism for many years. We welcome the emphasis on genuine local decision-making in the White Paper and agree there should be as much flexibility as possible for commissioning consortia to decide their own size and

form. However local decision-making does need to take place within a clear national framework.

For early work on establishing GP commissioning consortia to progress, there are a number of important points that we feel need clarification as quickly as possible. Failure to resolve these issues will impact negatively on the motivation of GPs and other clinical staff to support the proposed policy and potentially waste significant amounts of management effort.

2.1 Consortia functions and management support

We urgently need clarity on the range of functions which GP commissioning consortia will be expected to carry out and the proposed management cost limits in which they must operate. Without this it will not be possible for developing consortia to plan their management support arrangements. Commissioning is a complex task, and management support needs to be adequate for the task if we are to avoid setting the consortia up to fail.

PCTs are currently in the process of reducing their own management capacity and cost to 2002/3 levels. While it is absolutely right to give management costs just as much scrutiny as any other component of health spend, it is important to understand that since 2003 PCTs have been required to take on a range of new commissioning responsibilities (e.g. introduction of payment by results, management of primary care contracts and other functions transferred under *Shifting the Balance of Power* in 2005).

We believe some of the functions that PCTs have been required to take on can be discontinued, and recognise that others will transfer to the NHS Commissioning Board, the National Public Health Service or to local authorities. However, there are many responsibilities now undertaken by PCTs (such as safeguarding children and vulnerable adults, infection control surveillance, local emergency planning and managing primary care estates and IT infrastructure) which we believe will need to continue, but which do not obviously map to any specific part of the new commissioning architecture. It is vital that the responsibilities for all parts of the new system are clear and transparent to all so that appropriate resources and expertise can be deployed accordingly. The PCT Network has offered to work with the DH and other stakeholders to support this work and has already completed a summary of current PCT functions and duties.

Even though the role and functions of GP consortia will be different from those of PCTs, as custodians of the majority of NHS resources their responsibilities will still be substantial. To operate successfully, it will be important for GP consortia to have access to expert commissioning support. Much of this expertise is currently within the existing PCTs. It is important that the NHS does not lose access to this expertise.

While operating within the context of the previous government's policies, PCTs have increasingly become high quality, professionalised commissioning organisations, with the skills and capability needed for the future. They employ dedicated staff with extensive commissioning skills and high quality relationships within their local health systems, who are committed to securing the very best health service and outcomes for the patients, families and communities they serve. These staff should form the

bedrock of the commissioning support that will be needed by GP consortia, the NHS Commissioning Board, the National Public Health Service and local authorities.

We urgently need to put in place an effective HR framework to ensure that future GP commissioners do not lose access to important knowledge, skills and expertise held by these staff during the transition period as it will be difficult and expensive to re-build it. Part of this framework should include clarification of whether and how TUPE applies.

We would not expect management support arrangements for GP commissioning consortia to be identical across the country. In many areas GPs have worked well with their local PCT and we would expect consortia to be given the freedom to evolve the new arrangements from current structures rather than start from scratch, where they have confidence this is the best approach. Where existing commissioning is strong, this approach would avoid unnecessary disruption and ensure continuity.

2.2 Accountability and governance

Another crucial set of questions for GP consortia relates to accountability and governance. We urgently need clarification on how the accountability for GP consortia and their member practices will operate.

As GP consortia will be responsible for billions of pounds of public money, there must be absolute clarity on how they will be held to account for both their financial performance and, crucially, the outcomes they are achieving. To date there has been no detail on the accountability framework.

This framework will need to make clear what the consequences of performance failure and rewards for success would be, both for the leadership of the consortia and for practices within the consortia. An accountability framework without a clear failure regime will not be acceptable to either clinicians or the public.

The relationship between the consortia and their member practices needs to be clear. Some have suggested that consortia should have powers to expel practices from membership. We would have concerns about the impact this could have on the care for the patients registered with expelled practices in these circumstances.

On the financial regime, it is important to clarify that GP consortia will inherit both contractual commitments from and the financial position of PCTs. To do otherwise would disincentivise GPs from engaging in current decision-making at a time when it is critical they become more involved (see the transition section below). If GPs are concerned about current PCT decision-making, the best solution is to engage more, not to withdraw. Designing an effective funding allocation formula and fair shares policy will be crucial.

The White Paper makes clear that GP consortia will be accountable to the NHS Commissioning Board. However, the governance framework will also need to clarify what accountability GP consortia will have to local Health & Wellbeing Boards (HWBs). The White Paper makes clear that HWBs will take on the existing scrutiny powers of local authorities but it is not clear what additional powers to strengthen local democratic accountability are proposed.

There is general support for a move to leaner corporate structures, but this should not be at the expense of the principles of good governance. Decision-making involving services as publicly sensitive as the health service and significant sums of public money needs to be absolutely robust and defensible, as does work on safeguarding and clinical governance

PCTs have worked extremely hard to learn and apply the very best standards of corporate governance. We know that when this is weak, disaster can follow – many of the nationally prominent patient safety and financial crises have had weak governance as a prime causal factor. Good governance includes principles of transparency (e.g. meetings in public) and external challenge, such as that provided by non-executive directors on PCT boards.

The NHS Commissioning Board will need to ensure that GP consortia are clear what standards of governance are expected of them. This need not involve detailed direction as to how to achieve these standards.

It will also be important to ensure that GP leadership of consortia is not at the expense of other clinicians such as nurses and allied health professionals (AHP) and specialist clinicians who are also essential to the commissioning process. Some of the very best improvements made during the past few years have been nurse, AHP, or pharmacist led. It will be important not to lose this.

2.3 Establishment of consortia

There needs to be clarification of the process for signing off the establishment of GP consortia. There should be an assurance process which while light touch, is robust enough to prevent ill thought through consortia forming.

We support the absence of absolute guidance on size of consortia as there is no evidence of any one size of commissioning organisation being optimal. However, in determining their configuration potential GP consortia will need to take account of factors such as clinical flows, critical mass necessary to negotiate effectively with and hold provider organisations to account and to manage financial risk, leadership capacity, and relationships with local government.

2.4 Conflicts of interest

Many GP commissioning consortia will see potential benefits of achieving further integration between primary care and community services and in developing more integrated services with secondary care. There is a risk that some consortia may see competition rules as a barrier to achieving these goals. Others will see consortia operating with serious conflicts of interest which need to be controlled.

While these tensions should not be insurmountable, there is considerably more work to do to develop workable solutions. In relation to conflicts of interest for GPs in acting as both commissioners and providers, the White Paper proposes two solutions: NHS Commissioning Board to commission primary care, and use of competition processes for extended primary care services. While this offers a partial solution, a range of challenges remain.

Separating the commissioning of primary care from other health services could undermine the effectiveness of GP commissioning consortia. For consortia to succeed they will need to be able to address performance issues with practices within the consortia. Holding contractual (and presumably performers list?) management responsibilities at the NHS Commissioning Board may lead to ambiguity of responsibility for failures in general practice.

In relation to the operation of competition rules for extended primary care services, it will be important to ensure that such controls are not perceived as bureaucratic barriers to change which de-motivate clinical engagement in commissioning. Many of the criticisms GPs made of Practice based Commissioning could continue. Equally too few safeguards over GP decision-making could lead to concerns from patients and other healthcare organisations over the legitimacy of decision-making.

GPs may also be perceived as conflicted in their role of promoting choice for patients once they take on full commissioning responsibilities. Under Any Willing Provider arrangements they may (intentionally or otherwise) lean towards recommending services they have a personal interest in as a provider of care.

This further argues for good governance arrangements with clear, transparent and robust decision-making. This could be augmented by publishing details of practice's income streams and profits.

2.5 Local decision-making or national standards?

While we have consistently supported local decision-making, there is undoubtedly an expectation in the general public that they should receive consistent standards of care across the country.

It will be very important for there to be clarity for patients and GP consortia about the limitations of local decision-making. Which decisions about what quality standards/access to services can they expect to be consistent across the country and what will be for local commissioners to decide?

Currently we assume that the NHS Constitution standards still apply. Are there any other national requirements? What will be the status of NICE work on national quality standards and commissioning guidelines developed by the NHS Commissioning Board?

Many PCTs have worked together, usually regionally, to develop clinical standards and policies which are evidence based, clinically supported (across primary, secondary and tertiary care) and are consistently applied. This has created clarity for patients and clinicians alike. It is not clear how will this be sustained and expanded in the new system.

2.6 Motivation and capacity of GPs to take on the commissioning role

For GP consortia to be effective, GPs as a profession will need to be motivated to meaningfully engage in commissioning. This does not mean that they will all need to take on leadership roles or 'macro-commissioning' tasks such as service or care pathway redesign. But it does mean they will have to comply with clinical protocols

which are produced and back the difficult decisions which their consortia will need to make on prioritisation of investment or decommissioning of services.

The outstanding question of whether the GMS contract will be used to make engagement in commissioning compulsory is an important factor. If not, we need clarity on the approach to GPs who do not wish to engage. Similarly many of the issues raised elsewhere in this response will be important factors in achieving genuine commitment to the proposals. In addition, clarification of the future of PMS contracts and the minimum practice income guarantee (MPIG) is required.

Most GPs would not currently regard themselves as expert commissioners. The expertise required for running a successful GP practice is not the same as that required to assume responsibility for large, corporate public bodies. While the White Paper is clear that consortia can buy in management skills and support, it will still be important that consortia are required to demonstrate that they have the necessary competencies before they are allowed to operate.

3. NHS Commissioning Board

We support the principle of a commissioning (demand-side) -led approach to the NHS and therefore welcome the establishment of a national body with a remit to focus solely on commissioning. We believe that the Department of Health has not previously provided sufficient support for the development of effective commissioning.

However we have concerns that the NHS Commissioning Board may by default take on a range of functions which mean it will either have to become large and unwieldy or alternatively that it may not have capacity to deliver. In principle we would support the NHS Commissioning Board being kept a small tightly focused organisation to ensure it focuses on only the tasks which need to be delivered centrally to support effectively local commissioning. The Board will need staff with the right capacity and capability to do the job. Much of the necessary expertise will be found in PCTs.

We do have concerns however that it will not be able to effectively commission primary care services given the complexity and scale of the task. This has been an important function of PCTs and one which has delivered considerable improvement in the quality of primary care services.

The management and elimination of unacceptably poor primary care, which is absolutely dependent on local knowledge, local systems of performance analysis and reporting, and other local sources of intelligence about GPs performance, is currently built upon high quality relationships between PCTs and the GP community, including with local medical committees. PCTs have used numerous methods to eliminate unacceptable practice, including use of financial, estates and employment levers to effect change without resort to formal regulatory processes. These processes can be lengthy, demanding and sensitive, requiring strong local relationships. It is imperative that in the new system this can be replicated. It would be highly regrettable for standards in these services to be allowed to deteriorate.

The role of the Commissioning Board in relation to specialised services will also bring challenges. Although there may be opportunities to standardise some of the

commissioning processes, the move towards congruence of specialised services will be highly complex and will require specialist expertise.

The interface between secondary and tertiary commissioning is crucial. There are risks that providers of specialist services could play GP consortia and the NHS Commissioning Board against each other. PCTs manage this by bringing secondary and tertiary care together into single contracts with tertiary providers, so they have a grip on all the interface issues, the trade offs etc. The system loses this at its peril.

We do not understand the rationale for maternity services to be commissioned by the Commissioning Board rather than GP consortia. Unlike the proposed role for commissioning specialised services and primary care services, no rationale has been put forward for maternity services being commissioned in this way. We believe there should be clear and transparent criteria for which services are to be commissioned by the Commissioning Board.

4. Local government role in the NHS

As stated above, the role of the Health and Wellbeing Boards (HWBs) needs further work. As with GP consortia local freedom to innovate will be welcome, but within a clear framework. In particular the accountability of GP consortia to HWBs needs clarification.

We assume that the scope of the public health function will be set out in more detail in the expected Public Health White Paper. It will be important for the accountabilities of local government for public health to be made clear. The outcome framework for public health needs to be properly aligned with the outcome framework for the NHS and for social care to avoid risks of perverse incentives.

There are concerns that there should be safeguards in place to protect the current public health spend which will transfer to local government. There are fears this could be vulnerable in light of likely local government spending reductions.

There are also concerns that the public health input to NHS commissioning will need to be protected in the transfer to local government. This could be achieved either by leaving funding for this function with the GP consortia or by making this a clear requirement for local authorities to deliver.

5. Moving from a managed system to a regulated market

The White Paper is clear in signaling a move to a more market driven health care system. What is less clear is whether any current form of system management will remain beyond the role of Monitor in ensuring continuity of essential services, but if not we would want to highlight the risks associated with such an approach.

Incremental decisions made by GP consortia combined with a downward pressure on prices are likely to leave some provider organisations financially and clinically challenged. Some small specialties will simply become unsustainable in some hospitals. The function currently undertaken by PCTs and SHAs in helping smooth the impact of such changes has been important in preventing the financial collapse of challenged providers – which would potentially have devastating consequences for patients. If the intention is to move away from such intervention, then many more

providers of NHS services are likely to find themselves in the failure regime. As well as rendering organisations financially unviable, reduced patient flow can have consequences for patient safety and clinical training.

Similarly it is not clear if there is any intention for any strategic planning of service configuration where it impacts beyond the scale of a single GP consortium. There are real risks that removal of the local system leadership role could lead to fragmented commissioning and service delivery, which may result in poorly co-ordinated and less effective services particularly for people with long-term conditions. Some of these functions could be undertaken by the Health & Wellbeing Boards, but only if they are given some authority to fulfill these responsibilities and if they develop the skills and knowledge to fulfill this role.

The policy of liberalising controls on the supply-side of the NHS at the same time as reorganising commissioning is risky. In previous health service reforms this has led to supply-side dominance and financial risk being passed to commissioners. There is a risk in this scenario that acute providers in particular continue to trade their way out of financial difficulty by seeking to attract more patients rather than delivering genuine productivity improvements. In a tightened financial environment, this approach will not be viable.

In this context the new role for Monitor as the economic regulator is critical. It is important to ensure that Monitor has a duty to work to support the interests of both commissioners and providers. It is also important that Monitor should be required to engage with GP consortia as well as the NHS Commissioning Board.

We support the promotion of patient choice. However there also remains a concern that choice on its own is not a strong driver of improvement, particularly in rural areas. Choice of provider, GP or even consultant team is simply a less realistic option in rural areas. We need policy which is flexible enough to operate differently in different settings rather than a one-size fits all approach.

6. Risks of fragmentation

It is important to highlight the risks of fragmenting commissioning by distributing PCTs' functions to four new bodies, three of which do not yet exist. There is a risk this will lead to disjointed commissioning, especially for patients with long term, multiple or complex needs. Taking heart disease – the UK's biggest killer - as an example, the full range of relevant commissioning responsibilities would include:

- health education in schools - commissioned by local authorities
- specialist lifestyle interventions such as smoking, physical activity, diet, obesity, alcohol – commissioned by the National Public Health Service and/or local authorities
- identification and treatment of primary risks by GPs and other primary care services – commissioned by the NHS Commissioning Board
- specialist services like stop smoking - commissioned by National Public Health Service and/or local authorities
- community and hospital treatment and rehabilitation for people with developed heart disease – commissioned by GP consortia

- emergency services and specialist hospital treatment, for example after a major heart attack – commissioned by GP consortia and NHS Commissioning Board
- palliative and end of life care – commissioned by GP consortia

It is not clear who will hold the ring in this system. Who will design the end to end care pathway? Who will ensure that all the parts of the system align around the pathway? Who will make the trade-offs between investment in different parts of the system – for example whether to invest in smoking cessation or heart bypass surgery? Who will bring the clinical networks together? It is hard to see how this will not result in increased duplication and driving up cost.

Similar questions apply to other complex services such as children's services, cancer, diabetes, respiratory, mental health, and dementia care. It will be very important to set out how these sorts of services will be commissioned effectively in the proposed system.

We believe that effective commissioning of these services will be dependent on the development of aligned outcomes frameworks for the NHS, social care and public health; clear statements of the responsibilities and accountability of providers, GP commissioning consortia, Health and Wellbeing Boards and the NHSCB; incentives, payment mechanisms and competition rules that encourage and allow appropriate cooperation between these partners; and adequate management resources in all parts of the system.

7. Transition

The White Paper and its associated consultation documents pay too little attention to the transition to the proposed new system. There are significant risks to the maintenance of both quality and finance which urgently need to be addressed.

New commissioning systems will take time to establish and will take time to bed in once put in place, before they start delivering better efficiency and quality. Meanwhile, financial pressures will start to seriously bite in the NHS from April 2011 as protecting the NHS budget in real terms will mean significantly lower growth levels than have been seen in recent years.

It is therefore important that we make sure the existing system simultaneously manages this financial pressure effectively while supporting the transition to give commissioning consortia a good chance of success.

To this end during the transition period it will be important to minimise the risk of talent drain from commissioning organisations. While PCT staff do remain highly committed to delivering a successful NHS, they realistically will be considering their own personal futures in the current uncertain environment. A good HR framework is required to help manage the transition and ensure staff with the skills and expertise needed are retained. The PCT Network has offered to work with the DH and other stakeholders to develop ideas for how this could be managed.

Furthermore, much of the language used by some politicians in explaining the proposals has been deeply unhelpful. Pejorative descriptions of public servants as 'pen-pushers' and 'bureaucrats' is unfair and counter-productive as it undervalues the

important role of managers and undermines morale of staff who remain essential to the success of the NHS.

We also need to identify and agree things that PCTs can stop doing now, engage GPs in tackling current financial and service challenges by promoting devolution of decision-making and budget holding within existing PCTs to PbC groups as quickly as possible, and encourage real-time evaluation and dissemination of learning about the opportunities and risks of new commissioning models. It is imperative that GPs begin to engage in decision making alongside PCTs straight away, rather than waiting until consortia are established.

While local GP-led commissioning systems are being strengthened, it may also be necessary to drive provider cost reductions through more central policy action (e.g. contractual controls within the standard NHS contracts).

During the transition period, the focus should be on managing the quality and the overall costs and sustainability of the system. The opportunity costs associated with dramatic and rapid reductions in management resource need to be acknowledged and a rational approach to whole system cost containment must be taken.

A failure to manage the transition effectively will mean either serious financial or quality failures or both in parts of the NHS. If this happens at any significant scale, there is a risk that the delivery of the overall White Paper fails. It is therefore vital that the transitional period is given as much attention as the design of the system proposed in the White Paper.

7. Conclusion

This paper sets out the PCT Network's response to the White Paper and the four consultation documents. It should be read in conjunction with the wider NHS Confederation response.

Although we support the objectives set out in the White Paper, we have highlighted a number of important issues which we believe need urgent resolution before the plans can be taken forward.

As the organisations currently responsible for the majority of commissioning decisions within the NHS, PCTs have significant experience and expertise which can help address these issues. The PCT Network is keen to work with the Coalition Government, the Department of Health and other stakeholders to resolve these concerns and to help ensure a successful future for the NHS.