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Health Sector Briefing

Commissioning a Patient-led NHS
Implications for community staff and their clients

CPHVA

Health Sector Briefing

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Introduction

The purpose of this Amicus Health Sector briefing is to provide an insight into the proposals set out in *Commissioning a Patient-led NHS*. We do not put forward an alternative blueprint. There will be discussion between Amicus members and organisations that share our concerns. Emerging from this we expect a consensus view.

Simply put, *Commissioning a Patient-led NHS* is at best a mechanism to address the continuing squeeze on Primary Care spending that is resulting in vacancy freezes and job cuts among care providers. At worst, *Commissioning a Patient-led NHS* is the green light to creeping privatisation of Primary Care services.

In the history of our union within the health sector there has never been a more serious challenge to our members delivering valued health services in the community. We need to unite with those with whom we have common ground and ensure our voice is heard.

Amicus is not opposed to change. We insist that change is for the better, not for worse.

Background

Commissioning a Patient-led NHS was published by the Department of Health in England on 27 July 2005. It built on previous publications; *NHS improvement Plan and Creating a Patient-Led NHS*. Its stated purpose is to change the way services are commissioned by front-line staff to reflect patient choices and improve the health of the whole population. It is considered to be the blueprint for the future development of the NHS. The proposed changes are:

- For Primary Care Trusts (PCTs) to withdraw from their provider function and be solely responsible for managing the commissioning of services
- To reduce the number of Strategic Health Authorities (SHAs) and line up those remaining to match the geography of government's regional offices
- To reconfigure, through merger, PCTs to largely mirror local authorities' boundaries
- To increase the emphasis on GP practice-based commissioning

Essentially, the intention is that GPs will take a much greater role in designing and commissioning appropriate services for their patient populations with the intention of providing value for money services locally and reducing the need for hospital admissions.

Practice Based Commissioning (PbC) is also about demand management and re-engineering payment for secondary care services i.e.

- It is claimed that practices will be better than PCTs at monitoring the internal cost mechanism, Payment by Results (PbR) and checking that patients are coded with the correct 'tariff', the pricing structure, and that hospitals have done what they say they have.

An example of this might be to set up specialist clinics in the community, or to appoint specialist nurse teams, for example, for osteoporosis or respiratory disease. These teams would invite patients to community clinics or visit them in their own homes reducing the need for hospital appointments or admissions. GP practices will be financially rewarded in line with their ability to better manage health needs within the community.

Much attention has been paid to the use of the private sector to provide 15% of elective care. These PCT proposals have the potential to privatise 100% of NHS provision outside of hospitals and move tens of thousands of health workers away from the NHS into private companies. Amicus believes this would result in the fragmentation of service provision and the abandonment of nationally agreed terms and conditions for NHS staff.

There is a great danger that lack of sufficient managerial ability in the new enlarged PCTs and within GP Practice Based Commissioning structures will mean greater inequalities in health and inequity of provision. Where will Public Health be sited and whose responsibility will it be? What influence will established health need have over GPs' commissioning intentions? Does 'patient choice' mean a return to meeting patient demand rather than health needs?

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A secondary aim is to reduce the current scale of management costs and bureaucracy by 15% by reducing the number of PCTs and SHAs. The intended saving is £250m in overhead costs, which will be redirected into services. Thirdly, to remove the current commissioning and provider function undertaken by PCTs by establishing new provider arrangements for community services.

Those, particularly, affected by this will be health visitors, community nurses, allied health professionals, primary care pharmacists employed by PCTs to work in GP practices and community health services pharmacists employed by PCTs.

Of particular concern has been the very short time-scale. SHA Chief Executives were initially required to notify the Department of Health by 15 October 2005 what their response was. One requirement was to describe how PCTs and SHAs would be restructured to better enhance their commissioning function. Secondly, to consider options for future PCT service provision. It is this secondary requirement, which is causing inevitable controversy, as there is the potential in the future for community services to be provided by any of a range of providers. In a subsequent letter to SHA Chief Executives on 26 August 2005 the Department has made clear that they want plans for service provision to follow the public consultation to take place this autumn and the publication of the subsequent White Paper: *Your Health, Your Care, Your Say*. These changes do not have to be completed before December 2008. Five Task Forces have been set up to help shape the White Paper with a series of consultation sessions to gather public opinion.

The Department is not prescribing future structures. It is the task of each health economy to demonstrate that their planned redesign of structures will allow for more effective commissioning, integration with local authorities and improved support for GP practices and the public. It is not clear who makes the ultimate decision if there is disagreement.

Commissioning a Patient-led NHS makes clear that it expects policy commitments to health, reducing health inequalities and delivering high quality health services to be fundamental to the reconstitution of PCTs but those working in public health have been vocal in their concerns that inequalities in the health agenda will not be met. (E.g. John Ashton, Public Health News 15 August 2005).

Response from PCT Survey

A survey of Chief Executives of PCTs conducted by the *Health Service Journal* (8 September) found over 50% felt the changes would have a negative effect on patient care. Generally the view was that the changes were driven by political considerations rather than being patient-led. Despite its intended purpose of financial control, 56% of Chief Executives said that it would have a negative effect on their budgets. There were also very considerable concerns regarding the inevitable further negative effects on an already demoralised workforce. 72% said that the DH's approach to PCT configuration was incoherent, 87% that it was rushed and 65% that it was politically inspired. None felt it was patient-led.

Health Visitors and Community Nurses

With the creation of PCTs two, three, for or even five management teams were necessary, where previously probably one team had delivered the role within Community Trusts. The PCTs often became competitive with one another, not sharing resources and as a result the expenditure has grown considerably over time. A significant part of this growth has reflected the move to developing primary care services. Within the primary care management teams are clinicians who lead teams. The £250 million projected savings on management will not be achieved without the loss of clinical leadership. For the nursing profession though these new structures have created career opportunities on scale that has never been available before. Community practitioners have joined the Professional Executive Committee (PEC) boards and others have become Directors of Nursing. Many specialist roles have been created and community practitioners have risen to the challenge, often being the forefront of delivering innovative services targeted at the particular needs of their populations.

Allied Health Professionals

The voices of Allied Health Professionals (AHP) have often been lost in health systems where they have not been represented. In PCTs, the AHP representatives on the PECs have successfully brought front line clinicians directly into the commissioning of modernised and innovatory services for patients. We fear that the voice of AHPs in commissioning will be lost in this PCT reorganisation, to the detriment of patient care.

There is absolutely no doubt that there will now be job loses on an unprecedented level, greater than anything previously experienced in the NHS. These can be expected to start over the winter 2005/2006. In Leeds, for example, it is expected 30 managers are to be reduced to two when five PCTs merge. Not only will posts be reduced, but also skilled practitioners will find themselves without a career and few suitable opportunities remaining available to them in healthcare.

Primary Care Pharmacists

The reduction in numbers of PCTs is likely to lead to a reduction in number of the senior pharmacist advisers (often known as Head of Prescribing and Medicines Management). There may be redundancies, but these are not as likely as with other professions because of the role in the economies of scale of prescribing. It would be anticipated that there would be reorganisation of pharmacy structures within PCTs. Because the numbers of staff involved in each PCT are quite small, there is a danger that some pharmacists will be forced into inappropriate posts for their skills and experience. There is a need for a transparent and fair process in any appointments and reorganisations of PCT pharmacists.

Implications of the proposed Commissioning Only function for PCTs

Health Visitors and Community Nurses, Allied Health Professionals and other service providers

This is the aspect of this policy, which has created enormous controversy as it has not been thought through and the implications for these staff and the services they deliver are considerable.

Indeed it could be that in the future they might be employed outside the NHS, *Commissioning a Patient-led NHS* suggests employment by voluntary providers and the independent sector. The challenges are immense. It makes no sense just at the time of expanding primary care to risk the fragmentation that introducing the private sector invites.

We would want to see NHS providers continuing to provide these services, for example, re-creating community trusts or incorporating community services within mental health trusts. That would allow continuity of service provision, maintenance of standards, collaborative working and good communication within healthcare.

If, as has been suggested, a range of alternative models take on service provision this can only lead to fragmentation and potentially compromise staff's ability to respond to the needs of the populations they serve. The intended outcome from multiple providers stated by *Commissioning a Patient-led NHS* is rather to create a degree of 'contestability to community services'. We interpret this as meaning a variety of providers in competition to employ staff and deliver services, which it is claimed will introduce innovation and greater choice. What it seems more likely to create is an even more demoralised workforce and to add to existing ongoing recruitment and retention problems, once the redundancies are complete.

We also believe that, contrary to the view of government, the development of multiple providers will serve to create greater inequalities and reduce the quality of service delivery. Although the government has stated that any provider service will need to work within the national standards set, it is unclear as to how these will be effectively performance managed and how current governance arrangements will be maintained. This is especially relevant if the management capacity in the community is to be drastically reduced.

It is clear that the government should learn from the bitter experience of the fragmentation of services in other public sector areas. For example:

- the railway system
- the outsourcing of cleaning services within hospitals and
- the provision of school meals.

The announcement by the Secretary of State for Education in September 2005 that she proposes to ban unhealthy food in schools acknowledges that there is a significant cost to the country from the resulting poor health of the current generation of children and when they become adults, because of a school meals policy that relied on minimal funding coupled with the installation of profitable vending machines.

Has the government assessed the economic impact if, as a result of fragmentation, health outcomes decline?

Options for the re-deployment of community staff currently under discussion seem to include:

1. GPs to directly employ all community nurses – whilst it seems inevitably that they will want to continue to employ practice nurses, other community nurses would be very concerned by this development.

- *Health visitors and community nurses currently not employed by GPs would be concerned about losing some of their autonomy to work in a holistic public health way with communities, as well as individuals.*
- *There are issues around clinical supervision, staff development and specialist support for working in areas, such as child protection.*
- *As we are already seeing GPs are not necessarily honouring the Agenda for Change agreements in relation to their staff. This does not give confidence for the future.*
- *Loss of the wider nurse community teams and peer support*

2. Social Services, Children's Trusts employing health visitors community nurses and allied health professions – Social services/Children's Trusts could potentially provide these services as they already work so closely with these staff groups.

- *We are concerned that management by Social Services trained managers risks a lack of understanding of the services these NHS staff need to be delivering.*
- *There would be considerable communication challenges for the community practitioners with those health providers they would need to liase with in terms of IT systems and confidentiality.*
- *Also at risk is existing pay and conditions provided within the NHS, as well as pensions and job security.*
- *Puts greater distance between families and GP practices when better integration of services is needed*

A principle of the NHS workforce is that it provides a 'cradle to grave' service and many allied health professions work across age groups and client groups. There is real concern that the fragmentation of the workforce into adult and children provider units will:

- Not allow for flexibility of the workforce to move across age and care groups, depending on local health and social care needs
- Impact on economies of scale e.g. in rural areas where many practitioners work with both adults and children across a variety of sites
- Affect career pathways

One Amicus CPHVA branch responded to a recent Amicus survey saying they are already employed within Social Services structures. They are expected to target their work at children who are very vulnerable or who have been abused rather than working in a preventative model of health care providing a universal service, which includes the search for health needs across populations. The aim of health visiting is to detect risk and support families to prevent mental, physical or social health problems rather than just to get involved when problems are overt.

3. Local authorities employing health visitors, community nurses and allied health professions – For health visitors and school nurses in particular there can be considerable overlap in their public health functions with local authority objectives.

- *Whilst this model could benefit working at the community level it would have implications in relation to one to one's work. The current NHS strategy for nursing (Making a Difference, 1999) supports a family centred model of practice. This entails good partnership working with social services, local authority, the voluntary sector, but particularly the NHS.*
- *This model could lead to a reduction in the currently close links with other NHS providers such as GPs with the implication of challenges to delivering on some health care needs of children and families.*
- *What would happen to staff's existing pay and conditions provided within the NHS, pensions and job security?*

Although some local authorities already employ allied health professions, a preferred arrangement e.g. for speech and language therapists is that the LA either pays for SLTs to work with children in schools or there is a pooled budget arrangement. It would be more appropriate to learn from best practice and to disseminate this rather than fragment services for the same reasons as outlined above.

4. Hospital Trusts (especially Foundation Trusts) employing health visitors, community nurses and allied health professions – Hospitals provide secondary care services largely focused on a medical and physical model of health rather than a social model, the preference of health visitors, school nurses and allied health professions working within community settings. They also seem always to be financially challenged.

- Would the community services receive the budgets they required when these budgets are challenged by the demands of secondary care?
- Coming from different models of health care there would be inevitable conflict in the types of models to be delivered in the community with the public health functions of community staff likely to be severely challenged
- Sets up a conflict of interest – trusts increasing their income by providing services to patients under PbR tariffs rather than within GP practices under practice-based commissioning arrangements – which by and large are likely to be cheaper and more appropriate for the patient. *Government policy is in this respect proposing opposing solutions that cannot both be correct*

5. Voluntary Groups employing health visitors, community nurses and allied health professions – There is potential for the voluntary sector to become providers of these services, e.g. Help the Aged could employ district nurses, NSPCC, health visitors.

- *One of the real challenges here is that these groups tend to operate on short term funding and contracts, totally inappropriate for the maintenance of community nursing services and allied health service provision for children and adults with long term care*
- *Whilst many voluntary groups make an extremely important contribution to community care and already employ nurses e.g. Marie Curie, we do not believe they have the structures to provide for the support needs of large numbers of community practitioners, e.g. training, supervision and development without compromising their own objectives*

- *Imagine the fragmentation of community practitioner services amongst a range of providers, this would not be better for patients*
- *There would be considerable communication challenges for the community practitioners with those health providers they would need to liase with in terms of IT systems and confidentiality.*
- *What would happen to staff's existing pay and conditions provided within the NHS pensions and job security?*

6. Private Sector employing health visitors, community nurses and allied health professions – There is no doubt that the DH expects there to be companies coming forward with proposals for employing community practitioners. Already two nurses and an allied health professional in Surrey have made public their plans to run community services in Mid Surrey (*Nursing Times* 13 September 2005).

- *In the drive for cost efficiency there is a serious risk that the quality of services be compromised? Privatisation certainly hasn't worked for hospital cleaning.*
- *There could be communication challenges for the community practitioners when liasing with other parts of the NHS in terms of IT systems and confidentiality.*
- *Those community practitioners delivering essentially a public health service would be very concerned by this way forward as the outcomes from public health interventions are long term and difficult to measurer. Private services tend to be profit driven.*
- *What would the implications be for the most vulnerable members of society who are heavy users of health services or need to be? They also need to attract disproportional amounts of funding, is this feasible in a cost driven model?*
- *Will community staff still have a role in planning and running services, this has been a successful aspect of the PEC boards established to advise PCTs? It is an intended outcome from the policy but will that engagement include the providers, community practitioners or only the commissioners, GPs?*
- *What would happen to staff's existing pay and conditions provided within the NHS, pensions and job security? Would they be protected? Our experience clearly shows that long-term protection is not guaranteed to staff transferred from public services to PLCs.*
- *What would happen if commissioners decide to commission only parts of the services offered by the provider?*

7. NHS Organisations to deliver community services possibly alongside mental health services or as stand-alone NHS Trusts or Care of the Elderly Trusts – This is a tried and tested model, which preceded PCTs and continues to works well where the provider and commissioning roles retained seperation. The advantage is that staff remain within the NHS, hold onto existing pay and conditions, have access to NHS systems of communication and access to training and supervision within a health environment. Certainly it is the model community practitioners can be expected to feel most secure with.

Implications for Primary Care Pharmacists

There are two groups of pharmacists working in PCTs who may be affected by the change to a commissioning role only of the PCT. These are:

Pharmacists (and pharmacy technicians) employed by PCTs working in GP practices Pharmacists, often known as community health service pharmacists, providing a public health type function by providing advice to community nursing and other staff on a variety of medicines issues, such as immunisation, non-medical prescribing, and to community hospitals, although the role tends to overlap with some functions of some PCT prescribing advisers, depending on the local service configuration.

The options for alternative employers for these pharmacists are similar to those for health visitors.

General Practitioners. This would only be appropriate for those pharmacists employed by PCTs working with GP practices. For community health services pharmacists employed by PCTs the geographical area their work covers is much wider than a GP practice. Although some GP practice pharmacists may not mind the change others may feel uncomfortable without the independence, which PCT employment brings in their role in examining GP prescribing and other systems for medicines. GPs may not wish to pay for pharmacists if funding is not transferred. Pharmacists may not wish to lose their NHS pension.

Social Services, Local Authorities and Children's Trusts. Pharmacists who work with these organisations normally also work in several other fields. Social services see medicines as clearly a health issue and, because of the culture, are unlikely to want to take pharmacists.

Acute Hospital Trusts. These Trusts could employ any of the PCT pharmacists, but past experience has shown that the work is not given proper priority. With the high vacancy rates in acute trusts there has been pressure on pharmacists working in non-acute areas to change to acute work to the detriment of community services. This option is likely to be opposed by many GPs for the reasons above and because the nature of the work is very different.

Voluntary Groups. This would not be appropriate for pharmacists, as they need a professional base.

Private sector. Some primary care prescribing advisers work for private companies. However their services have to be commissioned by GP practices or PCTs. There appear to be currently some reservations by GP practices and PCTs about using such advisers for many reasons including lack of flexibility in roles. For community health service pharmacist's private organisations would be unlikely to have a sufficiently broad based contract to utilise their skills appropriately. For both groups it would fragment a small workforce with all the attendant problems such as difficulty in implementing a coordinated medicines strategy, work force development and capacity planning.

Other NHS organisations. (See above). This option would work well for non-GP practice pharmacists but might work less well for those pharmacists working in GP practices, as the prescribing links with hospitals are much stronger for acute work.

Conclusion

Amicus members need to be alert to planned developments in response to this document and their implications for community practitioners and other members of the health sector. Whilst the DH has reassured SHAs and the unions that restructuring of provider services will not take place immediately there is no-doubt that much planning and discussion is underway and staff are feeling very vulnerable.

Of more immediate threat though are the redundancies and job freezes already taking place in response to PCT overspends which have to be eliminated by the end of this financial year i.e. April 2006. These cuts are in direct conflict with the current policy agenda for public health.

Aside from the implications to services five of the seven models suggested pose insurmountable challenges in relation to protecting staff's terms and conditions of employment, including membership of the NHS Pension Scheme. UK legislation, despite recent changes, does not and cannot provide cast iron protections.

Amicus is committed to lobbying to slow down the *Commissioning a Patient-led NHS* proposals before irreversible changes are introduced. We believe that a bottom line must be the retention of NHS staff within the NHS. This is driven by our member's firm conviction that it is a *national* health service that enables staff to work for the good of the service rather than play loose in a job market of untested providers. In order that we maximise our member's opportunity to express their views in all available arena we will be publishing updates to this briefing note and a campaign pack.

A White Paper is due to be published in December called 'Care outside Hosptials'. Much of it may have already been written but Amicus will try to influence its contents as well as reacting to its contents once published. It is not too dramatic to say that we may be about to see the wholesale dismantling of NHS provision in our communities.

Amicus is not opposed to change, but we oppose change for changes sake. We will support proposals that secure adequate and secure expenditure for the provision of primary care services, which also have the confidence of the NHS workforce. *Commissioning a Patient-led NHS* does not meet this criteria.

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