Our future in red tape

The government wants to reduce bureaucracy in primary care, but it could make things worse

By Howard Catton

Like all good holiday reading, Sir Nigel Crisp’s letter Commissioning a Patient-led NHS, sent to all NHS chief executives just before many went on their summer break, contained much that was familiar and anticipated, but it also held an unexpected twist.

The emphasis on patient-centred services was familiar, the requirement to reconfigure and reduce the number of strategic health authorities (SHAs) and primary care trusts (PCTs) expected. However, the news that PCTs would only have a minimal role in provision was a surprise twist that came out of the blue.

The significance of this policy shift should not be underestimated. The RCN acknowledges and supports the important role that non-NHS providers have and should continue to have in delivering NHS care to patients. However, this has been on the basis of adding capacity to the NHS. The Crisp letter goes far beyond this in saying that the role of PCTs in provision should be reduced to a minimum, and that they should only provide services where it is not possible to have separate providers. As opposed to other providers joining the NHS extended family, it feels as though the NHS family may be about to break up.

Legal challenge

It is because of the magnitude of the policy change set out in the Crisp letter that the RCN has taken the rare step of applying for a judicial review of the government’s failure to carry out public consultation on this policy change.

The lack of consultation means we can only speculate about what the government’s endgame with modernisation of health services. One guess is that NHS primary care organisations will commission health care on the basis of NHS principles, but withdraw almost entirely from any role as provider of services. In doing so, these organisations would also cease to be the employer of the staff who provide the services.

However, we also know the prime minister, in his speech to the Labour
Party conference this autumn, admitted that his one regret was that he had not pushed his reform programme further. So might there be another endgame?

The recent decision by Thames Valley SHA to put out to tender the management of a PCT appears to take reform a step further. As well as PCTs relinquishing their role in providing services, this signals that a PCT could also give up the management of its commissioning function.

It is the prospect of the NHS not providing or commissioning NHS services, or employing staff, that has led nurses in Thames Valley to lobby the SHA and MPs for consultation on this decision. The issue has been raised in the House of Commons.

So why might all of this be important to patients and staff? Figure 1 illustrates how, up until July 28, many expected the structure of delivering and managing primary care services to look. However, since the Crisp letter, the future looks more like figure 2.

If a PCT’s management function is to be contracted out, a new senior management team would be created. The relationship of the new team with the PCT would in all likelihood be based on a contract, with the possibility of new PCT non-executive directors being appointed to manage the relationship between the PCT and the new senior management team.

The management team would then be responsible for decisions in respect of the PCT’s key functions. Broadly, these are threefold: managing the relationship with primary care contractors for services such as medicine and dentistry, commissioning hospital services, and the direct provision of primary care services.

Let us take just one of these functions, the provider role, and assume that, broadly, this comprises community hospitals and walk-in centres, alongside therapy, nursing and specialist services.

How it might work
A private provider may be interested in the management of community hospitals and might enter into a partnership with a high street pharmacy for the walk-in centre services. A foundation trust may want to manage therapy services, while some voluntary and charitable organisations could tender for the provision of specialist services.

As for nursing, would it be possible to set up a new private profit or non-profit making organisation to provide all nursing services, and could the provider of nursing services sub-contract part or all of the nursing services to another provider? If it is a profit making company, could it float on the stock market?

From this speculative analysis a few of the critical questions may be:

- Will there be additional bureaucracy?
- What will be the cost?
- Will competitive relationships between providers change the culture of the NHS?
- Will it be easy to identify who is accountable?
- Will contracts and information be open and transparent, and what about complaints procedures?
- How quickly will services be able to respond to patients’ needs?

The answers to these questions are unlikely to be the next bestseller. However, it is a debate we all need to have before next summer.

Howard Catton is RCN head of policy development and implementation

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Figure 1. The old model

Figure 2. The new model

Strategic health authorities

Mental health

Palliative care

Diabetes

Maternity

Specialist services (voluntary and charity)

Therapies (foundation trusts)

Nursing (public limited company)

District nursing

Health visiting

School nursing

Community hospital walk-in centres (private provider)

Provider role

Primary care trust with new non-executive directors

New senior management team

Contract

Commission hospital services

Primary care contractors

Practice-based commissioning

Practice-based commissioning