The coalition Government’s white paper, *Equity and excellence: liberating the NHS*, has thrown the spotlight on GP commissioners with its proposal to make GP-led organisations responsible for managing the vast majority of NHS commissioning budgets by April 2013.

While the proposal to fully transfer commissioning responsibilities from PCTs to GP consortia marks a significant organisational change, PCTs and GPs have been pursuing the principles of clinically-led commissioning for some time. Whatever the detail of the Government’s policy looks like post-consultation, local health economies will need to accelerate their progress in turning these principles into practice. In this context, both GPs and primary care trust (PCT) staff have indicated an analysis of how some of the most advanced GP commissioning organisations have achieved their goals under practice-based commissioning (PBC) would be useful in helping local health economies to avoid ‘reinventing the wheel’.

This discussion paper has been produced using information gathered from interviews in four different areas with GPs and PCT staff who have worked together on GP commissioning. In each area, a GP commissioning organisation has been successfully established and is now redesigning aspects of care and making decisions that affect how NHS funds are spent.

It explores how GPs, managers and other colleagues have been able to overcome barriers to progress and seeks to establish what learning has arisen that will be of use to GPs and managers in other localities as they increase their activity around GP commissioning.
‘A recent paper highlighted five examples where PCT commissioners, GPs and others have used PBC to develop health systems offering more integrated care’

Introduction

In order to engender conversations which were as frank and candid as possible, the names of the areas involved and identities of individual interviewees have not been published.

While it does not attempt to provide a comprehensive picture of the innovation and achievement of all GP and PCT commissioners across England in developing GP commissioning models, we hope this discussion paper will go some way towards helping GPs, managers and other colleagues develop the systems and relationships required for successful GP commissioning.

Background

PBC has now been a feature of the NHS landscape for more than five years. The aim of the policy was to involve primary care clinicians more closely in commissioning decisions, but it soon became the focus of criticism, with commentators claiming that it was slow, bureaucratic and not fulfilling its goals.

A Department of Health survey conducted in 2007 found only 13 per cent of GPs thought PBC had improved care. A study into the progress of PBC published 18 months later identified a series of barriers to progress.

These included:
- defining the roles and responsibilities of GPs and PCTs under PBC arrangements
- capacity among GPs to engage in PBC
- a lack of reliable, timely data to inform commissioning decisions
- relationships between stakeholders
- complexities around managing financial and clinical risk
- conflict of interest (both between GP provision and GP commissioning and between services commissioned by GPs and PCTs)
- poor relationships between GPs and Government.

The study found that “in its current form, PBC is clearly not operating effectively”.

Further research highlighted a “lack of interest and priority” at PCT level and “burdensome governance and information issues” but found that progress had been made in some aspects of PBC.

However, a Department of Health survey of practice-based commissioning leads conducted earlier this year found increasingly strong relationships between PBC leads and PCTs (86 per cent – up 4 percentage points since 2007) and evidence that business cases and service plans are being acted upon (79 per cent of leads submitting business plans had at least some acted upon.). And, a more recent paper highlighted five examples where PCT commissioners, GPs and others have used PBC to develop health systems offering more integrated care. This suggests that some health economies have been able to surmount the hurdles that have become associated with the policy, a finding that is supported by our own research.

Achievements so far

In each of the four areas studied for this discussion paper, a GP commissioning organisation has been established and is contributing in a substantial way to decisions about the commissioning of NHS care.
commissioning as a barrier to progress. It stressed the importance of functional relationships, good communication, reliable information and trust.

Our interviewees felt that GP commissioning has tended to improve relations between PCTs and GPs. One GP even went so far as to suggest that the development of the schemes in his area had “settled a war… we went from not speaking to full engagement.”

The importance of building up trust and respect was mentioned by many interviewees, both GPs and NHS managers.

Despite their progress, some issues seemed to provide particular challenges. Specifically, the role of GPs in taking ownership of actual budgets has been limited (predominantly because of existing statutory PCT responsibilities) and the GPs have generally had to negotiate with their local PCT for access to specific funds for a specific service.

Similarly, although in some areas patient engagement is clearly at the heart of the model, others have been less able to demonstrate significant public and patient involvement.

**Roles, relationships and leadership**

The King’s Fund’s 2008 report highlighted disagreement between GPs and PCTs around roles and responsibilities in commissioning as a barrier to progress. It stressed the importance of functional relationships, good communication, reliable information and trust.

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The consortia have achieved a number of successful outcomes:

- a new approach changing the function of a threatened acute facility to enhance local provision
- a reduction in emergency admissions
- cost and activity reductions in long-term condition treatment
- increasing cross organisational joint working between primary and secondary care in order to reduce referrals
- a programme of pathway redesign to remove artificial barriers between primary and secondary care
- multi-million pound savings from prescribing budgets
- increased dialogue between primary and secondary care clinicians
- improved patient safety through data-sharing agreements between GP practices and community healthcare providers.

The consortia have achieved a number of successful outcomes:

- drawing up service design/commissioning proposals incorporating recommendations about the use of NHS resources
- getting these proposals implemented.

**Between them, GPs and PCTs in the areas studied have achieved the following milestones:**

- establishing a GP consortium steering group and winning a mandate from local GPs
- forging a constructive working relationship with local partners
- engaging sufficient numbers of GPs to be able to make credible commissioning decisions across a significant population base
- drawing up service design/commissioning proposals incorporating recommendations about the use of NHS resources
- getting these proposals implemented.

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The importance of building up trust and respect was mentioned by many interviewees, both GPs and NHS managers. One PCT manager described “senior executive support and willingness to not get in the way but to clear the path for someone else’s vision” as being a helpful approach.

Both PCTs and GPs recognised as essential the existence of an enthusiastic core group of clinicians who take a lead in driving forward the strategy of the GP commissioning group and ‘sell’ the project to less enthusiastic peers.
In some cases, a group of GP leaders motivated by the desire to solve a particular local challenge has moved into this role organically. In other areas, leaders have been selected through a more formal approach.

In one area, a PCT area-wide conference and a series of meetings jointly sponsored by the PCT and the local medical committee (LMC) have been used to select the consortium leaders.

LMC involvement was seen by interviewees as important and has helped both PCTs and putative GP consortia to broker agreements and add credibility to their conversations from the GP perspective. All the GPs we spoke to stressed that LMCs have played an important role, particularly in helping to establish the initial relationships.

That said, the relationship challenge is more complex than a simple bilateral debate between PCT and GP consortium. Patient and staff engagement was also highlighted by several GPs as being a challenge and a motivation.

One consortium has set up a model where patients as well as staff are eligible to become ‘members’ and can then elect people to the organisation’s council. This organisation has also ensured that nurses, practice managers and salaried GPs, not just partners, are included in decision-making.

Some GP leads reported that communicating with GP colleagues who are part of the consortium but perhaps not as actively engaged as the leaders, without slipping into ‘bureaucracy’, has been challenging.

**Purpose and scale**

Many of the most successful GP commissioning schemes have come about because a group of GPs shared a common goal such as preserving a local facility or maintaining local working relationships in the face of organisational reconfiguration. Having a positive driver such as this has been helpful in maintaining momentum and bringing on board GPs who are not actively engaged in formal commissioning roles.

Where no specific large-scale objective has existed but the motivator has been “implementing PBC policy”, PCTs have sometimes needed to influence GPs in order to ensure that the projects planned will be of sufficient scale and ambition to generate a critical mass. Related to this issue is the fact that in some areas GP commissioning work exposed the difference between the PCTs’ population focus and the GPs’ more patient-based approach. A PCT manager defined this as follows: “The difficulty for practices was that they felt they could design a little scheme, set up an interface service and reinvest in a local service. While they are doing that, emergency admissions rise and then they are overspent.”

One GP consortium lead said his local PCT had effectively forced the newly established consortium to focus on a single, large-scale project, rather than a series of smaller-scale schemes, by refusing to consider any proposals other than those that addressed emergency admissions. Although this was initially perceived in a negative way by GPs, one said that in fact it had been “the best handcuffs we’ve ever had”. PCTs’ understanding of and ability to view the whole health system has been an important part of shaping GP activities, even if it has been a source of tension.

‘Many of the most successful GP commissioning schemes have come about because a group of GPs shared a common goal’
Incentives and levers

The more committed GP commissioners have seen incentives as something they offer to their GP colleagues in order to win their support rather than something the PCT offers to the consortium to encourage it to behave in particular ways.

One organisation commissioned a community echocardiography service to help all GPs in the area to hit QOF (quality and outcomes framework) targets – the rationale being that GPs in the area were therefore more likely to support the work of the consortium.

Another offered 25 per cent of savings to practices, with 75 per cent pooled at consortium level. This funding has been used to pay for extra services such as physiotherapists and health trainers. GP leads in this consortium felt that as participating in the scheme involved a “massive amount of work” for practices, they had to be able to offer something more than goodwill.

GPs have sometimes not viewed the existence of incentives from the PCT as important – as far as they are concerned, they are engaging in commissioning work because they are committed to the principle of clinical decision-making and want to drive the commissioning agenda in their area.

Organisational form

Participants reported that the majority of the queries they had received from peers looking to set up their own commissioning organisations related to organisational form. Models in use include bencoms (a type of social enterprise), community interest companies and companies limited by guarantee.

One consortium leader who had been closely involved in determining organisational form at the outset of their scheme stressed that the most important part of the process around deciding organisational form was to establish the roles that would be undertaken within the consortium and the expected degree of collaboration between consortium members. Answering these questions had helped to illustrate which type of approach would be most suitable. This consortium leader felt that the same approach was necessary when deciding the ideal size of a consortium – in other words, the size of the consortium would be determined by its purpose, rather than fitting a national template.

Conflicts of interest

Attempts to address perceived conflicts of interest seemed to be the area where national policy has the greatest potential to block local innovation.

Many organisations have formed relationships with local acute providers that are based more around cooperating to make joint decisions about efficient provision than around holding providers to account through tight contract management. One GP said: “[The local hospital trust] does not have making a surplus as its agenda. If a pathway cuts out payment by results, they’ll do it if it’s better for patients. They are driven by clinical rather than financial priorities.”

Such relationships contrast with the invoice checking approach associated by some GPs with GP fundholding. It is not yet clear how sustainable they will be when consortia are responsible for enforcing actual contracts with acute providers. However, the GPs involved value these...
collaborative approaches and hoped to retain them.

One consortium lead defined the commissioner-provider split as “almost a political mantra”, adding that it should instead be about good governance. “You (as GP commissioner) don’t have a situation where you don’t offer patients choice of provider. It’s about putting good probity and governance around systems, not having an absolutist policy.”

In another area, separate board structures have been introduced for a GP commissioning organisation and its co-terminous GP provider organisation, which is providing additional services under an APMS (alternative provider medical services) contract. GP leaders hope that the separation, combined with good probity and governance around systems, not having an absolutist policy.

Managing risk

GPs and PCTs appeared most polarised in their attitudes towards risk. PCTs have a statutory duty to ensure NHS funds are used efficiently and effectively and are regularly criticised where this is perceived not to be the case. PCTs have sometimes been reluctant to move beyond well-established approaches because of an understandable desire to ensure systems do not fail. PCT managers feared GPs undervalued some processes around governance. One said: “They would have a view that we have been slow to implement. Part of our response would be that they underestimate the complexity and some of the processes around procurement and governance to make sure new systems are safe and effective.”

From the GP perspective, this caution could seem overly bureaucratic and was viewed by some consortium leaders as affecting their credibility with their peers. Bridging this gap has challenged both PCT managers and GPs seeking to implement GP commissioning schemes.

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For PCTs, using influencing skills and capitalising on strong trust relationships has been important. One PCT manager, who had secured agreement from the PCT to devolve real budgets to consortia at a relatively early stage, noted: “The nature of the NHS is utterly risk averse – we’re very lucky the chief executive trusted me. The chief executive was obviously very worried at different times and wanted assurances, and some colleagues were completely anti and had to be won round. The penalty for failure in the NHS is so severe that when someone says ‘we need to embrace risk’, every chief executive in the room is stiffening and saying ‘we know what that means’.”

The area in question has benefited from being part of a national pilot scheme. Participation in this scheme seems to have led to an acceptance of a greater degree of risk and, presumably, acknowledgement in principle – both locally and from the centre – that success is not guaranteed.

However, another GP consortium lead remarked that it sometimes felt as though the PCT spent more time on risk management than on commissioning. They said: “There was a process – we come up with an idea, it goes through our [consortium] board, gets approved and gets lost for months [at the PCT].

On the other hand, in some areas managers indicate they have made a point of ensuring that some consortium goals are achieved quickly, in order to avoid demotivating GPs.
As a first step toward aligning these different attitudes to risk, a consortium lead who had in the past worked in a PCT suggested an approach to evaluating risk where a distinction was drawn between decisions where the outcomes could involve genuine clinical risk and those where there was not a patient or clinical risk and where it might be possible to ‘take a punt’.

**Funding allocation**

The most creative approaches to funding allocation are taking place at a sub-PCT level. One health economy has devised its own local allocation formula to upweight practices which carry out large amounts of maternity-related work in a young and deprived area. Another consortium is pooling the majority of commissioning budgets in order to remove some of the contention from the process.

In several cases, PBC management allowances are being pooled, and the money used to pay for staff who provided data analysis and management services across the consortium.

**Real budgets**

The area where most consortia have taken on ownership of actual budgets is in prescribing. In one PCT area, £9 million has been released in savings as a result of more efficient prescribing. This has been achieved through a combination of devolving responsibility to GPs and introducing fines on the basis that inefficient prescribing breached the contractual duty to use NHS resources to best effect.

Many consortia have received sums from PCTs to enable them to pay for a specific service after proposing that the service should be commissioned, but there is scant evidence of GPs holding significant numbers of real budgets. Where GPs are holding budgets, these are of sufficiently small scale to pose little risk of destabilising the overall PCT commissioning budget if poorly managed or if plans do not succeed.

This means that there are generally limited mechanisms in use for divesting actual budgets to GP organisations. GPs are very clear that the bottom line remains the responsibility of the PCT, and recognise that taking responsibility for this would be a huge change.

One PCT manager, who has begun to devolve actual responsibility for some budgets to consortia, reported that a £1.8 million scheme where practices were each allocated a small sum determined by the number of patients on their list but allowed to pool this to develop larger schemes had proved successful.

The manager reported that designing PBC tasks in this way had helped GPs to conceptualise the opportunities to achieve greater results afforded by pooling budgets. GPs have begun to work around thresholds, referral criteria and managing resources and are aware that overspending will have to be compensated for. The manager defined this as a ‘process methodology’ that addressed common behaviours and relationships as well as applying systematically processes that were often used in isolation.

The PCT had built on the success of the £1.8 million scheme by devolving responsibility for two actual budgets which were perceived as “low risk but interesting” – physiotherapy and minor surgery, though the cash was not moved physically into a GP consortium bank account. However, the manager felt that handing over the entire budget to a consortium at once would be unrealistic and a staged approach was best.
Information and support

The quality of the data available to GP commissioners is another problem which is continually raised in relation to PBC – including in the King’s Fund’s 2008 report.

PCTs reported that the quality of information available could have a direct consequence for the cost of running PBC programmes. One manager said: “It ended up costing more than it should have done if we’d known what the numbers were.”

The PCT which had encouraged its GPs to focus on emergency admissions has used its status as an information pilot area to develop more user-friendly ways of presenting data. It is able to provide its local consortium with daily reports on emergency admissions, and is developing a risk tool to help identify patients at greatest risk of admission so that GPs can make sure a care plan is in place.

This project has been driven by the GP consortium which identified the tools that would be useful and enlisted the PCT to develop them.

Another PCT found that sharing practice referral data on a monthly basis prompted consortia to intervene where their own practices were referring outside normal patterns.

What does this mean for the development of GP-led commissioning?

The white paper proposals to make GP consortia responsible for the budget for the majority of NHS services will require GP commissioning input of a completely different scale from what has been achieved under previous schemes such as PBC.

In areas where GPs have already identified leaders and the development of consortia is underway, some of the challenges of establishing GP commissioning arrangements will have already been overcome, but in other areas it is likely that considerable focus from PCTs and GPs will be required.

Transition

Many of the most successful PBC schemes came about because GPs were able to use the scheme to achieve an objective that mattered to them locally. This acted as a positive driver, encouraging GPs to participate and making

Recommendations for PCT and GP commissioners

Recommendations that emerged from the interviews with PCT and GP commissioners include:

• build trust and cooperation between all parties, but especially between GPs and PCTs
• enable GP leaders to establish themselves and provide them with the support to lead peers effectively
• engage local medical committees early on, particularly around brokering the agreements needed for the formation of consortia
• ensure plans are of sufficient scale to make an impact
• encourage innovation and creativity in GP consortia
• introduce real budgets gradually to ensure that consortia are able to manage them effectively.
commissioning schemes seem more attractive to colleagues who were, in principle, less keen on getting involved in commissioning. It was often influential in deciding the scale of a GP commissioning scheme – in other words, the GP leaders designed their commissioning arrangements to be of sufficient scale to deliver their objective.

However, there is a risk that many of the drivers for implementing the white paper could be perceived as being negative – one GP characterised these as “a fear of imposition, a fear of a salary cut [and] a fear of losing services”. This raises an interesting question around rolling out GP commissioning across the country, in the absence of an external positive driver arising from the GP community, and possibly with a perception that only the negative drivers outlined in the previous paragraph apply.

By sensitively encouraging the development of GP commissioning in collaboration with LMC representatives, it should be possible for PCTs to carry out the work they will need to do around the development of consortia without appearing to be ‘directing’ future commissioning approaches. Adopting inclusive approaches such as joint conferences appears to have worked well.

Where the proposed structure and objectives of a consortium are not sufficient to produce a critical mass, it is likely that the PCT, as the existing statutory commissioning organisation, will need to influence the direction of the consortium’s development.

The action taken by the PCT that required its consortium to devise plans to address a specific delivery challenge (reducing emergency admissions), and in doing so provided the helpful ‘handcuffs’ identified by the GP earlier in this document, may no longer be seen as appropriate in a post-white paper environment. In the next few years, PCTs could consider working with local GP leaders to design very targeted local enhanced services (LESS) that will encourage this focus, which GPs participating in this study agreed was important.

As the white paper and its associated documents are clear that GP commissioning will retain a strategic focus, evidence around the scalability of savings could also be compelling in encouraging GPs to adopt the population-based approach they will need to make strategic commissioning decisions.

‘Risk management is an area where both PCT managers and GP commissioners could benefit from assimilating some of each other’s knowledge and experience’

Risk management is an area where both PCT managers and GP commissioners could benefit from assimilating some of each other’s knowledge and experience. Both PCTs and GPs will need to move outside their comfort zones in order to strike a successful balance between approaches which are perceived as being too risk averse or taking insufficient steps to manage risk.

PCTs would benefit from finding ways to speed up decision-making processes, while GPs will need to acquire a deeper understanding of risk management and procurement processes, and will increasingly be required to prove that they are using such disciplines in their decision-making.

Seconding senior staff from the GP consortium into the PCT and from the PCT into the consortium for meaningful periods of time may enable individuals from each organisation to build knowledge and change working practices quickly.
As ever, high-quality data will be fundamental to the success of GP commissioning. PCTs should work with consortia to establish the best possible data management systems – and put in place legacy arrangements to ensure that the development and management of these are maintained after 2013.

Funding
Although the amount GPs can expect as a management allowance has not yet been disclosed, there was concern among GPs that the size of their future management budgets would be insufficient to cover the hugely expanded task ahead, to the standard achieved using the PBC management allowance. In particular, consortia were concerned that they would be unable to afford high-performing PCT staff, who would then go elsewhere as PCTs wound down.

Both GPs and PCTs were well aware of the potential for changes in the allocation formula for commissioning budgets to impact on the financial stability of future consortia. One consortium highlighted the fact that, although it considered it had improved patient care, it had never generated any freed-up resources. Its lead said: “We just get less money to do the same as everyone else.” Another highlighted difficulties because the deprivation level of its population was so far above the national average.

A PCT manager defined funding allocations as “the most important issue facing consortia” but felt that the impact of the geographical footprint of the consortium on the budget it would receive was less important than the necessity for a robust, fair and consistent approach to allocations nationally.

Consortia should be able to devise their own internal systems for funding allocation, which should be transparent and decided by consensus. However, the statutory status of consortia will have a bearing on the types of organisational form that GPs will be able to use – for instance, many of the social enterprise models that PBC consortia are using are likely to be unsuitable as a basis for a statutory organisation. In practice, this makes it even more important for new consortia to be clear about what they want to achieve before they consider organisational models.

The future GP commissioner role
In establishing consortia, the network of relationships will need
to be much broader than simply involving GPs and PCT managers. Encouraging engagement of patients, practice staff, clinicians from other sectors, local politicians and local authority officers will be beneficial – in particular, building robust patient involvement systems will help consortia to demonstrate democratic legitimacy.

 Consortia warned that GP commissioning should not revert back to the GP fundholding of the 1990s, or in other words “checking every invoice”. In fact, one consortium lead suggested that even if GPs wanted to do this, they would be unlikely to be able to afford enough management resource to do so.

Avoiding conflict of interest is potentially an area of significant policy confusion where GPs might value some support. This support should be around enabling GP consortia to set up good governance systems that will help them to demonstrate probity, rather than enforcing rigid policies that will stifle innovation.

Confederation viewpoint
In designing the new GP-led commissioning arrangements proposed in the white paper, it will be important to learn from the progress made on practice-based commissioning in many parts of the country. This paper sets out some lessons from four areas that we hope will be of use to GPs and PCT staff as they work to put in place effective and robust GP-led commissioning arrangements.

Consideration of the achievements of well-developed practice-based commissioning consortia – and the managers who have worked with them – suggests that, if done well and supported with good management, GP-led commissioning can play a significant role in driving the quality and productivity improvements that the NHS needs to deliver over the next few years.

However, the scale of the changes that will need to be implemented in order for these achievements to become widespread should not be underestimated. The challenge faced by PCTs is particularly acute, given the requirement for them to deliver large-scale efficiency savings while at the same time implementing new ways of working, including potentially ensuring an effective transition to GP commissioning.

The lessons from well-developed practice-based commissioning suggest some more general points which could assist the transition to the proposed new commissioning arrangements:

• be clear where responsibility lies – until GP consortia are established on a statutory basis, PCTs retain statutory responsibility for commissioning

• handle conflicts of interest with care – putting excessive safeguards in place risks demotivating clinical engagement but insufficient safeguards could undermine patient confidence in GPs

• balance risks and rewards – in a culture where failure is associated with extreme sanctions, people are understandably reluctant to adopt an approach that carries a greater risk of failure

• judge success on quality as well as financial performance – although financial issues are easier to measure, used on their own they can distort priorities and are unlikely to motivate clinical engagement.

‘In establishing consortia, the network of relationships will need to be much broader than simply involving GPs and PCT managers’
The Primary Care Trust Network

The PCT Network was established as part of the NHS Confederation to provide a distinct voice for PCTs. We aim to improve the system for the public, patients and staff by raising the profile of the issues affecting PCTs and strengthening the influence of PCT members.

The NHS Confederation is the only independent membership body for the full range of organisations that make up today’s NHS. Its ambition is a health system that delivers first-class services and improved health for all. As the national voice for NHS leadership, the NHS Confederation meets the collective needs of the whole NHS as well as the distinct needs of all of its parts through its family of networks and forums. The PCT Network is one of these.

For further details about the work of the PCT Network, contact pctn@nhsconfed.org or visit www.nhsconfed.org/pctn

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