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Providing for the future

Changing and divesting PCT provision of community services

An NHS Alliance providers' network discussion document

November 2006

Providing for the future: changing and divesting PCT provision of community services

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For full uncorrected transcripts, please go to the full report on the NHS Alliance website: www.nhsalliance.org

The NHS Alliance Provider Network would like to acknowledge the contribution made by Andy Cowper in interviewing participants and producing this paper.

Introduction to the report

The provision of primary care is changing.

In the DH's July 2005 *Commissioning A Patient-Led NHS*, the initial guidance was that primary care trusts (PCTs) must plan to divest themselves of provision of primary care services. Coming as it did out of the blue to the front line (as well as to a lot of senior figures in the DH), there was considerable confusion, much to-ing and fro-ing and a public apology for the handling of the situation from Health Secretary Patricia Hewitt at the 2005 NHS Alliance conference.

However, despite some modulated wording, the overall policy position from the DH has continued to point towards PCTs divesting themselves of provision. The formula that PCTs can continue with provision in Hewitt's phrase "unless and until" they themselves choose no longer to do so has held - so far.

Now PCTs are going through the process of the DH 'Fitness for Purpose' review. The financial impacts of significant ongoing deficits and the recent restructuring of most PCTs also form the backdrop. Yet in an NHS focused on sharpening up commissioning, concerns continue to be raised about possible perverse incentives and conflicts of interest inherent in PCTs buying their own services from themselves.

It seems, therefore, that new models of provision in primary care will be the way forward to address this dilemma. Already there is useful learning from out-of-hours and urgent care providers (see NHS Alliance report '**24/7: primary care solutions to urgent care**', October 2006).

But, crucially, PCTs must not confuse new structures with solutions. Greater understanding of local capacity, demand and needs should inform decisions about these changes.

'*Providing for the future*' recommends that PCTs analyse what the new market in primary care provision will require and sustain, before choosing new organisational structures (like community foundation trust or social enterprises). The report notes that to do so, PCTs will require significant business planning skills and a good understanding of their existing cost base - neither of which were seen as widespread in PCTs by those interviewed.

The report also reflects uncertainty among managers about the rules of the new system for divested or new providers. In particular, participants perceived a significant lack of clarity around regulation and competition in the new market, and were concerned about 'loss-leading' by corporate entrants to the market. There was also evidence of concern and confusion about these changes among PCT staff.

The report is a result of discussions over the last few months within the PCT leadership group of the NHS Alliance Provider Network. It highlights current issues and concerns and offers food for thought for all leaders of PCT provider services, many of whom are just coming into post. Particular thanks go to Bashir Arif for shaping and driving this project. It is based on structured interviews with PCT service directors and chief executives, as well as senior policy advisors, during the first half of November 2006. For full uncorrected transcripts, please go to the full report on the NHS Alliance website: www.nhsalliance.org

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Foreword by Richard Lewis, Senior Fellow, Kings Fund

Looking to the future of provision

Since the Department of Health announced last summer that primary care trusts were no longer to provide services directly, the future of community health services has been the subject of intense debate.

Of course, the Department has since retreated from that position amid controversy: PCTs can provide services. However, it is also clear that their prime role is in leading a revitalised commissioning function for the NHS. It is not surprising that some PCTs are re-evaluating whether or not they should be in 'the provider game'.

This shift in focus to commissioning sits alongside another policy trend, that of the 'mixed market'. This has been most obviously pursued in elective hospital care, with the determined introduction of independent sector providers to challenge NHS dominance.

Yet more recently, the desire for greater diversity among suppliers of care has extended to general practice and is set to extend further to community health care as well. If patients value choice of hospital, so the argument goes, they will equally value choice in community services.

Indeed, it can be argued that choice in community services is more important. After all, patients tend to have much more enduring relationships with those providers than they do with providers of more episodic hospital care.

At the moment, PCTs tend to operate as monopoly providers with few (if any) alternatives available to patients. In future, a market comprising a wealth of providers offering a wide range of services, carefully tailored to diverse communities, may be a tempting prospect.

Yet while the policy aims may be clear, the means of implementation are potentially complex. In essence, the NHS is trying to create a market where one has not traditionally existed. This presents a number of key questions that must be answered:

- what sort of providers are wanted?

- how can they be attracted to the market or, if necessary, created? how can a 'level playing field' be created?
- how should the market be regulated?

It is clear from the Government's White Paper on community care issued earlier this year that a real diversity among providers is desired. This certainly includes the independent sector, for whom a nationally-supported procurement process is under way.

It also includes 'social enterprises'. Social enterprises have managed to capture the NHS *zeitgeist*, yet in truth there remains considerable confusion as to exactly what they are. According to the Government, social enterprises are organisations that follow normal business disciplines but that have a social aim, reinvesting financial surpluses for the benefit of that social aim. The King's Fund recently published a report concluding that there may be potential benefit for the NHS in encouraging social enterprises in community and primary care (the report is available for free download at http://www.kingsfund.org.uk/resources/publications/social.html).

Social enterprises appear well aligned with NHS values – putting patients ahead of profits. It is perhaps no surprise that PCTs seeking to divest themselves of responsibility for service provision have seen social enterprise models as a potentially useful vehicle for this evolution. The creation this year of Central Surrey Health, an employee-owned social enterprise offering nursing and therapy services provides a good example of how PCT services can be transferred to new types of provider organisation.

However, bringing this new type of organisation into being is unlikely to be easy – there are tricky legal and business issues that need to be resolved. Fortunately, the Department of Health has recently created a Social Enterprise Unit specifically to address these difficulties. The Unit is likely to be a useful source of advice, support and, importantly, money to help bring forward a range of new providers.

The expected transfer of PCT staff into alternative forms of organisation raises a crucial question of how much competition within the community services market place is desirable. There is currently very little, and this is unlikely to change if PCTs choose to divest their service provision responsibilities to a single alternative organisation. They will have, in effect, replaced one monopoly with another.

However, if more patient choice is a priority, this might mean that a number of different and competing organisations should be created. In this way, a competitive market might be created.

While such a strategy will appeal to those instinctively 'pro-market' managers and practitioners, it does raise new problems of its own. For example, by their very nature PCT provider organisations are already quite small: breaking them into smaller units and making them compete may increase total overheads and transaction costs. Small organisations will also find it harder to achieve financial stability and access to sufficient working capital. Furthermore, they may feel vulnerable if they are dependent on one PCT purchaser. It may not be surprising if we see mergers in future between newly independent community service providers – which may prove good for their financial viability, but less so in terms of patient choice.

Can social enterprises and the 'third sector' compete with the private sector, if community services markets are created? One area where the private sector may have an advantage is in their experience of bidding for contracts. Completing the bureaucratic hurdles sometimes imposed in tendering processes may involve both costs and skills that are relatively lacking in such new organisations as the providers will be, not yet clued up in the ways of markets. This disadvantage may be accentuated if large private organisations, with staff experienced in the bidding process, are pitted against small community organisations.

So the ways in which PCTs seek to 'build' markets are important. PCTs should insist only on the minimum bureaucracy consistent with a robust process. In this way, they can be fair to small and large enterprises alike. Indeed, the Government has already issued guidance on public sector procurement that reduces the barriers to market entry for small and medium sized enterprises. These issues are already familiar to local authorities who are more advanced in creating care markets.

The recent Department of Health commissioning framework allows PCTs to develop their role as 'market-makers'. PCTs have powers to encourage the market entry of providers offering desired services where these are not likely to be available without additional support. PCTs may invest capital in new ventures; pay providers a premium on top of the normal rate; or guarantee income for a period of time.

These mechanisms may prove particularly helpful in developing a diverse market of providers of community health services. However, PCTs will need to have clear criteria to justify their use of these sorts of incentives. It is possible that unless they are careful, in future PCTs will face challenges that they have 'rigged the market'.

Whatever PCTs may do to encourage new and innovative providers of community care, the transfer away from PCT employment may feel risky to many staff. This may act as a break on innovation. Indeed some social enterprise models may well require that staff formally share in this risk, as staff may be co-owners of a new business. This may feel like a big step for people who might see themselves primarily as care providers, and not as entrepreneurs.

However, the recent announcement that the Government will allow community foundation trusts is likely to prove attractive to both commissioners and staff. After all, foundation trusts are now a known quantity, and many of the early fears have eased - for example, that foundation trusts would simply cease to be part of the NHS. A community foundation trust may offer the most straightforward way of PCTs divesting themselves of provider responsibilities, without leaving themselves open to the charge that they are casting off NHS staff to an uncertain future in a private market place.

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Executive Summary

1. Progress towards divesting provision is extremely variable.

2. Organisational form should follow function.

3. The future market means that new provider organisations will need business planning skills.

4. Concerns were raised about the impact on financial management of divesting provision if organisations are still in major financial recovery next financial year.

5. Commissioning is perceived to be unsophisticated.

6. Competition, market management and regulation all remain very unclear, as do the new organisational forms.

7. The nature of these reforms is unclear to many staff.

8. New commissioners may have incentives to provide services themselves.

9. Community provision is regarded as holding the primary care system together and successfully managing demand.

10. Measuring the quality of care provided is important.

11. Community and other staff skill mixes need to change to provide more responsive care.

12. Arbitrary freezing of posts, without properly analysis of their value in community provision, creates significant problems.

13. Other existing NHS providers may bid for community provision contracts.

14. New private sector providers with existing profitable business elsewhere may be able to loss-lead to enter the provision market.

15. NHS terms and conditions, particularly pensions, remains a massive attraction to staff working in the service.

16. Approaches from the private sector about provision have been rare.

17. There has been very little tendering out of services in recent months among respondents.

Key findings

1. **Progress towards divesting provision is extremely variable**. Most respondents (and their colleagues, locally and regionally) are at very early stages. This was partly ascribed to pressures and uncertainties following the latest PCT restructuring, 'fitness-for-purpose' reviews and financial turnaround.
   "we've been distracted by the recent restructuring"
   "The recent reconfiguration's taken lots of time, effort and energy"

2. **Organisational form should follow function**. There is a significant danger of choosing an organisational structure for the new provision before fully understanding the business case, cost base and market for the services. The business case, cost base and market need to influence the choice of organisational form. Providers need to become very clear about their core business, and prepared to stop doing their non-core business.
   - *"It's about helping the provider organisation learn to challenge itself: to ask 'what are we good at; what is our core business; where should we diversify; and what do we need to stop doing?' Once we can answer those questions, that will inform our organisation and ownership arrangements."*
   - *"Before we decide on the form, we need a robust organisational entity. That means asking ourselves, 'do we have a viable entity' before we look at configuration. If the answer is 'no', then what would make us viable? Partnership; integrated service provision; stopping doing some of our current activities; doing others on a bigger footprint?"*
   - *"The risk is that people go for new models as an end, rather than a means. We must be clear about the purpose of change, then use organisational models to fit that clarity of purpose on what services to deliver."*
   - *"The changes help us focus on what is our core business, and non-core business."*

3. **The future market means that new provider organisations will need business planning skills**. Currently, these skills may not be available from within PCTs. Understanding the real cost base of provision

was also seen as essential, yet likewise was not considered to be widespread.

- *"We need clear business plans for each element of service (including purpose, wider market, competitors staff, estates, HR, money): all with the same rigour as if we were running an independent business. This is public money, and we have stewardship responsibility to the public."*
- *"We don't have some of the skills that we need to answer the fundamental questions: skills in market analysis, trend prediction, etc."*
- *"We've been focusing on operational logistics to look at the full cost of running our businesses, so getting to the notional costs of premises' rent, HR support, training and other existing support from the PCT so that we'll walk away with a financially viable organisation with no nasty surprises."*
- *"Many provider services like ours who've gone through the financial recovery process are sure as hell leaner and have more understanding of process."*
- *"We need a cadre of competent, enthused and risk-taking staff from PCTs. That's a big ask, and we must question the feasibility of heroes coming forward – the NHS undoubtedly has heroes, but it sounds like weak policymaking to rely on them."*

4. **Concerns were raised about the impact on financial management of divesting provision if organisations are still in major financial recovery next financial year.**

- *"If we're in bad financial recovery again next year, then are we easily going to hand over our community provider arm and become unable to control it?"*

5. **Commissioning is perceived to be unsophisticated.**

"The commissioning capability for community services is just not there, as providers know."

"I can say to a commissioner, 'we offer a service pathway for an Asian baby with respiratory problems, and which leads to an outcome which changes the child's health status by x, all at a cost of y pounds, and here is the skill mix we've used: that's my business case'. Are commissioners sophisticated enough to understand that argument? No."

"NHS commissioners can interrogate us more effectively than they can a private company: they know about what we do.

"We've broadly cocked up 3 years' worth of private sector commissioning – now we've reconfigured and rebadged the commissioners in the PCT mergers, but without many more skills or greater acumen."
"I know that many commissioning colleagues have not developed robust service-level agreements (SLAs) or contracts for community services."

6. **Competition, market management and regulation all remain very unclear, as do the new organisational forms.** Furthermore, there are concerns whether the organisational forms available will match the required community services function.

- *"What will be defined as best value? Will every tender really be contested? Is there the capacity? We don't know how the new market will work and have no understanding of the rules. And I don't think the Department of Health does, either."*
- *"The concern is how we go from a directorate within the PCT to the new organisational form. And we don't yet know about organisational forms, or about regulation. The danger is that we work on organisational shapes, rather than look at the product and at what market wants – and then pick an organisational form."*
- *"The commissioning framework allows commissioners to develop risk-sharing arrangements with a suitable business case. PCTs have some tools for that – but they need help to apply them so as to achieve the objective of diverse provision that is also fair and transparent."*
- *"The lack of infrastructure support to facilitate autonomy and ability to compete is a big problem."*
- *"Predatory pricing, abuse of dominant market position etc. will all be real issues."*
- *"Most social enterprises just do one, relatively straightforward thing on a relatively small scale. Would a social enterprise or other mutual-type organisation work as well providing community services, which are many and complex?"*
- *"Nobody has done a big, diverse social enterprise in health yet – all the examples have been just one strand of work. A provider-run arm doing paediatrics, sexual health, nursing, audiology, all with complex interdependencies: whether that will work in the social enterprise model, I don't know."*
- *"Social enterprise remains unproven on a larger scale."*

7. **The nature of these reforms is unclear to many staff.**

- *"Our PCT has about 1,200 staff, of whom about 1,050 are in our provider directorate: the vast majority of PCT employees. They need a very clear direction of travel. And I don't think that they have one."*
- *"Staff are very unhappy and concerned about post losses."*

8. **New commissioners may have incentives to provide services themselves.**

- *"GP practice-based commissioners may provide services themselves and keep the money."*

9. **Community provision is regarded as holding the primary care system together and successfully managing demand**. However, it has been a 'Cinderella service': a poor relation in terms of resources, and first in line for cutbacks.

- *"Community services bind all other services together: they're the cement between general practice, acute care and social care."*
- *"We are the thin blue line between success and failure. We control more demand than almost any other part of the sector."*
- *"Historically, community services have simply acted like a sponge – when there's a change elsewhere or disinvestment, community services first in the line and staff have soaked up the shortfall."*
- *"In the past, when community and acute services were provided by the same organisation, whenever there was pressure in the system, community services suffered."*
- *"When money is tight, the PCT or acute trust comes to us for a bigger chunk of savings than they could do if we were autonomous."*
- *"Community trusts' budgets were always getting raided to sort out acute trusts' deficits."*

10. **Measuring the quality of care provided is important**. However, measurement of what community services provide is imprecise and rudimentary. This creates problems for both providers and commissioners.

- *"In developing service specifications (the outline contract with commissioners, what's in and out), we need robust outcome measures, not just to look at inputs."*
- *"We can identify activity, but not outcomes or impact. Lack of information and infrastructure is a real problem."*
- *"Community services … are not neatly measurable"*

- *"Historically, we're poor in NHS at describing outcomes and performance measures around community services."*
- *"By being focused on the services we provide or commission, and getting quality, cost and activity well co-ordinated and managed, we can only see better outcomes – which we all want."*

11. **Community and other staff skill mixes need to change to provide more responsive care**. Presenting such new ways of working should not be perceived as criticism of present and past practice by staff, but this may happen.

- *"We need to start creating generic roles across boundaries, to make patient pathways seamless."*
- *"It's hard to change how local authority staff function and make them more flexible workers"*
- *"As soon as you put a spotlight on a service, it results in staff feeling that they're being criticised for what they're currently doing. We have to move away from defensiveness, towards the art of the possible."*

12. **Arbitrary freezing of posts, without properly analysis of their value in community provision, creates significant problems.**

- *"Locally, we've lost 20% of workforce to financial recovery – the problem was, that this was done in a relatively arbitary way: they just froze posts, with no real business appraisal of whether these were the right posts, the right grades, part of the right provision: it was just about saving costs."*

13. **New private sector providers with existing profitable business elsewhere may be able to loss-lead to enter the provision market (bid low now, and quibble about what's in the contract later).**

- *"Many provider services like ours who've gone through the financial recovery process are sure as hell leaner and have more understanding of process. Whether that will then get us a contract remains to be seen, particularly if others in come under price, planning later to negotiate 'ah, but that was not in the contract …' as has been seen in several places."*
- *"People are willing to loss-lead to get into this market. They'll expand their base and as they grow, their unit costs reduce (up to a certain point)"*

14. **Other existing NHS providers may bid for community provision contracts.**

- *"Clearly, foundation trusts are gearing up to provide community services."*
- *"NHS partners positioning around us to do vertical integration – the acute sector are clearly keen to get into that."*

15. **NHS terms and conditions, particularly pensions, remains a massive attraction to staff working in the service** (particularly older staff, who may provide more community services), and so potentially a significant disincentive to joining organisational forms that do not offer it. Several participants noted that this more immediately seemed compatible with presenting community foundation trust status as attractive – involving as it would staff remaining part of the NHS pension scheme. NHS values, too, were mentioned as a strong influence. However, some felt that this had changed and staff were now less apprehensive.

- *"Staff have seen budget cuts, heard about productivity issues, and possibly they're worried about their futures."*
- *"Some staff are very worried (the age mix in community services tends to be older) and have concerns around pensions and NHS terms and conditions. They're very wary of independent sector and private sector terms and conditions."*
- *"Staff fear movement away from NHS core values."*
- *"12-18 months ago, I think there was fear of private sector takeovers. Now it's moved on, and I think people are comfortable with the idea that they could go back into a community organisation."*

16. **Approaches from the private sector about provision have been rare.**

17. **There has been very little tendering out of services in recent months among respondents.**

Questions for further discussion

- How are these changes going to improve patient care?

- What are the opportunities for genuinely integrating primary care within local communities, bringing together community health services, general practice, local authority and other services?

- Who will pick up the provision of those services that a local provider deems to be 'non-core'?

- How rigorous and consistent are PCTs' attempts to understand the real cost base of provision?

- Are commissioners sophisticated enough to understand and interrogate what providers are offering them?

- What provisions are being made regarding intellectual property?

- How do the changes fit with the long-term conditions agenda?

- If practice-based commissioners create their own services (DES, LES etc), how robust will the planning and assessment of quality be?

List of acronyms

DES	designated enhances dervices
DH	Department of Health
FT	foundation trust
GPwSI	GP with special interest
ISTC	independent sector treatment centre
LES	local enhanced services
LIFT	Local Improvement Finance Trust (primary care premises development with private sector – a mini-PFI)
OOH	out-of-hours
PCT	primary care trust
PEC	professional executive committee
PFI	private finance initiative
SE	social enterprise
SHA	strategic health authority
SLA	service level agreement
SME	small and medium-sized enterprises