The future of primary care trusts

Commissioning a patient-led NHS: this is the first in a series

Primary care trusts (PCTs) are the strategic leaders of locally managed health improvement and healthcare systems. They are ideally placed to fulfil this role because they have key partnerships with health and social care providers; responsibility for managing a broad range of contracts and relationships far outside traditional organisational boundaries; and an impressive track record of delivery. The shift in vision for the NHS to one of personalised, high-quality, cost-effective care that is delivered close to home and in partnership with the patient and community in a way best suited to local needs, will be realised at PCT level.

This Briefing explains our view that it is this outcome that the future functions of PCTs should be designed to deliver, irrespective of the size or configuration of individual PCT organisations.

Key points

• Any development programme for PCTs must be tailored around the delivery of a clearly expressed purpose.
• While most elements of PCT development will be managed locally, some will require a driver at national level.
• PCTs should be reconfigured on the basis of purpose, outcomes and best fit.
• Excellent organisational development processes will be required.
• The central development of policies should enhance and support coherent local PCT development.

Achievements

Over the past four years, PCTs have achieved much by managing the implementation of the NHS Plan. They have been pivotal in delivering access targets and reducing waiting times, working as commissioners alongside secondary care providers.

Since their inception, PCTs have worked in partnerships and, more than any other part of the NHS, have matured within a complex environment. They have adapted not only to the new challenges of a modernising NHS but also to the agendas of local authorities, voluntary sector organisations and patient groups. Through the development of professional executive committees (PECs) and the opportunities offered by practice-based commissioning, they have begun the task of re-engaging clinicians and placing them at the centre of strategic decision-making. They have redesigned services within communities and across the traditional boundaries of primary and secondary care, and have developed managed care networks across the NHS Plan’s key result areas and National Service Framework disease groupings.
Purpose and outcomes

By definition, fitness for purpose requires clarity about:
• what that purpose is
• the outcomes associated with achieving it
• how, ideally, these outcomes should be delivered.

PCTs deliver three core functions:
• improving health
• provision of services
• commissioning for their local population.

The development of independent family health service (FHS) contractors and their services has been key in the delivery of the NHS Plan. With the implementation of the new General Medical Services contract (nGMS) and the other new FHS contracts, while relationships remain close, they are maturing into those of commissioners and providers. This new clarity will further support delivery.

Alone in the healthcare system, PCTs have the knowledge and experience of these areas and of local communities, their healthcare needs and the opportunities for personalised care inherent in primary care provision. They have led the way.

In an outcomes-based system, the best fit will depend on:
• the health experience of the local community
• service configuration
• resourcing, including funding and infrastructure
• staff skills base and capability
• inter-organisational relationships
• levels of public involvement.

There is no single solution that will prescribe a best fit, shape or size for organisations working in this environment.

Reorganisation comes with its own costs and, in this environment, should be considered only where it ensures that outcomes are achieved and that best value and fitness for purpose are delivered.

Services and functions should be considered in tiers of collaboration, from single practices to cross-health communities. The positioning of functions should be dependent on best fit against desired, locally agreed outcomes.

The organisational best-fit demands of the range of PCT functions are very variable, from the localism of community health needs assessment through to contracting with major acute hospitals serving multi-PCT populations. This range is incompatible with any single-size or stand-alone structure, and has led in places to the development of tiering without the need for restructuring. In some places, however, new arrangements may be required to achieve best fit.

In this context, fitness for purpose asks questions about which function is best delivered in which tier and, most importantly, for what outcome.

Future role of PCTs

Any review of the future role and functions of PCTs should ensure their fitness for the delivery of locally and nationally defined outcomes. As indicated above, fitness for purpose should be determined with reference to the functions and responsibilities of PCTs in the emerging policy context of choice and personalised care, contestability and the new managed market.

Strategic planning

Strategic planning is vital to ensure that the delivery of a patient-led NHS remains at the heart of future service models.

PCTs recognise that they should lead the management of strategically planned outcomes, not the delivery of each function in-house. The majority already undertake long-term strategic planning, using local expertise and, in particular, working in partnerships with other local agencies and their local communities to ensure that joined-up strategies are produced and implemented.

In terms of service strategy, as the new managed market develops, PCTs will need new skills in supporting market entry and in market management. These will build upon the skills of the most able PCTs in service planning and commissioning.

Health improvement

Community-wide health structures, notably local public service boards (LPSBs) and local area agreements (LAAs), will ensure that the most appropriate range of outcomes, that place health at the centre of planning activity, can be developed.

PCTs are centrally placed to deliver the local health leadership role and to ensure that the health voice is heard in local-authority-led well-being arrangements. They already are active players in local strategic partnerships (LSPs) and, therefore, have a key role in the development and delivery of well-being strategies responsive to local communities. LSPs, LPSBs and LAAs will increasingly serve as vehicles for tangible population health improvement,
securing delivery beyond what the NHS can deliver alone.

**Needs assessment**

While practice-based commissioning decisions will form the backbone of commissioning activity, they will still need to be linked into the strategic plans.

Strategic plans will be developed by PCTs, taking into account the views of care networks and partnership organisations. Epidemiological approaches to needs assessment should be supplemented by market research techniques, so that the population can be segmented not just by need but also by how different groups think about and access healthcare.

Actuarial techniques may be used to understand risk and need. Programme budgeting will link expenditure to pathways and quality and outcome data. The strategic plan of service delivery, managed by the PCT in its health leadership role, will be an aggregate of all these information sources.

**Financial management**

Close-to-home care will require – and help to produce – the financial changes in the present system that are necessary to deliver the shift from healthcare to health improvement. The full roll-out of tariff-based activity is critical to the success of the whole system.

The planning and commissioning roles of the PCT will ensure the best distribution of resources along a pathway of care. The possibilities for pooled budgets within partnership-delivered services will increase the complexity of the governance arrangements that are necessary. In a plural system of primary and secondary care providers, contracting and best value issues will mean that PCTs will further enhance the range of their financial and contract-management skills. The development of these skills may require further partnerships, this time, potentially, with commercial providers of strategic commissioning and procurement services.

**Care delivery**

Networks of care and defined care pathways will inform individual care decisions, produce strategic targets for delivery and work alongside practice-based commissioning to inform patient choices.

There will be no single model for the provision function within PCTs. Delivery models will be closely related to local requirements. Choice of treatment is not choice of location but of care pathway, provided through integrated partnerships, fully-owned community services and independent sector and voluntary and community providers.

The role of PCTs will be:

- to ensure that their local communities are fully engaged in the development of these choices
- to assure quality through kite-marking the range of providers required for the achievement of real patient choice
- to implement pathways and deliver services where this is most appropriate, either individually or in groupings of PCTs, ensuring that cost-effectiveness and economy of scale deliver an effective service.

**Vertical integration**

Much has been written recently about the possibilities for vertical integration of services, particularly in areas where foundation trusts are still exploring their freedoms and capacity.

Integration should be led by primary care clinicians through practice-based commissioning and planning in partnership with local communities. This will ensure that integration is broadly based and delivers the outcomes required by the communities served, rather than the organisations involved. The unique position of PCTs, working within and consulting with their local communities, will enable such integration to complement the moves to bring care close to home, delivered as part of an individually tailored package in the right place, at the right time and by the right person.

**Models of delivery**

In discharging these functions, PCTs will need to identify where collaborative arrangements will support delivery.

**Flexible structures**

The distinction between structures and outcomes will enable a range of local models to be developed. Each of these will respond to and respect local differences, both in community requirements and the healthcare environment. In a system where choice and outcomes are the key drivers in defining the delivery model, tiered systems will be necessary to ensure that tasks are completed at the most appropriate and cost-efficient level, either within or between organisations.

In this tiered, outcome-responsive environment, there may be:

- networks of PCTs, collaborating on the elements of commissioning activity
• specialist PCTs with expertise in the provision of some care pathways or a wider range of community-based services
• jointly appointed public health professionals working across PCTs or with local authorities, and co-ordinated health-improvement activities to meet the needs of local communities.

Local innovation by PCTs has ensured that these models already exist in some areas, and the resulting structures are uniquely suitable for local needs. Over time, these structures too will need to evolve to ensure that fitness for purpose itself is not a concrete concept, fixed at a particular point in time. Local variation should be welcomed where it enables outcomes to be achieved.

Infrastructure management
The differentiation of structures to achieve outcomes may also include removing functions, such as human resources (HR), payroll and procurement, from individual organisations and bringing them together into agencies that provide services across several PCTs.

PCTs will lead these changes and monitor their effectiveness and value for money. Such structures will compete for business across PCT networks. Hubs of shared services will enable efficiency, and competition will ensure cost-effectiveness.

Conclusions
Any development programme for PCTs must be tailored around the delivery of a clearly expressed purpose, based on the functions outlined above. While most elements of development will be managed locally, some will require a driver at national level if PCTs are to be supported to deliver their maximum potential. These are:
• improved information systems beyond Connecting for Health, with clear links to other partners
• clear HR frameworks that take into account the changes a market will involve
• first-class leadership and management-development programmes to enable market-management skills and competencies to be embedded in the organisations
• clear agreements about autonomy, performance management and new accountability and governance arrangements. The performance management structures for PCTs must enable a new culture that supports rather than penalises managed risk-taking behaviour as part of the evolution of more effective service delivery and health improvement.

Re-configuration of PCTs should only be considered within the context of the functional framework outlined in this Briefing, using purpose, outcomes and best fit as outlined.

The next stage in the development of PCTs will require excellent organisational development processes. In the first instance at least, this should be managed at local level by strategic health authorities, with the full engagement of PCTs.

The central development of policies should enhance and support coherent local PCT development to enable the outcomes outlined above to be achieved. PCTs as strategic leaders, through representative bodies such as the NHS Confederation’s PCT Chief Executives’ Forum, will expect policies to be developed in partnership with the service and to reflect its major concerns.

Comments and suggestions on the issues raised in this Briefing would be very welcome and should be sent to: nigel.edwards@nhsconfed.org or jo.webber@nhsconfed.org

This paper is part of the NHS Confederation’s work on commissioning a patient-led NHS. For more information visit www.nhsconfed.org

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