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HSJ PRIMARY CARE DEVELOPMENT

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A NEW HAT FOR GPs

BUT WILL THEY WEAR COMMISSIONING WELL?

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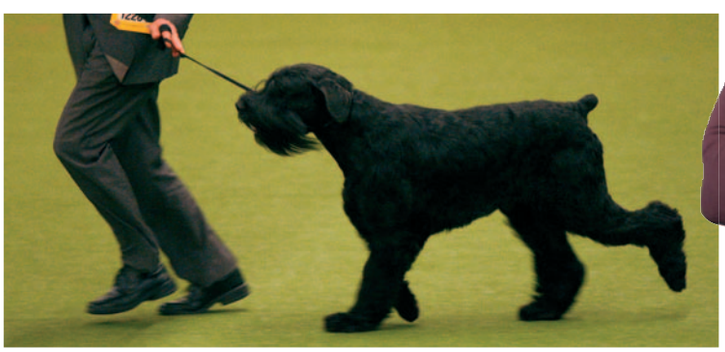

A NOTE FROM THE EDITOR

PCTs step into the foreground

For too long primary care has been the underdog of the NHS, taking care of routine healthcare while hospital trusts held the limelight with their high-profile services.

But times are changing. The government sees primary care as more efficient than secondary care and as a gateway to specialist services, so is keen to build on its role.

Primary care trusts in England now control over 80 per cent of the NHS budget and have the power to shape services in their locality, partly by giving GPs commissioning budgets. Meanwhile, PCTs have been charged with improving their own skills and becoming world class commissioners.

As PCTs attempt to make services more responsive to their local populations, they also need to be more accountable to them. While local people can become members of foundation trusts and elect governors who can hold managers to account, PCTs do not have this direct accountability.

The question is, how is this accountability to be achieved? Should local authorities have more responsibility over PCTs or should local involvement networks, set up in each local authority area at the end of March, be given a chance to find their feet before any further reforms?

Yet despite the emphasis on local accountability, there are no signs that the government is planning to relax its target culture and give PCTs more flexibility.

The recent impasse between the government and the BMA over GPs extending their hours is evidence of this.

The government insisted on a rigid model, which the BMA was against. Some PCTs say the resulting deal will be difficult to implement because GPs will be reluctant to sign up to it. Others predict the directed enhanced service will not meet their patients' needs. ●

Ingrid Torjesen

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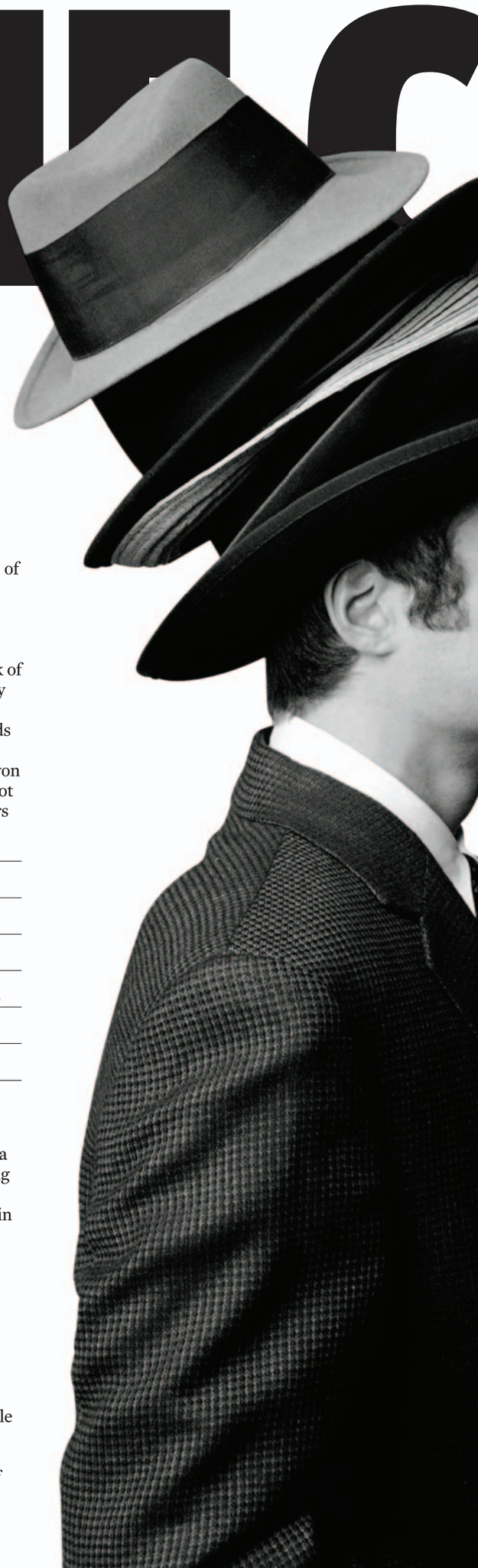

While GPs have not greeted the role of commissioner with universal enthusiasm, its proponents believe that when the right skills and flow of information are in place, it will transform PCT performance, says Rob Finch

For years sceptics have said there is little time to save the NHS. But if the NHS needs saving, enthusiasts of practice-based commissioning believe it the best tool for the job.

At its best, practice-based commissioning could use clinicians' expertise to transform traditionally fragmented, institutionally based and expensive care into integrated, value-for-money care that saves more patients' lives.

Coupled with this, since December the Department of Health has been driving to make commissioning "world class" – a drive that goes far beyond a mere attempt to "save" the health service.

Practice-based commissioning, put simply, is an attempt to address a perceived lack of skills in commissioning at a primary care trust level and to gain better patient care by placing responsibility for health provision spending in the hands of groups of GPs.

In principle, this should mean that practices should have won first refusal over most commissioning decisions by the end of 2006. Yet the reality of practice-based commissioning lags behind this aspiration. It has been dogged by numerous factors, not least primary care trusts' need to hit short-term financial targets, shifting focus from the programme.

Meanwhile, GPs have proved reluctant to engage – perhaps haunted by memories of the abolition of fundholding – and PCTs have found it difficult to relinquish responsibilities as well as provide useful data to inform commissioning decisions.

Indeed, there is little overt criticism of the fundamental principles of the scheme, but operational problems with it are regularly flagged up. Earlier this year, a report on the GP contract by the National Audit Office said: "Many PCTs lack the advanced commissioning skills needed to identify and analyse local health needs and negotiate appropriate services with local providers.

"Money earmarked for enhanced services has not been spent as intended, partly because of overspends which have occurred in other areas of the contract and PCTs' inability to implement effective local commissioning."

Worse still, latest government data on participation in the scheme shows a stubborn reluctance among GPs to get involved, or a lack of belief among practices that they have been fully engaged. Less than half have actively commissioned services, and less than two-thirds have an agreed commissioning plan.

NHS Alliance chair Dr Michael Dixon, a Devon GP, says: "Practice-based commissioning cannot properly get off the ground until commissioners have access to accurate, meaningful, real-time information. That is absolutely basic."

'Practice-based commissioning is not dead in the water but it's the minority who are doing it in the way in which it was described'

And chair of the National Association of Primary Care Dr James Kingsland, who is also a Wirral GP, agrees. He says: "PCTs are not giving budgets, they're just saying how much you've spent as a measure of activity. Sadly that's still in the majority.

"It still feels uncomfortable to me. PBC is not dead in the water, but it's the minority who are doing it in the way it was described.

"The places where commissioners are enthused is where there's a facilitative chief executive. Where they're not, practice-based commissioning stagnates."

With the GPs who might be considered the apostles of practice-based commissioning a little frustrated and anxious, it might seem there is scant hope for the policy.

But Steve Field, chair of the Royal College of

AP FITS

General Practitioners, suggests: "The planning needs to be over a longer time span. If we could look over a three to five-year time-plan and have more sensitivity to look at patient needs then we would have a system where the influence is at the coalface with patient and public involvement."

Indeed, such a long-term view is already being taken in Somerset, where PCT facilitation, coupled with a motivated provider and active practices has led to a three-year contract being swiftly agreed for services for chronic obstructive pulmonary disease (see case study on page 4).

Professor Field believes that despite such good examples, more could be done to help kick-start practice-based commissioning.

"A more compelling vision needs to be articulated for what's being done for GPs and the public," he says.

That is where world class commissioning comes in. The architect of the scheme is Mark Britnell, NHS director general of commissioning. He says that world class commissioning is "a statement of intent" to raise ambitions to create the first comprehensively implemented quality commissioning programme. The somewhat clichéd vision is "adding life to years and years to life".

NHS Confederation Primary Care Trust Network director David Stout echoes this. "It sets an ambitious goal – a direction and focus that is very welcome for most people," he says. "I think it sets a challenge to PCTs in the way they currently operate. The most immediate challenge is the assurance framework. There's no PCT that currently claims to be world class in every element of that."

At the core of world class commissioning is an attempt to improve health, reduce inequalities, improve treatment quality and give people choice. It is also underpinned by a need to make "considered" investments.

In order to become world class, PCTs and general practices are being asked to take a longer-term and more strategic approach to the commissioning of services, with a focus on providing a proactive rather than reactive health service. To do this, commissioners need strong knowledge management and analytical skills to ensure they develop a long-term view of community needs. Of utmost importance is PCTs' ability to listen and communicate back to their communities, as well as developing stronger negotiating, contracting, financial and performance management skills.

The DH acknowledges the National Audit Office's criticisms of the current state of commissioning and, to support the development of world class commissioning, is helping to create a support and development framework to give commissioners advice on driving improvements.

Alongside learning from the outcomes of other commissioners' work and training existing staff, he says PCTs will look to buy in skills where they are missing, adding that for some areas PCTs will be breaking new ground and "leading the world".

Apart from this "vision", world class commissioning is defined by a set of "competencies" (see box), with an assurance system and a support and development framework. The main focus of world class commissioning is on the 11 competencies, across which there is considerable overlap. Fortunately, for each of these competencies there is an outline of the outcomes that will show whether the commissioner is truly world class. These competencies are as close to performance management as PCTs are ever likely to get. As Dr Dixon says: "It will become a determinant of whether PCTs rise or fall."

So to make things easier, the DH is also promoting use of the framework for procuring external support for commissioners, which gives PCTs the option to buy commissioning expertise in a range of areas such as data analysis, contract management and public engagement. More than 80 PCTs have already shown interest in buying in the expertise they need through the framework. Others are learning from experience or attempting to train staff up. Mr Stout explains: "The kind of structure people are thinking about is a learn-share-buy framework."

Despite this, some still perceive the framework as a threat, serving ➔4

GETTY

COMPETENCIES

- **Locally lead the NHS**
- **Work with community partners**
- **Engage with public**
- **Collaborate with clinicians**
- **Manage knowledge and assess needs**
- **Prioritise investment**
- **Stimulate the market**
- **Promote improvement and innovation**
- **Secure procurement skills**
- **Manage the local health system**
- **Make sound financial investments**

COMMISSIONING CHRONIC OBSTRUCTIVE PULMONARY DISEASE SERVICES IN SOMERSET

Reducing emergency admissions for chronic obstructive pulmonary disease has long been identified as one of the most simple and effective ways of improving patient care and saving money for the NHS.

This is being tackled in Somerset by a concerted effort from the GP practice-based commissioners, the PCT and a little private sector involvement that has helped dramatically reshape COPD services.

Initiated by WyvernHealth.Com, a consortium of GPs representing 71 of the county's 75 practices, Somerset PCT has invested more than £500,000 in a service that has taken provision away from the traditional secondary care-based provider.

A partnership between nursing and supplies firm Clinovia and the GP-led firm Avanaula Systems won the three-year contract offered by the PCT for providing routine case management and support for people with COPD to help cut hospital admissions.

The service includes pulmonary rehabilitation and information classes and oxygen assessment clinics for people with respiratory problems on long-term oxygen. It also runs 24/7 urgent response, including home visits, as well as in-hours unscheduled care rapid support.

Breathing more easily: Somerset GPs are commissioning COPD services in new ways.

Six-month roll-out

Implementation will take place over the next six months, rolling out across the county in phases to allow time for feedback.

The new service has the support of patients, who were engaged in the commissioning process. On the day the new system went live, the PCT held an event to explain to patients how the new service operates.

Chair of the Yeovil Breathability Support Group Jennie Woolmington says the PCT showed "eagerness to listen" to COPD patients during the tendering for the service. She adds: "It is hard for people to understand what it is like to live for years with chronic breathing problems. Many of our members find it leaves them unable to do most of the activities the rest of us take for granted.

WyvernHealth.Com chair David Rooke says the advantage of the new service is that it takes away some of the fragmentation.

Dr Rooke says: "All too often patients who suddenly experienced a worsening of their condition could find themselves having to be admitted to hospital because there is not sufficient support within the community.

"This new service is intended to offer patients care close to, or in, their own homes and reduce unnecessary hospital admissions.

"For patients who need to go to hospital, the new service will facilitate a timely and safe discharge."

Dr Richard More, a Somerset GP and operational director of Avanaula, says the company entered into a partnership to bid for COPD services when it realised "more was being said than being done" about reducing emergency admissions. He says the COPD service shows how well commissioning can work when you have a motivated provider, good practice-based commissioners and a "facilitative PCT".

"That's what I perceive – that Somerset are ahead of the curve on world class commissioning: they did exactly what the public would want. Somerset marked the tenders in a very vigorous way. As a taxpayer, I believe it was good value as they gave us a good grilling – it was not a cosy number."

3← to spur PCTs to succeed or have their commissioning function entirely replaced by an outside agency, as was feared when the scheme was announced. And if the world class commissioning competencies come to be seen as a "star rating" for PCTs, this threat could become greater. Time is of the essence, as these competencies are likely to be assessed within the 2009-10 financial year.

If PCTs are to succeed, they are likely to want to focus on practice-based commissioning, which is a major factor in achieving the first four of the world class commissioning competencies. In particular, clinicians must be seen to be actively engaged and PCTs will be assessed on their ability to show this is happening in reality as well as on paper.

The King's Fund has been investigating practice-based commissioning for the past two years, and senior fellow in health policy Dr Nick Goodwin says: "The vision for world class commissioning is that the local health economy takes collective responsibility. Practice-based commissioning is one element of a range of partnership arrangements to get a collective responsibility for change."

He says that a lack of policy clarity has meant "the rules of engagement" between PCTs and practices have taken a long time to work out. Early efforts in practice-based commissioning "turned GPs off" because PCTs were too disciplined in getting GPs to create full business cases for every potential service change.

He warns: "One of the things we're seeing is PCTs using it as a demand management tool. We're seeing referral centres being established and some GPs might be being encouraged to do this, as they're seeing they can save money to reinvest. But it's not commissioning – it's demand management."

'Commissioning is just one part of the health service and its success must be seen as part of a wider investment in the system as a whole'

So what can be done by PCTs to ensure that not only think tanks like the King's Fund but also the DH, clinicians and the public believe their commissioning is world class?

Currently there is very little evidence to demonstrate how commissioners can best influence healthcare providers, and use the commissioning process to achieve improvements in the health of the population. That at least is the conclusion of researchers from Birmingham University's Health Services Management Centre.

Professor of health policy and management at the centre Chris Ham says: "While it is encouraging to see the government providing a framework to help commissioners understand and develop their role, there must also be an understanding that it will take time to build up our knowledge of what approaches work best. Commissioning is just one part of the health system and its success must always be seen as part of wider investment and regulation in the system as a whole."

The centre's *Towards World Class Commissioning Competency* review says that although the health service already has many of the competencies required, there is much that could be done to mobilise these more effectively and to bring in new expertise from elsewhere.

The report, published almost simultaneously with the world class commissioning vision, identifies the importance of getting public health expertise to reduce the demands on the healthcare system and to involve local people in priority setting and decision making. It says a focus on commissioning "competency" in isolation will never achieve the desired results.

So to make the NHS truly world class, commissioning needs empowered and motivated people given the right tools to make it work. ●

ALAMY

ENHANCED SERVICE

The government's guidance on extended hours is not the only way for GP practices to answer the pleas for better access. Ingrid Torjesen looks at some local solutions

CRYING OUT FOR FLEXIBILITY

Improving patient access to routine general practice is a government obsession. First the focus was on cutting waiting times by promising access to a GP within 48 hours. The agenda then moved on to improving GP provision in under-doctored areas, and introducing initiatives to bring in private providers to achieve this and ramp up quality in underperforming areas.

Since Gordon Brown took over the premiership last year, the focus has been on centralising GP services in new-build polyclinics and his fixation on making GPs more available for routine appointments outside of core hours.

Such has been the government's vehemence on this in recent months, it prompted a virtual war between it and the British Medical Association.

The argument was not over whether patients should have better routine access to GPs, but on how much of a priority it should be and how it should be achieved. Outside of government, the view is that a rigid approach to effecting it is the wrong path, but that is exactly the route that has been taken.

The Department of Health published guidance on the directed enhanced service on extended opening hours in April, which most primary care trusts will use to help meet the NHS 2008-09 operating framework target to commission 50 per cent of practices to provide extended hours.

The directed enhanced service is worth £2.95 per patient to practices in return for providing 30 minutes of extra hours per 1,000 patients in minimum one-and-a-half hour slots. A single GP is meant to provide the extra clinical sessions. The BMA had wanted a more flexible approach on timings, GPs to be able to work in tandem and for some appointments to be with nurses.

National Primary Care Research and Development Centre director Martin Roland says: "The DES is the end of a tortuous political negotiation, so to expect the conclusion to be logical is expecting more of human nature than is realistic. It is a compromise, as are all political negotiations. The needs of different population groups are very different, so to address these things in a national contract isn't necessarily the most sensible way to do it, because it doesn't give you maximal flexibility."

He says people who need speedy access at convenient times, and if possible close to their work, tend to be fit and healthy employed people with minor illness. However, the main users of the NHS – the elderly who have multiple illnesses – need a different kind of access: continuity of care from people who know them and their multiple problems.

He adds that a lot of research shows patients value being able to see the same doctor more highly than they value speedy access.

Professor Roland is also a GP at a surgery in central Manchester where most patients do not commute and many are unemployed. The practice is piloting extended hours but Professor Roland says the evening surgeries do not meet the patients' needs. "In the winter and autumn, people don't want to come out at night because it isn't very safe round here."

Imperial College London professor of health policy Nick Bosanquet says: "We need to be moving to a situation where there is local responsibility and local power to develop services that fit local needs. How far away we are from this, when there has to be a national agreement on something which may not be necessary in a lot of areas, yet in other areas we might need longer opening times.

"The danger of this national agreement is that it will turn out to be the maximum rather than people thinking creatively and flexibly about what fits local needs."

He praises the approaches taken by PCTs such as Barking and Dagenham and Kensington and Chelsea, which have set up their own local enhanced service. The Barking and Dagenham PCT scheme began last year and was one of the first.

Barking and Dagenham PCT assistant primary care contracting director Jemma Gilbert says it restricted the local enhanced service to practices that were providing good access in hours and meeting a series of other quality measures, such as scoring well on the quality and outcomes framework.

Now the directed enhanced service is available, the PCT will operate a three-tier system. The ➔6

5← directed enhanced service will be available to all practices.

Those that meet the PCT's quality measures will be eligible for the local enhanced service, which is worth slightly more at £225 per one-and-a-half hour clinical session. All but six of the PCT's 42 practices have qualified for the LES.

Ms Gilbert says the PCT considers the difference a "quality premium". She warns: "If a practice isn't achieving the criteria or doesn't maintain them, that could be removed and reclawed."

Four practices that have scored very well will be allowed to open between 8am and 8pm at weekends and paid the same rate for doing this as the local enhanced service.

"We have got three who are champing at the bit out of the four that are eligible," Ms Gilbert says.

BMA GPs committee chair Dr Laurence Buckman says many PCTs will be forced to consider a local enhanced service because they are worried about hitting the target of 50 per cent of practices providing extended hours, as the inflexibility of the directed service makes it unattractive to practices.

Dr Buckman emphasises that the stalemate with the government over extended hours was not, as the media presented it, about the government wanting more hours than GPs were prepared to deliver, but about flexibility.

He says the BMA had been keen to reach an agreement because it did not see extended hours as a main issue. "I have made it quite clear what I regard is a key matter and it isn't extended access. The government see that as the only thing that matters. There are bigger issues to talk out."

The issue that concerns Dr Buckman most is the movement of large private sector companies into primary care aided by initiatives such as polyclinics, which the government again argues are needed to improve patient access to GPs.

The interim report of health minister Lord Darzi's next stage review published last October committed the NHS to establishing at least 150 of these GP-led centres, which will provide walk-in services from 8am to 8pm, seven days a week to both registered and non-registered patients. The aim is for the centres to also house some community-based services, outpatient clinics and diagnostics, to promote integration. The NHS 2008-09 operating framework sets PCTs a target to complete procurement of at least the GP services this year.

Dr Buckman says that, like other vacant practices, polyclinics have to be put out to tender. "NHS GPs can bid but there are some spectacular examples recently where quite good GP tenders have ended up being given to the private tender instead."

'GPs are independent and run small businesses but they are not trying to make massive profits out of their patients'

It is not surprising the GPs have concerns about polyclinics because they will be competing against them. But they are not alone. Patients and health policy experts also have serious concerns about the initiative.

Patients Association vice-chair Michael Summers says he finds the concept of a national health service manned by NHS GPs contracted out to private companies "rather strange".

"GPs are independent and run small businesses," he admits, "but they are not trying to make massive profits out of their patients. Private companies would inevitably be thinking to themselves, 'We are a company with shareholders which we have to satisfy; we have to show that we are making a profit.'"

He suspects that the polyclinic initiative could be more about saving money than improving access. "Perhaps the government thought, 'One way we could save money on having independent

KENSINGTON AND CHELSEA PCT PILOTS ITS OWN WAY TO ADD HOURS

Kensington and Chelsea primary care trust began a four-month pilot of extended GP hours at the end of March. It is evaluating patients' experience with the aim of turning the pilot into a local enhanced service and offering that instead of the directed enhanced service.

The scheme is funded at a similar rate to the directed service, at £180 for each 1½ hours. However, practices are being encouraged to provide more extra time, as they can apply to offer an extra 1½ hours per week per 1,000 patients. They are also being allowed to do this more flexibly than the directed service in both time and workforce.

The service must be GP led, but practices can decide to offer a combination of GP and nurse appointments and other nurse services.

The trust's primary care commissioning director Frankie Lynch says this allows the full portfolio of patients' needs to be catered for, because some patients will want health promotion and screening services provided by nurses at more convenient times as well as GP appointments. The trust will also pay for more than one health professional to provide extended hours at the same time.

Ms Lynch says: "I suspect that we will go down the road of an LES. Having spoken to practices, they really welcome the fact we have got it as a mixture of nurses and doctors and not just doctors.

"What we've picked up is that the DES is really quite restrictive and practices will probably not do it."

So far, 16 of Kensington and Chelsea's 43 practices have signed up to the pilot.

Larger capacity

Ms Lynch is frustrated that the NHS 2008-09 operating framework target is for half of practices to provide extended hours. "If they had said half our registered population, we would have hit it, because it is larger practices that are doing it. Inevitably, larger practices have the capacity: they can manage their reception staff and capacity better."

But she is keen to point out a couple of single-handed practices are also involved.

One thing about the pilot that has not gone so down well with local practices is that the PCT only allows those that can demonstrate a high level of quality care in core hours to provide extended surgeries.

To be eligible, practices must have an open list, be open 40 hours per week, provide clinical hours for 70 per cent of opening hours or a minimum of 16 clinical hours per 1,000 patients, hit 24- and 48-hour access targets, offer telephone consultations and, most controversially, have scored at least 900 points on the quality and outcomes framework.

Ms Lynch says: "Barking and Dagenham did a very detailed bit of research on extended hours and who could extend it and they said you have got to allow the practices who have genuinely got the capacity to deliver this."

GPs dotted all over the country is to have them dotted around in fewer places and larger practices.'

"That might be all right in London, but what about in rural areas? How can we have polyclinics miles away from anyone? It isn't practical."

Integrating general practices with community and some secondary care services in one building might be a good idea for some areas, but imposing rigid models on communities is the wrong way to go about it, says NHS Alliance chair Dr Michael Dixon.

"These things need to be grown on the basis of the services currently available and involving the frontline professionals and patients in organically developing a better integrated service," he says.

NHS Confederation PCT network director David Stout thinks the polyclinic is one way of improving patient access to a range of services and their integration but not the only way. "I don't think they are the answer to life, the universe and everything."

"I think that it is unlikely that the current model of general practice will all be ensconced somehow into a polyclinic model in the sense of a series of single buildings encompassing all general practice," he says.

Professor Bosanquet is a vehement critic of polyclinics, arguing that the concept, which was first raised by Lord Darzi's report *Healthcare for London* last July as a solution for the capital, is not evidence-based.

"What was striking about the original Darzi report on London was that it has no analysis of primary care in London at all, yet it makes the most sweeping recommendations about it," he says. "They can see the weaknesses but they don't understand the strengths and the need to empower local people to do more within the range of resources that are there."

'Polyclinics are one way to improve patient access but I don't think they are the answer to life, the universe and everything'

He adds that while everyone agrees there should be more integration of services, setting up lots of capita projects side to side with existing GP services was just "going to cause a turf war world for a couple of decades".

Professor Roland says: "There is a view that small practices dotted around the place is somehow old-fashioned and it would be better if they were all put into a spanking new building, but there is very little evidence that that is a good idea."

He admits that there are some circumstances when centralising GPs in new buildings is sensible, such as when they are in shabby premises or are unsalvageable single-handed practices. But this was only likely in some areas of London and other metropolitan areas.

Elsewhere, he supports the Royal College of General Practitioner's federated model of general practice in which general practices are able to access community services, diagnostics and community matrons housed in a central building but are not based there themselves.

But Professor Roland cautions against moving specialist services out of hospitals into the community, arguing that it would not be an efficient use of NHS resources. "Specialists work more efficiently in big hospitals where they have access to teams of junior staff and sophisticated investigations," he says.

Community-based specialist services would, however, improve access for patients, even if the clinics were further away than the local hospital, he admits. "They may be more accessible because hospitals are incredibly difficult to park in. Although that sounds a trivial issue, it is quite a big issue for patients."

Conversely, polyclinics would actually reduce access to GP services and patient satisfaction with them, Professor Roland warns.

"There is quite good evidence that patients don't like big practices and satisfaction is higher in smaller practices. Plus, if you do concentrate all practices in large facilities you reduce access for patients and you potentially reduce choice. People have further to go and that is a particular problem for the old and disabled." ●

ANNA-LOUISE FELSTEAD

HOW TO WALK T

ACCOUNTABILITY

Despite political consensus on the need for community involvement, PCTs are not directly accountable to their public. Ann Shuttleworth and Julie Griffiths ask why

Cross-party consensus in British politics can be difficult to find, but the three main parties appear to agree about one aspect of healthcare – that primary care trusts need to become more accountable to the communities they serve.

In a speech on the NHS in January, prime minister Gordon Brown spoke generally of devolving more responsibilities to a local level, while both the Conservatives and Liberal Democrats appear to favour giving local authorities greater influence over PCTs – although they differ on how it should be achieved.

This political accord is unsurprising, given the size of the budgets controlled by PCTs, says Richard Lewis, a director at Ernst and Young's health advisory practice and a senior associate at the King's Fund. The average PCT budget is £230m a year and between them the 152 PCTs in England received £70bn in 2007-08 – over 80 per cent of the total NHS budget.

"Given the public accountability of foundation trusts, it could be seen as an oversight that this has not already been done for the organisations commissioning their services," says Mr Lewis, who co-authored the King's Fund report *Should PCTs be made more accountable?*, which was published in April.

Foundation trusts were set up with accountability to an independent inspector. Local people are also able to become trust members and elect governors who can hold managers to account. This means service users can exert a real influence over the trusts' leadership.

PCTs have diverse lines of accountability, none of which directly involve the people they serve. In addition to their strategic health authority, they are answerable to the Healthcare Commission for the quality of the care they commission and provide, and to the Audit Commission for financial management.

At a more local level, they are open to scrutiny by the local authority and are also accountable to their publicly appointed boards, whose members are drawn from the local community. However, while non-executive board members may come from the local community, the Department of Health says they are not appointed to represent the local community but to use their experience gained in other fields and as local residents to govern the PCT.

Mr Lewis sees local accountability as having both political and instrumental advantages. "Politically, it's about generating a greater sense of legitimacy about the work of PCTs," he says. "The instrumental benefit is that it will, in theory, ensure better quality services."

An example of how it might improve services is by involving local people in deciding how services are provided. While this is unlikely to lead to solutions that suit everyone, people feel their voices have been heard. They may also have

THE LOCAL TALK

invaluable insights that are only obvious to service users but that make the difference between a service succeeding or failing.

Patients Association vice-chair Michael Summers is in no doubt that more local accountability is needed. He acknowledges that engaging local populations will be challenging but emphasises stronger local links are the only way to ensure the health service is accountable.

"If accountability is national, it becomes very bureaucratic. If it is local, then we can deal with problems directly," he says.

Local accountability makes sense when it comes to improving service and securing value for money, says Mr Summers. "Different areas require different financing and they have different needs. Local accountability will mean money will be better spent and it will drive up standards."

But Ruth Thorlby, who co-authored the King's Fund paper with Mr Lewis, points out that local accountability has its downside, because it will inevitably mean more disparity in services, which may be unwelcome to many people.

"People want a nationally guaranteed NHS and they don't like variation. Yet local devolution will mean it varies greatly," she says.

This may become a driver for PCTs to get the local population involved in decisions. Lack of rancour may also become a measurement of the success of accountability, she says.

Ms Thorlby believes politicians need to provide greater clarity about what they mean when they talk about increasing local accountability. The aim of accountability – whether it is to give more democratic validity to the NHS or to improve the quality of services – will determine how it moves forward.

However it is achieved, Ms Thorlby says local accountability will raise the profiles of PCTs.

She says there is a lack of understanding among the public about what a PCT is and does. If this were changed, PCTs might find more support for their role.

"The public focus tends to be on hospitals or GPs. I don't think people understand PCTs at the moment. If they do, their understanding is minimal and they think PCTs are bureaucratic structures.

"Having an awareness of who's spending the money on your behalf can only be good," she says.

But do local people actually want to be actively involved? Public engagement with initiatives to extend democracy is notoriously difficult to achieve, and this may be the case with PCT accountability if the model adopted requires active public involvement. One proposal is to introduce foundation PCTs – but would these achieve real engagement?

Members would have ownership of the PCT in much the same way as with foundation hospital trusts and, similarly, elect governors to represent their interests. A council of governors would be established to advise on the strategic direction of the PCT.

However, the King's Fund report identifies some problems with the model. Improved services would only come about if governors had the time, →12

ACTION IMAGES

TIME LINE

1974 Community health councils were set up.
2003 CHCs were replaced by public and patient involvement forums. There were 394 forums – one for each PCT.
2008 PPI forums were replaced by local involvement networks. There are 150 LINks – one for each council – and they have a broader remit to cover social care as well as health.

11← expertise and support from the board to develop knowledge, it says.

It might be hard to attract members, particularly in areas where there are foundation hospitals, and even trickier to ensure there was representation from minority groups.

Ms Thorlby says all of this means that foundation PCTs might find it tough to get the local accountability they want. "It's to make sure there's a local voice. You have to go after a large representation of people."

Low visibility

Mr Lewis says: "It is too early to say whether public involvement has worked with foundation trusts – certainly many people have become members of their local trust, but this does not necessarily translate to them being actively involved."

Hospital trusts have some major advantages over PCTs in gaining public involvement – they have a high level of local recognition, and people tend to feel a sense of ownership about their local hospital. In contrast, PCTs achieve far less recognition, and it is arguable whether they could generate the same level of enthusiasm as the hospitals from which they commission services.

People are aware of specific NHS facilities, whether they are large hospitals or single GP practices – and proposed changes that involve closing these are often fiercely opposed. It is difficult to imagine PCTs inspiring the same emotional reaction – indeed, the reconfiguration of primary care services in 2005 halved the number of PCTs in England yet it was virtually ignored by the media and the wider public.

The quality of hospitals' work is far easier to evaluate than PCTs'. Major failures such as those that led to scores of patients dying due to MRSA infection at Maidstone and Tunbridge Wells foundation trust make national headlines. Local media also covers less catastrophic problems, while people admitted to or visiting hospitals gain first-hand experience of how well it works. Evaluating the quality of commissioning in a way that is meaningful to service users is harder.

If their lack of public visibility means the government decides against giving PCTs foundation status, an alternative route to local accountability may be to channel it through local authorities. This might mean having council representatives on PCT boards, which could work in different ways.

A designated post within the cabinet for health might have an automatic membership to the PCT board. It could go further by replacing non-executives with other local authority cabinet members. Again, there may be downsides. Cabinet members would need a new knowledge base, which would take time. And there would be the danger that the true lines of accountability would continue to flow upwards to SHAs.

Local Government Association senior policy consultant Jenny Finch says channelling accountability through local authorities may give local people perceived greater influence, because many are familiar with their local council but know little about their PCT. However, this would not necessarily translate into reality.

"Many people do not take up existing opportunities to take part in local consultation mechanisms, so it doesn't necessarily follow that channelling accountability of PCTs through local councils would lead to local people having greater influence over their PCT," she says.

But one potential benefit is the opportunity to improve co-ordination of health and social care. However, Ms Finch believes mechanisms for this are already in place in the form of local strategic partnerships and local area agreements, and that local authorities and PCTs should be given the opportunity to make these work effectively.

How well these partnerships work in improving the health and well-being of local communities is not clear, but there is certainly variation. There is probably a case for a nationwide evaluation to identify examples of good practice that could be replicated elsewhere.

Ms Finch points out that while they may be accountable through strategic partnerships and local area agreements, PCTs are also answerable to SHAs. This is likely to affect how much they can effectively co-ordinate their services with those provided by local authorities. "It's not that they clash. The targets are different," she says.

The Local Government Association is keen to increase the local accountability for health services, and has established a cross-party commission to look at how local councils and NHS providers can best work together to achieve this and reconcile it with national funding. The commission will also consider how local people can be engaged in decision making about resource allocation.

'Commissioning is a hugely complex area – it's not the kind of thing people immerse themselves in for bedtime reading. It's a full-time job'

The commission is peopled by experts in health, local government and patient interests, such as chief executive of the King's Fund Niall Dickson, who chairs it, Mencap chief executive Dame Jo Williams and independent MP Dr Richard Taylor, and will publish recommendations in June.

If PCT accountability is channelled through local authorities, could this lead to difficult but necessary decisions being avoided for political expediency? Ms Finch believes not.

"All organisations have to make these decisions sometimes and I don't think local authorities would avoid them any more than national government does if it's the right thing to do," she says. "All public service organisations have to make difficult decisions, based on factors such as the resources available, or evidence that a particular intervention is better or a service isn't viable. One important aspect is to ensure service users and local people can have an effective input to the decision-making process, if they wish to."

Mr Lewis has a slightly different view: "It has to be a possibility, but having said that, the NHS doesn't exactly have an illustrious history of taking difficult decisions, so a reluctance to do so at a local level would not necessarily constitute a great change."

Giving people the chance to have effective input into decision making involves setting up structures that are open and inclusive enough to encourage those whose voices are rarely heard. Real public involvement goes beyond listening to the "usual suspects" – the confident, articulate and usually comfortably off – and making genuine efforts to represent the whole community. It is just possible that a brand-new type of organisation can do this.

April this year saw the introduction of local involvement networks in each local authority area. These replaced patient forums and are charged with providing a stronger voice for local people in the planning, design, commissioning and provision of health and social care services. Their structure can be defined locally, as can their ways of working. However, they are required to be open and inclusive, accessible to all and to reach out to gain the views of the wider community. They must also communicate the information they receive to service planners, commissioners and providers, and feed back responses and outcomes to the wider community.

National Association of LINks Members vice-chair Ruth Marsden says closing one body and replacing it with another every few years is unhelpful in encouraging involvement from local populations. There is a dearth of people willing to invest their time and energy in their local NHS in the way the government wants, says Ms Marsden, who was vice-chair of the National Association of Public and Patient Involvement Forums before it disbanded on 31 March.

"The problem is finding people who are knowledgeable enough. Commissioning and the health service in general are hugely complex areas and it's not the kind of thing that people immerse themselves in for bedtime reading. It's a full-time job," she says.

The recent pace of reform to an area which changed little in 30 years is not helping.

"All this tweaking and alterations followed by new initiatives is no good. Things need to be left alone," says Ms Marsden.

PCTs seem to agree. NHS Confederation research published earlier this year shows that more than 80 per cent wanted the current system, which includes LINks, to be given a chance to develop before any more changes.

The same research, *Principles for Accountability: putting the public at the heart of the NHS*, found almost 40 per cent of PCTs would support foundation trust-style membership. And a quarter liked the idea of appointing council representatives to PCT boards.

Agreeing a model

So will LINks be able to fulfil their challenging brief? "It's too early to tell," says Mr Lewis. "The NHS has struggled to find an appropriate forum to represent users since the abolition of community health councils in 2003. The Commission for Patient and Public Involvement in Health appears not to have fitted the bill, but we now need to give LINks time to bed in before commenting on their effectiveness."

While politicians may agree that PCTs need to have greater local accountability, it remains to be seen what form that should take. However, if local communities are to be motivated to engage with the process and local people are to be persuaded to get involved, the government will need to listen to their views on what model to adopt. It may also have to give individual communities the option of choosing the model that works best for them rather than imposing a single solution.

If local accountability is introduced well, it should make PCTs more responsive to the needs of the people they serve. It may also make those people learn to love their PCT. ●