

How can PCTs shape, reflect and increase public value?

Iestyn Williams, Joan Durose, Edward Peck, Helen Dickinson and Elizabeth Wade

December 2007

The vision ... is to create self-improving institutions of public service, independent of centralised state control, drawing on the best of public, private and third sector provision. These institutions must be free to develop in the way they need to, responsive to the needs and preferences of citizens, and with a flexible workforce that is able to innovate and change. Out of this vision will come a new concept of modern public services: one built around the user of the service (HM Government, 2007).

Current health system reforms position commissioning bodies not simply as the 'coordinators' of a local NHS system but, potentially, as the only 'pure' NHS body existing at a local level ... The principles of publicly funded health services are not, however, being questioned. It is the PCT that will be accountable for making sure that these principles are upheld for the local population ... In effect, the PCT becomes the 'NHS Local' (Wade et al, 2006).

Public managers are duty bound to have and present ideas of public value ... But if the ideas are to succeed they will have to incorporate much from the surrounding environment. They will have to fit with the political aspirations of overseers. They will have to engage the employees who will be asked to help achieve the new goals. And they will have to meet the test of plausibly representing a set of purposes that citizens and taxpayers would choose to support if they had deliberated carefully on the question (Moore, 1995).

Executive summary

Recent policy and reform signal a shift from the NHS as a national institution to the implementation of 'NHS Local'. As the primary custodians of public resources, PCTs are charged with reversing the trend towards disengagement from the public sector. They will need to ensure that money is spent in such a way as to ensure 'public value'. Broadly speaking, the term 'public value' refers to the distinctive contribution that public sector services make (or should make) to society. It is this contribution that provides the justification for continued investment in publicly funded services. In the current context, where the work of governments, managers and professionals is examined to a previously unprecedented degree, more attention will need to be paid to the question of how legitimacy can be both increased and demonstrated. In order to become definers of 'public value' commissioners must address a series of inter-related questions. This paper summarises those questions and suggests strategies available to PCT commissioners as they take their central role in the NHS.

What is it that makes the public sector important?

The value of having a publicly funded health care system is less assumed than it has been. The benefits no longer speak for themselves. As the trend towards market solutions in Western society picks up pace, advocates of public sector principles and services will need to re-articulate the latter's distinctive contribution. Inevitably, this will bring to light some of the current system's inherent limitations, tensions and trade-offs. It can also be a time when public sector organisations engage with the public in an open and developmental relationship which recognises the work of governments, managers and professionals alongside the role of the citizen. The opportunity to shift the rules of engagement can only be realised if more attention is paid to the question of how legitimacy can be both increased and demonstrated.

What should be the contribution of a publicly funded health service?

The objectives of health care are hard, if not impossible, to pin down. What we want the NHS to do for us is dependent on our individual circumstances and how we understand our relationship to the health care system, and this will change repeatedly throughout our lives. As long as this remains the case it seems unlikely that a single dominant principle will emerge as the *raison d'être* of health care. This means there are no simple solutions to the problems brought about by resource scarcity. Those responsible for resource allocation will have to develop a more sophisticated and flexible understanding of what the public wants from their health care system and what relationships can be most beneficial to all parties. The shift to 'NHS Local' represents, among other things, recognition from the government that this task cannot be managed from the centre. However, unless they can engender a genuine sense of shared responsibility for priority setting, PCTs run the risk of becoming the 'folk devils', rather than the trusted guardians, of the new NHS.

How can the pursuit of priorities be carried out in a way that is fair and acceptable?

In a context of multiple priorities and competing interests, the focus should be on maximising support for the *process* of decision making rather than the decisions themselves. Public faith in institutions that are seen as flexible but fair can offset the discontent resulting from the rationing of care. The role of evidence is important here as are frameworks such as Programme Budgeting and Marginal Analysis and Accountability for Reasonableness.

How can PCTs become leaders of this process?

If PCT commissioners are to become NHS leaders then tough choices will need to be made in an open and inclusive fashion. A good example here is the process of determining which treatments be categorised as 'Not Normally Funded'. In discharging these duties according to the requirements of evidence, process and involvement, PCTs can invoke and publicize their role as deliverers of public value rather

than seeking to minimise attention to such activity. The role of the clinical community is key in establishing and communicating the basis for commissioning decisions. PCTs will also need to become active players in the *politics* of health care. This will involve using the strategies available to them to reassert the importance of common goals and values when these come under threat, and also leading the process of re-articulation when these goals and values become outdated. Methods of public consultation and dialogue should take into account the broader climate and desired policy frame. There is a role for experience and judgement for example in deciding when to challenge opposition and when to acquiesce – at least temporarily - in the interests of public harmony and the pursuit of longer term objectives.

Achieving support for decision making is an area of crucial importance and one which has hitherto been neglected by commissioning organisations. This is perhaps not surprising given the many other duties and challenges they have faced. However, in order to become viable and trusted institutions, PCTs must now prioritise the issues of profile and legitimacy. By drawing on some of the principles and methods outlined in this paper, they can begin a process of engagement and dialogue which will help to underpin and demonstrate their contribution to public value.

Introduction

Getting commissioning 'right' has never been more crucial for the NHS and its partners. Under the new arrangements PCTs will play a pivotal role not just as steward and dispenser of public resource resources but also as catalyst for a new relationship between the health care system and civic society. In attempting to implement the government's vision for the new NHS, PCT commissioners face challenges, some familiar and unresolved, others new and unprecedented. This paper looks at the changing role of health commissioning and assesses some of the options available to PCTs as they seek to embody 'NHS Local' and to increase 'public value'. In particular, the focus is on how the good work of commissioning organisations can be informed by and connected to broader social values, so that public value can be demonstrated and increased.

Section one: Commissioning in the reformed NHS

A number of key themes can be identified in health care reform, which reflect a broader concern of the government to change the shape and nature of the public sector and the ways in which it engages the public. The Health Services Management Centre (HSMC) has responded, in a series of research and discussion papers, to the changing landscape of health care commissioning. This section draws out themes and implications from this and other literature relating to the role and requirements of PCTs in the reformed NHS.

Responsive services and the personalisation of care

Traditionally, the structure and organisation of the NHS have embodied the principle of egalitarianism in which the needs of the many outweigh the demands of the individual. This collectivist approach has been accompanied by state involvement in both the funding and delivery of health care and an acceptance on the part of the public of the authority of clinicians to make decisions on their behalf. This combination of a nationally organised system and widespread trust in the ethical authority and expertise of the medical professions to act in our best interests has enabled the NHS to deal with the challenges it has faced whilst retaining a healthy rate of public support.

Recent reforms reflect the belief that these arrangements are increasingly outdated. Monolithic public sector institutions and

paternalistic models of care are seen as unsustainable in an age of the sophisticated service user. The erosion of the public faith in traditional party politics is echoed by dissatisfaction with unresponsive public services. Put bluntly, people are less inclined to sacrifice their own interests in the name of fairness and similarly less inclined to assume that 'doctor knows best', especially where this leads to them having to wait longer for, or not receive, medical interventions. In contrast to the previously passive recipient of health goods, the contemporary health care consumer is less willing to accept the 'bitter pill' from clinical or political authority.

Thus, as the nature of political engagement and allegiance change, so must the institutions and services that were designed to reflect inherited political values. Attempts to 'shift the balance of power' to local organisations and communities, as well as reforms aimed at introducing market-like incentives, reflect this concern to make the NHS a more responsive and flexible institution. The introduction of payment by results and greater competition on the supply side are recent examples.

In its vision for the public sector, the government is seeking both to reflect and to encourage the changing relationship between public sector institutions and civic society. Its emphasis on increasing patient choice between providers and its apparent intention to increase the use of individualised budgets both point to a commitment to breeding an educated consumer of health services, one empowered to both make informed decisions and to customise the package of care they receive.

However, in an acknowledgement that precepts of fairness and equality remain important to our understanding of public service, this individualisation of health care is accompanied by a renewed emphasis on increasing access to services and reducing health inequalities. What's more, each of these objectives is to be pursued in a context of the increasing gap between expectations and resources. With the recent growth in NHS spending set to end we can expect the rationing debate to resurface with a vengeance in the months and years ahead. The task for the NHS is to consolidate a commitment to public sector principles and ethos whilst simultaneously fashioning a new, flexible and personalised relationship with the consumer, and to do both of these things in a context of resource scarcity.

Implications for PCTs

PCTs are at the centre of these prescriptions for a new contract between citizen and the state, and the expectation is that in their capacity as commissioners of local services they will exercise new flexibility and powers in order to respond to the demands of the populations they serve, and actively work with those populations. The range of activities contained within this new vision of commissioning are encapsulated in Woodin's (2007) definition:

'... a proactive, strategic role in planning, designing and implementing the range of services required rather than a more passive purchasing role. A commissioner decides which health care interventions should be provided, who should provide them, and how they should be paid for, and may work closely with the provider in implementing changes.'

In fulfilling this role, the commissioning PCT will act as the 'eyes and ears', the 'brain' and also the 'conscience' of the local NHS. The responsibilities of the eyes and ears are to observe and report on what the system is currently delivering and prepare for likely changes on the horizon. The primary responsibilities of the brain are 'identifying and implementing the optimal solutions for delivering stated objectives' (Wade *et al*, 2006: 5). The role of 'conscience' underpins each of these technical and administrative functions and is the primary area for exploration in this paper. Wade *et al*, (2006) summarised the role of the conscience as being to:

- establish health system objectives;
- dovetail these with the objectives of other local commissioners;
- ensure appropriate partnerships with other health and social care agencies, proactively managed;
- provide stewardship of public resources (including reporting and accounting outcomes);
- ensure robust and appropriate methods are in place for making decisions about funding priorities, and;
- ensure that the pursuit of other functions does not create or increase inequalities.

Underlying these prescriptions is a shift from the NHS as a national institution to the implementation of 'NHS Local'. As the primary custodians of public resources, PCTs are charged with no less than the reversal of the trend of disengagement from the public sector. The extent to which this devolvement will actually take place remains somewhat uncertain, as does the ongoing

role of national agencies and Strategic Health Authorities in pursuing the civic engagement agenda. However, irrespective of these debates, PCTs will need to ensure that money is spent in such a way as to deliver on the goals and expectations of their patient populations. In the process, they will be required to fashion an active and empowering relationship with citizens and to enter into a genuine dialogue so fundamental values can be identified and pursued. This civic partnership will deliver on the public expectations of a modern, personalised service whilst safe-guarding principles of equity, fairness and value for money.

Public value

It is helpful to think of this conscience role in terms of the pursuit of 'public value'. In this context 'public value' refers to the distinctive contribution that public sector services make (or should make) to society. It is this contribution that provides the justification for continued investment in publicly funded services (for example in the face of competition from those who would advocate more market-based approaches). The notion of 'Public Value' is associated primarily with the work of US Public Management expert Mark Moore (1995). Moore's ideas have been both critiqued and re-worked and Moore's use of the term leaves its precise meaning open to interpretation. What is fairly clear, however, is that public managers can be neither passive nor overly prescriptive in pursuit of public value. Instead, they need to both reflect and shape the values and aspirations of the communities they serve (Kelly and Muers, 2002).

Legitimacy and commissioning

Recent drives to strengthen the commissioning function reflect its status as the Achilles heel of health care, both at home and in health care systems elsewhere. Within the English NHS, PCT commissioners are faced with a series of debilitating barriers and hurdles (Smith *et al*, 2004). The first relates to the need to become both visible and integral to the communities they serve. The challenge this presents is illustrated by the absence of public interest in, for example, widespread recent PCT merger and reconfiguration. Although the NHS remains a popular institution, PCTs find themselves behind hospitals and general practice in the public's conception of *what the NHS is*. At the same time they are also less embedded than local government in the public sense of 'place' (Glasby *et al*, 2006). It is conceivable for

example that substantial sections of the population will at any time be unaware of the PCT area to which they belong. Crudely put then, the challenge for PCTs is therefore to go from 'faceless bureaucrats' to the public embodiment of the NHS for a given community and place.

Perhaps more damagingly, PCTs have in recent years taken on the unwelcome, if familiar, mantle of deniers or limiters of treatment (Ham and McIver, 2000). Far from offering an alternative to unpopular political institutions, PCTs have themselves become synonymous with the failings and/or limitations of the health care system. The recent case of Herceptin is the latest in a line of instances in which local commissioners have suffered the opprobrium of public and media backlash against the perceived unreasonable withholding of life saving medical treatment.

In summary then, in order to embody NHS local, PCTs will need to: demonstrate effective decision making; manage their relationships with a range of interest groups; establish a more significant place in the consciousness of the local population and a more visible presence on the public sector landscape, and; undo the damage done by high profile incidents in which they have been cast as rationing bureaucrats.

Section two: what can PCTs do?

We have seen that the role of commissioners as the conscience of local health care is crucial to the new NHS and that they face a series of hurdles if this role is to be successfully performed. This section looks at some of the strategies available to overcome these barriers.

The role of evidence and information

It is now commonly accepted that health care commissioners should make optimal use of the evidence and information available to them. The importance for public value is in communicating the evidence base of decisions to stakeholders and the wider public, particularly as PCTs become subject to greater scrutiny in line with their growing profile and responsibilities. If PCTs are to come to reflect what it means to deliver 'public value' they will need to be seen to be at the forefront of the drive towards informed decision making. Methods such as Health Technology Assessment and the related discipline of Economic Evaluation are increasingly available and understood, and should be drawn upon when technology coverage decisions are taken.

However, such methodologies do not remove the need for involvement and discussion in commissioning. Engaging a range of stakeholders – not least the broader public – in order to both establish and pursue priorities cannot be sidestepped through appeals to science and research. Whilst the latter can be called upon to improve the pursuit of public sector values and objectives they cannot tell us what those values and objectives should be. Technocratic approaches are helpful when decision makers are pursuing single objectives (for example maximising health) but less so when a number of competing objectives are simultaneously pursued (Williams and Bryan, 2007). A more flexible and consensual approach is offered by Programme Budgeting and Marginal Analysis (PBMA), a method, based on economics, for enabling explicit choices to be made from within a constrained budget (Mitton and Donaldson, 2001). PBMA avoids the heavily prescriptive approach of health economics whilst retaining the key economic concept of opportunity cost.

Clinical input

Experience suggests that evidence and analyses *do not speak for themselves* and cannot be expected to deliver full public support for commissioning organisations. Like NHS managers, academics with expertise in decision making tend to have a far smaller residue of trust and authority to draw upon than their medico-scientific counterparts. For this reason, the input of clinicians into commissioning needs to be enhanced.

It seems reasonable to suggest that an alliance with broader clinical opinion might have helped the PCTs who sought to limit or delay access to Herceptin and that, in general, a successful partnership between managers and clinicians will help the former secure support for tough choices. Wade *et al*, (2006) suggest three possible strategies for incorporating clinical expertise and opinion into commissioning:

- through a restructured professional executive committee;
- by contracting in clinical experts who are independent of the local market, and;
- by seconding provider clinicians into commissioning bodies.

There is also a need to engender a greater level of understanding and involvement in the decision making process itself. This applies to all stakeholders including clinicians, the media and patient groups – how can the views of patients and the public be 'taken seriously' but also be subject to the demands of expertise and evidence?

In cases such as Herceptin there is a prior need for the issue to be 'framed' in such a way as to foreground medical research and opinion (as opposed to, for example, civil liberties and choice). 'Frames' are essentially ways of understanding a policy issue in order to provide 'conceptual coherence, a direction for action, a basis for persuasion, and a framework for the collection and analysis of data' (Rein and Schoen, 1993: 153). Experience suggests that successfully developing and using your preferred 'frame' can be half the battle. The role of high profile medical opinion will be key in establishing such decision making frames.

The importance of process

'Accountability for reasonableness' (A4R) is a framework for decision making which recognises the importance of following a process which is considered fair and inclusive by all interested parties. Daniels and Sabin (1998) convert the concept of 'reasonableness' into four tests that decision making processes should pass: publicity, relevance, appeals and enforcement.

- Publicity (transparency including reasons for decisions)
- Relevant reasons (as deemed by appropriate interest groups)
- Revisability (in light of ongoing evidence, debate and appeals)
- Enforceability (mechanisms for insuring the first three conditions are met)

The key to 'accountability for reasonableness' is the requirement to formally acknowledge the role of deliberation and debate – as well as information and evidence – in priority setting. It also acknowledges fairness as an end in itself rather than simply a means for pursuing goals such as health gain. Guidance and decisions are more defensible and legitimate if they meet the criteria of A4R and unpopular outcomes are more likely to be accepted by stakeholders.

As they become more publicly visible, PCTs will need to demonstrate accountability for reasonableness in their decision making. They will need to be transparent about the reasons for decisions and enable those who object to have the opportunity to appeal against them. Measuring current governance and decision making arrangements against these criteria is likely to be an interesting exercise for PCT commissioners. This may also be useful in the development of policies on Interventions

Not Normally Funded. Ensuring that the process for determining such decisions are transparent and reasonable is just as important as the evidence base and ethical frameworks devised to compile INNFF lists in the first place.

Involving the public

We have seen that a key element of 'NHS Local' will be an increased and enhanced level of public involvement in health care priority setting. We have also indicated some of the ways in which decision making processes may be made more accessible and accountable to stakeholders and the wider public. But these mechanisms are unlikely to be sufficient in themselves to deliver the level of involvement or legitimacy which PCTs require.

Research suggests that commissioning organisations have as yet been unsuccessful in facilitating genuine public involvement (Smith *et al*, 2004). The corporate board model of governance – in which members of the public are appointed as non-executive directors - has yet to generate the degree of public 'voice' envisaged and Patient Forums have also been limited as a means for engaging the public (Wade *et al*, 2006). It seems likely that in order to address public value PCTs will have to consider alternative approaches.

There is a substantial literature, which appraises the options for generating meaningful public involvement. Glasby *et al*, (2007), for example, consider available governance models, and much has been written about the benefits and limitations of deliberative, citizens panels as a means of both engaging and educating the health care consumer (McIver, 1998). In the short term, PCTs have begun to embark upon 'community conversations' to establish the direction and priorities of the local NHS. Community conversations describes the shared responsibility that is essential to address the fundamental questions regarding the shape, objectives and limits of a publicly funded health care system.

The literature on public involvement is too extensive to recount in full here. However, it is of critical importance that public values and attitudes are explored, rather than assumed. Through dialogue with the community, PCTs will be expected to create a health service that embodies the principle of 'public value' and in the process to foster a new relationship between services and the community. A genuine dialogue with

local populations will also help to identify inequalities and to maximise public support for their reduction.

A recent survey of Chief Executives within a PCT Network supported by the NHS Institute and HSMC suggests that these conversations are already underway. However, the multiple purposes to which such discussions are put have yet to routinely include setting the future priorities and direction of *commissioning* (Durose, 2007). These connections will have to be made and commissioners should see community conversations as one of a number of options available to them in their quest to increase public value. Selection from within these options requires judgement as they include high profile community consultations which offer different risks and benefits to the more focussed deliberation using citizen's panels, and the possible institutional involvement through governance structures.

Leadership

Up until now this paper has outlined some prescriptions for the better use of information, mechanisms for improving the process and accountability of decision making, and strategies for making public involvement more explicit and effective. However, these factors will not by themselves be sufficient in the drive to make PCTs the embodiment of public value. Evidence, systems, process and dialogue are necessary but do not supplant *agency* and *leadership* in successful public management. Leadership is required in all aspects of health care and will be essential to establishing PCTs as the conscience of NHS Local.

The issue of leadership is much discussed and its importance well established. Until now however, little attention has been paid to how leadership skills are to be used to connect commissioning organisations with the wider public. PCTs will need to shape and lead as well as just oversee. In a society characterised by division and uncertainty, NHS Local will be required to galvanise stakeholders to articulate and achieve common goals. This will require PCTs to engage the trust of those above and below so that difficult decisions and new opportunities can be tackled head on. Moore (1995: 299) sees successful public managers as 'explorers commissioned by society to search for public value'. This means exercising active leadership, albeit within the constraints of political and public accountability.

The role of PCTs in shaping and reflecting public value is pivotal. This is the priority for today. NHS managers and clinicians know what must be done to ensure efficiency and effectiveness; their challenge lies in taking on the mantle of the conscience of public sector organisations and ensuring that the public are able to understand and prepared to support what they do.

There is an understanding of many of the techniques and tools that can be used, as well as the frameworks and the experiences that can enable the process. PCTs now need to lead by demonstrating that their commissioning processes make the connection between evidence, information and clinical and public involvement.

References

- Daniels, N. and Sabin, J. (1998) The ethics of accountability in managed care reform *Health Affairs* 17(5): 50-64.
- Durose, J. (2007) *New Conversations with Communities*. HSMC unpublished paper.
- Glasby, J., Smith, J. and Dickinson, H. (2006) *Creating 'NHS local': a new relationship between PCTs and local government*. Health Services Management Centre, University of Birmingham.
- Ham, C. and McIver, S. (2000) *Contested Decisions: priority setting in the NHS* London, King's Fund.
- HM Government (2007) *Building on progress: Public services*. London, Cabinet Office.
- Kelly, G. and Muers, S. (2002) *Creating public value*. London, Cabinet Office.
- McIver, S. (1998). *An independent evaluation of citizens' juries in health authority settings*, King's Fund, London.
- Mitton, C. and Donaldson, C. (2001) Twenty-five years of programme budgeting and marginal analysis in the health sector. 1974-1999. *Journal of Health Services Research and Policy* 6(4): 239-248.
- Moore M.H. (1995) *Creating Public Value. Strategic Management in Government*. Cambridge Harvard University Press.
- Rein, M. and Schon, DA. (1993) *Reframing Policy Discourse*. In F.Fischer and J. Forester (eds.) *The argumentative turn in policy analysis and planning*. Durham NC, Duke University Press.
- Smith, J., Mays, N., Dixon, J., Goodwin, N., Lewis, R., McClelland, S., Mcleod, H. and Wyke, S. (2004) *A review of the effectiveness of primary-care led commissioning and its place in the UK NHS*. London, Health Foundation.
- Wade, E., Smith, J., Peck, E. and Freeman, T. (2006) *Commissioning in the reformed NHS: policy into practice*. Health Services Management Centre/NHS Alliance.
- Williams, I. and Bryan, S. (2007) *Cost-effectiveness analysis and formulary decision making in England: findings from research*. *Social Science and Medicine* (forthcoming).
- Woodin, J. (2006) *Commissioning in Walshe, K, and Smith, J (eds) Healthcare Management* Open University Press.