Making a difference

how primary care trusts are transforming the NHS
The voice of NHS management

The NHS Confederation brings together the organisations that make up the modern NHS across the UK. Working with our members, we are an independent driving force to transform health services and health by:

- influencing policy and the wider public debate
- connecting health leaders through networking and information sharing.

What are our values?

- championing health and health services
- engaging our members
- speaking out independently and with responsibility
- leading the debate
- working in partnership and embracing diversity
- providing value for money.
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PCTs and the new system

A priority for the NHS Confederation is to promote the role of PCTs, who face a particularly challenging agenda as new contracts, patient choice, payment by results and a greater diversity of providers all transform the system.

The NHS Confederation is publishing a series of reports looking at how these pieces of the health policy jigsaw fit together and their impact on PCTs in particular.

The reports will focus on:

• how PCTs are making a difference
• learning from existing examples of integrated management across PCTs
• the relationships between PCTs and acute trusts and how they can be strengthened
• exploring new models of commissioning
• where next for PCTs.
Introduction

The last two years have witnessed unprecedented change and unprecedented scrutiny in the NHS. At the centre of the maelstrom have been primary care trusts (PCTs), charged with turning policy aspirations into a reality on the front line.

The onus has been a heavy one: PCTs are now responsible for three-quarters of the NHS budget in England. They must commission services as well as provide some themselves. They must formulate strategic plans for the future as well as ensure adequate care for their populations today. They have to forge complex and fruitful relationships – with GPs, local authority, voluntary and commercial sector partners – often where none has existed before, or worse, where the history of such relationships has been a poor one. All this would be a demanding agenda for long-established bodies; for organisations still in their infancy it is testing indeed.

It is perhaps small wonder then that much of the spotlight has focused on what PCTs have so far failed to achieve, with reports from the Audit Commission and Commission for Health Improvement (CHI) this year both focusing on PCT performance. Yet, while independent challenge and scrutiny is clearly important, we are in danger of overlooking the remarkable improvements in the state of the health service that PCTs have brought about in a short and difficult time – and for which they have so far had scant credit. While the system around them was changing fundamentally in so many ways, they have set in motion initiatives that have made a real difference to patients, and in places have begun to solve perennial problems that have dogged the NHS since its inception. Often PCT management ingenuity has been brought to bear to extract surprising results in the teeth of unpromising circumstances – all this while the organisations themselves have had to mature at an unnatural pace.

Not every PCT can boast of outstanding achievements yet, but many can and the five in this report are certainly leading the way.

What is the role of PCTs?

Primary Care Trusts, set up over the last four years, are now responsible for health and healthcare services in their locality. PCTs have three key roles:

- to purchase care for local communities from hospitals and other local providers
- to directly provide services such as community nurses
- to work with local agencies to tackle health inequalities and improve public health.

Each PCT covers a catchment population of around 170,000 people and is responsible for budgets of up to £330 million. Some of the larger PCTs cover over 70 GP practices in their area.

GPs are at the heart of PCT decision-making. A GP is a key member of the board and often chairs the Professional Executive Committee (PEC) made up of a range of clinicians who oversee the day-to-day running of the organisation.

A challenging agenda

Just some of the current challenges facing PCTs include:

- managing 75 percent of the NHS budget to buy and provide services on behalf of their local population
- implementing a new contract for over 32,000 GPs that will improve the quality of patient care
- preparing for a new contract for nearly 10,000 community pharmacists
- managing over 300 million procedures by GPs and practice nurses every year
- managing the public health agenda to prevent illness, promote health and reduce health inequalities across the country in accordance with National Service Frameworks
- working with local government to provide joined up health and social care
- managing the largest ever investment in IT to improve access to healthcare and patient outcomes.
Ensuring that new houses have gardens is a campaigning issue for South Cambridgeshire PCT. “We’re lobbying for things that you might ask, ‘why is the health service doing that?’” admits Chief Executive Sally Hind.

“We’ve effectively designed out most physical activity from our lives, so need to encourage, as part of our Physical Activity Strategy, exercise which people will do and enjoy, like gardening.”

With population growth of 37,000 people in its patch by 2016, 20,000 of which will be in a single new town development, the PCT is keen to anticipate the demands that so many newcomers will make on its services. Encouraging healthy lifestyles to begin with is the first step towards responding. It also wants houses designed so that, as people grow old or become frail, they can continue living in them.

The policy is typical of how the PCT systematically analyses problems. Its plan for improving the existing 140,000 population’s health displays the same approach. “We analysed mortality and morbidity on all of the significant key areas and said, where do we sit in comparison to others, and where is there scope for improvement? That gave us a robust set of pointers as to where we should put our efforts and energies,” says Ms Hind. “We weren’t then rushing off on the first good idea somebody had. We’re systematic in asking: what needs to be done? How are we going to do it? Who else do we need to engage?”

The technique perhaps owes something to Ms Hind’s geography and statistics degree. “You wouldn’t believe how often both of those subjects have turned out to be useful.” She joined the NHS as a management trainee after university, and has spent all of her career in it except for a year as a head-hunter. “I earned a lot of money and really didn’t enjoy myself at all.” She picked up valuable business acumen, but quickly realised that profit-making was insufficient motivation. “I felt that my values were better suited to working in a public service.”

Ms Hind became South Cambridgeshire’s chief executive in April 1999 when it was a primary care group (PCG). It was fortunate to be part of a forward-thinking health authority that encouraged PCG autonomy by devolving commissioning to localities. “That was a wise move because it meant you built the competency from an early stage – particularly important here as we didn’t have a single GP fundholder.”

As a result, the PCT was set up to succeed, Ms Hind feels. That has culminated this year in services for older people being integrated across health and social care, with 140 social services staff and a £15 million budget transferring to the PCT. It means further responsibility and challenges for the PCT. “Whereas in an acute or mental health trust they’re focusing on delivery, in a PCT you plan and try to prevent, you deliver and you commission. Wearing all those hats can sometimes be a real challenge, but there’s value in keeping the functions within one organisation because you’re seeing things all the way through,” says Ms Hind.

++ The number of people who quit smoking in England using local
South Cambridgeshire is piloting patient choice in orthopaedic services for the strategic health authority, grappling with predictions of patient flows, the best way to provide help for patients to make informed choices and how to initially move to offering what Ms Hind calls a series of ‘set menu’ – choices hopefully leading eventually to an à la carte menu, with choice at every stage of the pathway.

In its two years of existence it has notched up notable successes: exceeding its smoking-cessation target by 187 per cent; a substantial number of GPs with a special interest, including an accreditation scheme that has attracted the royal colleges’ attention; and developing health advice for teenagers via ‘Teen-Texting’ – a service that has aroused interest from around the country and overseas.

On the horizon are plans for further improving children’s services through integration, responding to population growth, managing demand and achieving significant shifts in activity from secondary care to primary care settings. And as the PCT is over its capitation funding target, this means creative investment, as it will receive less growth money than many others.

“It’s part of our NHS nature to look at all the things that might go wrong,” says Ms Hind. “The challenge is to make sure we don’t get so angst-ridden that we fail to put all our energies into delivering and achieving the benefits that are there for us.”

‘Whereas in an acute or mental health trust they’re focusing on delivery, in a PCT you plan and try to prevent, you deliver and you commission.’

Sally Hind
South Cambridgeshire PCT

smoking cessation services doubled last year compared to 2001/02 ++
Medicine and management in North Bradford

Dr Ian Rutter
Chief Executive, North Bradford PCT

Few jobs can be more demanding than those of a GP and an NHS chief executive. Yet Ian Rutter combines both. For three days a week he heads North Bradford PCT, and for two he practises medicine.

Dr Rutter joined the organisation when it was still a primary care group and has noticed how the chief executive’s role has become dramatically more complex and increasingly demanding since then. “It feels quite different, and a much bigger job than when I started.” Ruthless segmentation is the key to fulfilling dual roles, he says. “I have a good team, and it works well.”

Not surprisingly, North Bradford has a strong record of engaging with its clinicians. “There’s no sense of them and us,” says Dr Rutter. It has 35 GPs with a special interest serving its population of 94,000, as well as GP and nurse leads in every clinical area. Power and responsibility have been devolved to practices through personal medical services contracts. A policy of openness and transparency means any clinician can compare their own performance with another’s. “Peer review is a powerful driver for quality improvement,” says Dr Rutter.

The PCT has also developed a culture of innovation and change. It has adopted the National Primary Care Collaborative’s approach of instigating small, local changes which precipitate larger ones that have a major impact.

North Bradford is soon to host one of the first independent sector treatment centres, providing a one-stop shop for diagnostic procedures and day-case surgery, reducing waiting times. Radically improving cancer survival rates is another aim.

The PCT is proud of its achievements but is aware it can do much more. “My guess is we’re doing quite well compared to the rest of the country,” says Dr Rutter, “but not as well as Kaiser Permanente or some of our worldwide colleagues.”

Listening carefully to the views of people who use its services is crucial to the PCT. A newly established consumer council has begun to expand the role of patients in developing policies and services. Members are recruited through a formal appointments process involving an interview and are paid an honorarium. Some practices have critical friend or patient participation groups. “They’re starting to be able to get their message directly to the practice that’s delivering their care,” says Dr Rutter.

He recently met local primary schoolchildren to find out how the PCT could improve services for them. “They hate dentists because they don’t like the taste of rubber gloves in their mouths,” he says. “Waiting rooms have nothing for them to do or to interact with to better understand their health.”

“Things that matter to consumers are not the things that overtly stand out to professionals. Some of that information will automatically start to feed into the mainstream of what we do,” Dr Rutter promises.

Relations with acute trusts are a key concern for PCTs. Dr Rutter is concerned that the payment-by-results system is not yet sophisticated enough to support the type of contracts that the PCT wants. Unless a number of key technical issues are dealt with, this may undermine previous work to develop a positive relationship. He warns: “A lot needs to be done urgently, otherwise there will be quite significant problems generated around the country.”
‘Things that matter to consumers are not the things that overtly stand out to professionals. Some of that information will automatically start to feed into the mainstream of what we do.’

Ian Rutter
North Bradford PCT

++ Nearly 9 out of 10 people are seen by a GP within 48 hours ++
Northumberland united

Linda Ions, Chief Executive
Northumberland Care Trust

Imagine an organisation with no delayed discharges, which has helped every teenage mother in its area back into education, where GPs and social workers sit in equal numbers on the professional executive committee and to which the local authority has delegated a quarter of its budget. Shangri-la? Not quite: Northumberland Care Trust.

Chief Executive Linda Ions is frank that integrating health and social care one stage further than most – Northumberland is one of only eight care trusts – brings advantages and disadvantages. She has to run the organisation through two different systems: the NHS and local government. Different rules apply in each to performance management and activity measures, for example. Timescales may not be synchronised, and local government is more politically dominated than the NHS. “But it’s do-able. I don’t regard it as two different jobs,” she says. “You can’t expect the whole world to change. You have to make the best of it.” And she is adamant that the advantages outweigh the drawbacks.

“Staff operate as one team. They don’t see themselves as being part of different organisations. That makes a huge difference to the way they work. There are things you take for granted which you realise you shouldn’t when you speak to others: staff being in the same building, shared records, the same computer system, social workers based in general practices. They may seem small, but they’re very significant.”

Services are better organised and easier to understand, says Ms Ions, a career NHS manager who has spent her working life at the interface of health and social care. Every user has a single care manager – whose profession may vary – as their ‘entry gate’ to the system. A MORI poll found that about 60 per cent of local people recognised the care trust or had had some contact with it.

Its patch is vast, covering 314,000 people and stretching 70 miles. The care trust’s 3,000 staff are divided into four localities, which encompass areas of both urban and rural deprivation. “The challenge is about how to take services to people in their communities and reducing inequalities,” says
Ms Ions. Rates for coronary heart disease, smoking and teenage pregnancy are high, but falling.

Working with young people is a priority, particularly where youth unemployment is high. “We have a responsibility as the largest employer in the county to help raise aspirations to look for learning and employment opportunities,” she says, so the care trust runs schemes involving apprenticeships and cadetships.

“We employ a lot of staff who you and I might think were quirky but the kids think are wonderful,” says Ms Ions. Falls in teenage pregnancy rates that exceed targets and the return of young mothers to education are among the results.

Looking to the future for care trusts, she says: “We would hate to see it undone. We’d lose an awful lot. You can achieve a similar outcome by different means: for example, seconding staff. But you miss something.”

The emergence of children’s trusts is likely to have an impact on care trusts, Ms Ions believes, as the latter deal mainly with older people’s services. Though she thinks ministers are keen to see more care trusts, they will not instruct organisations to set them up. “Children’s trusts might just force the issue.”

The voices of care trusts are heard, Ms Ions says, but their influence is limited because they are few in number. Nevertheless, they will face many of the same issues as their more numerous colleagues in PCTs. “As always, secondary care access remains the biggest challenge, and the rise in emergency admissions that many are seeing. The challenge is how we work with primary care and others to tackle the emergency care workload.”

‘Staff operate as one team. They don’t see themselves as being part of different organisations. That makes a huge difference to the way they work.’

Linda Ions
Northumberland Care Trust

conditions are reducing hospital admissions by as much as 15 per cent ++
Scaling up in Selby and York

Jeremy Clough
Chief Executive, Selby and York PCT

At first glance, Selby and York PCT looks an odd animal. York’s 210,000 population might well have expected a PCT of its own, and probably would have had one, except that when the boundaries were drawn Selby’s 60,000 people had no natural place to go. The resulting organisation is bigger than its main local government partner, the city of York unitary authority, while North Yorkshire county council and two district councils are partners too.

It could have been a bureaucratic nightmare. But what might appear a hotchpotch in local government terms makes perfect sense as a health-planning entity: people in both York and Selby turn naturally to York District Hospital for their acute care. “We have a one-to-one relationship with the local acute trust,” explains PCT Chief Executive Jeremy Clough. “Therefore there is no balance of power issue.”

Hard work has cemented good relations with all the local authorities, he says. Together they have formed a health and social care partnership board, prompted by the need to solve operational problems such as delayed discharges. These have now fallen from 80 to 20. “Policy changes like reimbursement have had an effect, but a lot of it is about better understanding.”

Mr Clough joined the PCT as its finance director in 2001, when it was very much in its fledgling stage, and became chief executive in February this year. Having worked previously in Doncaster – which has three PCTs – he soon recognised that Selby and York’s singular presence in its area meant it would attract the limelight. “I suddenly realised I was entering a world where problems were going to be played out on the front page of the local newspaper,” Mr Clough says.

But the organisation’s scale brought benefits too, which meant it was undaunted by the overnight revolution in PCT responsibilities heralded by the government’s move to shift the balance to the front line. It can support a large management structure that makes it ‘big with capability’, says Mr Clough. Where some PCTs may have doubled up roles, Selby and York has specialist functions and departments. For example, it has separate heads of governance, patient experience and learning disabilities. In addition, more than half its executive directors are clinically qualified. “That’s a big change at the top of the organisation.”

Mr Clough sees the performance of the whole health system as the most notable achievement. “We have been a central part of the NHS at a time of unprecedented change, performance management and improvement. PCTs need to take more of the credit for this delivery.”

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++ PCTs are implementing a new contract for over 30,000 GPs
Learning disability services have been one of the PCT’s biggest individual successes. “We’ve taken a service that was neglected and turned it into one to be proud of,” says Mr Clough. “It’s integrated with the local authority and has been given an emphasis it’s never had before.”

Mental health services have undergone a similar transformation. The trust employs 20 consultants and runs a full range of community, inpatient and secure forensic mental health services. “The services are flourishing in this organisation. We’ve created a different feel. There’s a sense of optimism among the staff. They’re a differently motivated workforce,” says Mr Clough.

But inevitably, a few clouds have appeared on the horizon. Like many others, the PCT faces a challenging financial situation and rising demand for its services, which makes investing for the future difficult. Mr Clough wonders whether the proliferation of national initiatives has been reconciled with the total resources of the NHS. “It is a concern that not enough work has been done centrally to plot the cost of the totality of system reform and show it is affordable. It is difficult to make sense of all of that locally,” he says.

And he is clear that the precious one-to-one relationship with the local acute hospital if, as seems likely, it soon becomes a foundation trust must be maintained. It may have an incentive to admit patients rather than co-operate in treating them in the community. “That alters the dynamic. We have a very strong partnership at the moment. We need to ensure we share a vision and objectives so they don’t exploit growth in a particular area that doesn’t fit with our goals.”
The Waltham Forest renaissance

Sally Gorham
Chief Executive, Waltham Forest PCT

Fate dealt Waltham Forest a tough hand: healthcare services in this North London borough were perceived for years as underperforming and suffering from chronic financial problems, with poor-quality primary care, emaciated community services, a struggling acute hospital, little management infrastructure and shabby buildings.

“I was given a list of a dozen practices that were never going to be redeemed – the worst caricatures of single-handed practices,” says Chief Executive Sally Gorham, who has now been in post for three years.

The health authority had misjudged the significance of PCTs and stifled their development, she says. So the area ended up served by Walthamstow and Leytonstone PCT, one of the few in London not coterminous with its local authority. Its GPs – who had never really been ‘loved’, says Ms Gorham – continued to feel that they were not part of anything.

Yet recently the PCT hosted an event for 200 people, mostly GPs. Such occasions, with all 68 local practices represented, are no longer unusual. The PCT is one of the few to have been reconfigured – as Waltham Forest – and now matches borough boundaries. It has achieved levels of participation by its clinicians that most other PCTs would envy, while relations with its local authority – which itself has not enjoyed the best of reputations – are excellent.

“We see ourselves as a group trying to take forward the renaissance of Waltham Forest,” says Ms Gorham. The local authority recently offered the PCT a carpark site on which to relocate three or four general practices and house a child assessment centre. “Once you know each other really well, it’s the informal network that delivers,” says Ms Gorham.

Closely involving GPs has been central to the PCT’s approach, born not least from Ms Gorham’s own experience. She joined the NHS at 21 as an occupational therapist, and moved into management when the Griffiths reforms of the mid-1980s encouraged clinicians to do so, becoming one of the NHS’s youngest unit general managers. But it was while heading another PCT and trying to set up a walk-in centre without GP support that she realised how crucial they were to any attempt at innovation. “You’ve got to have them with you. If you haven’t, you’re absolutely lost,” she says.

So when Waltham Forest’s financial situation made it impossible to establish locality management, she devised a structure based on grouping the PCT’s
Making a difference

general practices into six clusters, with the GPs on the professional executive committee each taking responsibility for one – ‘not as managers, but as the communication link with the PCT’. After initial reluctance, they embraced the idea.

“We put a lot of performance management data into the cluster areas and we held events on cluster bases. Now everyone talks ‘cluster’ all the time. We organise virtually everything in the PCT around them,” says Ms Gorham. Each is configured to reflect the community councils or area committees that the local authority uses for consultation.

The PCT has made major strides in helping improve services at Whipps Cross Hospital, in developing high-quality care for coronary heart disease ahead of the requirements in the General Medical Services (GMS) contract, in encouraging the roles of specialist nurses and community pharmacists and in redeveloping practice premises. It is even retraining refugee health workers as cardiac technicians. And despite its history of poor financial management, it has broken even.

For the future it is working on practice-based commissioning, readmission avoidance and chronic disease management. “The whole organisation is about being positive, about Waltham Forest being one of the best PCTs in London, about improving performance and believing in people and their ability to achieve that,” says Ms Gorham.
Conclusions

The striking feature of these case studies is the demanding role that PCTs have been given:

- the scope of their work is very large, ranging from health improvement in schools to tertiary neonatal intensive care
- they have to be innovative and prepared to challenge accepted ways of doing things, including clinical work
- to do this effectively they have to build high-quality relationships with clinical staff in GP practices and in hospitals as well as with local government and other organisations
- PCTs have to integrate care, balance priorities, actively engage with local people, meet government priorities and a wide range of other objectives simultaneously.

PCTs have to do all this with limited managerial capacity, with both the Audit Commission and Commission for Health Improvement recognising that PCT management resource is thinly spread.

A number of emerging policies provide new opportunities for PCTs to make a positive impact on how healthcare is delivered by using choice, payment by results, new contractual arrangements for staff and new approaches to commissioning. However, one of the most significant issues that PCTs face is how to deal with this large number of different policies – many of which do not immediately appear to interrelate – and to turn these into a coherent whole in such a way that they successfully engage with the interests and aspirations of local people and, crucially, with those of their clinicians. Without this coherent story it is very difficult to get any enthusiasm for the role of the PCTs or their objectives from stakeholders, the public or even policy makers.

The PCT chief executives also highlight how these individual policies bring their own challenges. There is concern that payment by results and the emergence of foundation trusts contain powerful incentives to undermine some of the collaborative working that the most effective PCTs have managed to develop. PCTs and the trusts they work with are ambitious for change but many are worried by tight financial situations, which they fear could make a mockery of their best laid plans for care in the future. And all are keen to tackle the challenges of coping with rising emergency admissions and finding better ways of managing chronic disease.

Some are thinking hard about the advent of foundation status for neighbouring acute trusts. Will it upset formerly symbiotic relationships? Could it undermine the PCTs’ mission? Whatever happens, it will clearly require PCTs to find new ways to engage their local community to ensure genuine involvement in key investment decisions.

These case studies demonstrate some of the PCTs’ aspirations for the future and their thinking about how their role can develop. In the next reports in this series we will focus on how PCTs need to change and adapt to meet the many significant challenges and opportunities ahead.

PCTs have been in existence for less than four years and they have been subject to significant change during this period. However, as usual, there are some who are already talking about the need for further
reorganisation, with PCTs in their sights. This report should give the sceptics pause for thought. In the face of an enormously challenging agenda and many competing claims on their time and resource, the case studies are a snapshot of the progress already being made. Of course, there can be no room for complacency, and there is much more to be done. But PCTs are now demonstrating the difference they can make and can claim credit for some outstanding achievements in their short history.

For more information about the NHS Confederation’s work in this area, please contact Nigel Edwards, Policy Director at nigel.edwards@nhsconfed.org
A priority for the NHS Confederation is to promote the role of PCTs, who face a particularly challenging agenda as new contracts, patient choice, payment by results and a greater diversity of providers all transform the system.

*Making a difference* is the first of a series of reports looking at how these pieces of the health policy jigsaw fit together and their impact on PCTs in particular.

*Making a difference* reflects on the scale of the task facing PCTs, who have been charged with turning policy aspirations into a reality on the front line. Drawing on case studies from across the country, it shows how PCTs are making a real difference and argues that PCTs should be given credit for the improvements achieved in their short history.