SUBMISSION TO THE HOUSE OF COMMONS HEALTH COMMITTEE

on the subject of CHANGES TO PRIMARY CARE TRUSTS

on behalf of the OXFORDSHIRE PFI ALERT GROUP

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 90's 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 5 to 1 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 July 28th 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 5 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 toPCTs, 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
Joint Union Office, Oxford City PCT, Old Road, Oxford OX3 7BG
Mobile 07905958321 mark.ladbrooke@unisonoxonhealth.org.uk

Dr Helen Groom,
General Practitioner, Oxford
Member of Professional Committee, Oxford City PCT
Dr Stevens & PartnersRaglan House, 23 Between Towns Road, Cowley, Oxford OX4 3FQ
01865 791850 drhelengroom@hotmail.com

Peter Fisher
President, NHS Consultants' Association
Hill House, Great Bourton, Banbury, Oxon OX17 1QH
01295 750407 nhsca@pop3.poptel.org.uk