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The legacy of primary care trusts

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.

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For more information on our work, please contact:

The NHS Confederation
29 Bressenden Place London SW1E 5DD
Tel 020 7074 3200 Fax 0844 774 4319
Email enquiries@nhsconfed.org
www.nhsconfed.org

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Introduction

Primary care trusts (PCTs) are the statutory NHS bodies responsible for commissioning most health services and for improving public health. Until recently, they also directly managed the vast majority of NHS community health services, such as district nursing, health visiting and children's services. They are currently responsible for managing around 80 per cent (£110 billion) of the NHS budget.

Since their launch, PCTs have often been subject to considerable criticism, culminating in the Government's proposal to abolish them in April 2013, with plans for clinical commissioning groups, the NHS Commissioning Board and local authorities to take over PCTs' commissioning and public health responsibilities.

While the rationale for and benefits of the reorganisation of the commissioning system could be, and recently have been, debated at length, one thing which is clear is that new commissioning bodies will face many of the same pressures and challenges PCTs have over the past decade. If they are to be given the greatest chance of success, it is important we reflect on and shape the learning from the experiences – both the successes and the failures – of PCTs.

As a contribution to this process, this paper sets out a considered assessment of the performance of PCTs since their establishment. It examines how their role has changed, as both provider and commissioner, since they were initially established, and how effective they have been, as assessed against what they have been asked to deliver.

A brief history of PCTs

The early years

Primary Care Trusts (PCTs) were launched in April 2000 and fully established across the country in April 2002.

The original 303 PCTs across England were initially established with three objectives:

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

From as early as October 2002, the role of PCTs was expanded to take on more specific and enhanced responsibilities for:

- improving the health of the community
- securing the provision of high-quality services
- integrating health and social care locally.

PCTs continued to take on new responsibilities after this, including managing the introduction of Payment by Results (a remuneration system for acute trusts for carrying out specified treatments), implementing and managing the new GP and dental contracts, and implementing practice-based commissioning (an initiative aimed at involving greater numbers of clinical staff in decisions about the shaping of healthcare).

The role of PCTs further changed with the introduction of independent sector treatment centres and foundation trusts from 2003. PCTs were now increasingly taking responsibility for the local delivery of national policy.

"Since joining the NHS, I have worked within an ever-changing system. Given the context within which we have been working, I am proud to be able to say that the health of our local population has improved; health services have improved and commissioning has worked.

"The greatest success has come when experienced managers have worked hand in hand with clinicians to develop partnerships, orchestrate change, improve health and improve services. I am confident that if we can retain experienced managers and clinicians, then together they will lead and improve the NHS."

John McIvor, chief executive, NHS Lincolnshire

Time for a step-change

In 2005, the Government's publication of *Creating a patient-led NHS* required PCTs to introduce a choice of elective care from the following year, and the accompanying *Commissioning a patient-led NHS* set out the need for a 'step-change' in the way services were commissioned to deliver better engagement with local clinicians in the design of services.

The configuration of PCTs was reviewed as a result of changes arising from this policy. It was felt that aligning NHS commissioning boundaries with local authorities would help drive greater joint working across health and social care. As a result, PCTs were reconfigured, leading to a reduction in their numbers from 303 to 152 to match the number of local authorities in England. The reduction in numbers of PCTs was also seen as a means to strengthen commissioning.

A separate element of the *Commissioning a patient-led NHS* policy was the announcement of the requirement for the separation of PCT provider responsibilities from commissioning responsibilities. This process began in earnest with the introduction of the *Transforming community services* policy, which aimed to have all community service arms of PCTs established as separate organisations within a given timeframe. This decision was quickly reversed by the Secretary of State, and the policy in relation to community services remained confused until as recently as 2009 when the requirement for separation was reinstated, with an implementation deadline of April 2011.

From 2006, PCTs were given additional responsibilities with little regard to the overall impact on the capacity of the organisations to deliver the responsibilities. By 2010, a joint piece of work by the Primary Care Trust Network and the Department of Health identified more than 60 separate statutory duties held by PCTs and a list of PCT functions which ran to 14 pages.[1]

The introduction of World Class Commissioning and 'clustering'

In 2007, an unpublished Cabinet Office review of commissioning arrangements in the NHS concluded there was no clear narrative explaining the purpose of commissioning or setting out the skills necessary to deliver effective results. This led to the implementation of the World Class Commissioning programme from 2008, which sought to articulate the purpose of commissioning, the organisational capabilities required to deliver it and an assurance framework to judge PCTs' commissioning capabilities.

While the World Class Commissioning programme was short-lived – PCTs only published two annual sets of results – the data indicated that PCTs were making progress in a number of areas including improved procurement skills, engagement with the public and patients, and stimulation of the market.

In the most recent reorganisation, PCTs have undergone 'clustering' in an attempt to ensure sustainability while streamlining management costs and driving savings in the run-up to their planned abolition in 2013. This move has seen a significant reduction in the number of chief executives and changes to chair and non-executive director roles, with a number of responsibilities shared across organisations and PCTs managed on a wider regional basis.

How to judge the success of PCTs?

External assessment of commissioning of services

Because of changes to the structure and responsibility of PCTs and the reduction in their numbers, any objective attempt to evaluate PCTs' effectiveness as commissioners is extremely challenging.

However, there have been a range of external assessments of individual PCTs' performance over the past decade, most notably from regulators including the Commission for Health Improvement, the Healthcare Commission, the Care Quality Commission, the Audit Commission, and the Department of Health.

These assessments measured performance against the main national targets for PCTs as set by the Department of Health. Historically, a PCT that did not perform well on delivery of national targets was seen as 'failing' by strategic health authorities (SHAs) and would become subject to harsh performance management intervention. As a result of this, many PCTs focused their attention primarily on delivering these national targets.

Not until the introduction of the World Class Commissioning assurance process in 2008 was a more flexible approach introduced which assessed performance against local priorities. However, even in this system it was the more quantitative rather than qualitative competency and governance ratings which were seen in the measure of performance.

Analysis of the second year World Class Commissioning results shows that PCTs were making significant improvements in their standards of commissioning as a result of the programme. The results show an average improvement of 39 per cent for the ten competencies on which PCTs were assessed in both years. It also showed that PCTs were making good improvements in engaging with their community partners and stimulating the NHS market.

"NHS Rotherham has played a leading role in transforming healthcare, with much improved maternity care; integrated services for babies, children and young people; innovative responses to smoking and obesity; brand new primary care facilities in our neediest communities; waiting times measured in days and weeks, not months and years; dramatic reductions in mortality; state-of-the-art mental health inpatient services; and huge improvements to end-of-life care.

"Taken together, these are testament to the imagination, dedication and excellence shown by commissioners and providers alike in seeking nothing but the best for the people and communities of Rotherham."

Andy Buck, former chief executive, NHS Rotherham (chief executive, NHS South Yorkshire & Bassetlaw cluster)

Measures of commissioning performance

One very important assessment of overall PCT commissioning performance is to review how well the Government's key priorities have been delivered.

It is helpful to consider performance under three headings which reflect the main commissioning responsibilities of PCTs:

- improving the health of the community
- securing the provision of high-quality services
- achieving financial balance and value for money.

Improving the health of the community

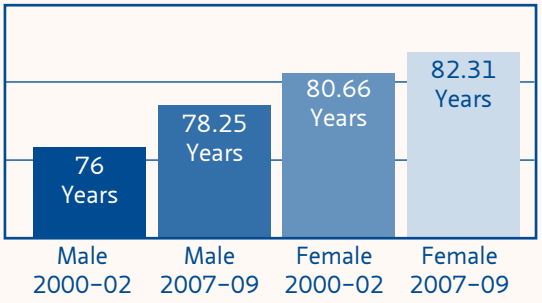
Research shows that there have been significant improvements in health outcomes in England since PCTs were established. Key indicators which have been used by government to measure health outcomes consistently show improvement, including life expectancy, infant mortality and cancer survival rates, as outlined in Figure 1.

Health inequalities have proved harder to shift, with gaps between the health of the richest and poorest in the country failing to narrow. Sir Michael Marmot has stated[2] that the health of the worst off in England has improved over the past ten years, which he described as "a most important societal achievement". However, with comparable improvements in average health, the gap between the worst off and the average has not narrowed. The Marmot review, published in 2010, stated that health inequalities remained "substantial" and required "urgent attention". It found that there remained a seven-year gap in the life expectancy between those living in the richest and poorest areas of England.[3]

Figure 1. Improving the health of the community

Life expectancy at birth, England

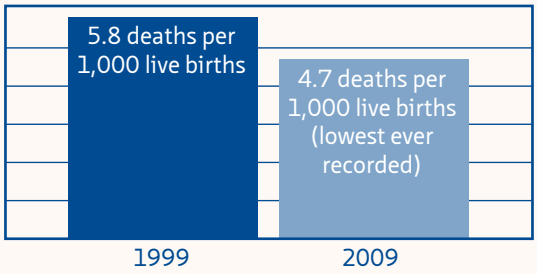
Life expectancy has increased for both males and females:



Source: ONS (www.statistics.gov.uk/STATBASE/Product.asp?vlnk=8841)

Infant mortality, England and Wales

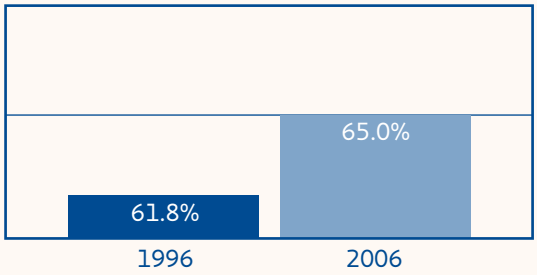
Infant mortality has reduced:



Source: ONS (www.statistics.gov.uk/statbase/Product.asp?vlnk=14409)

Cancer survival rates, England

The one-year cancer survival rate in England has increased:



Source: ONS (www.statistics.gov.uk/pdfdir/canpct0910.pdf)

Five-year survival rates for all major forms of cancer improved, when comparing the 2001–06 and 2003–07 periods, with the exception of bladder cancer for women. Rates of improvement were as much as 3.5 per cent among men with Myeloma and Non-Hodgkin's lymphoma.
Source: ONS (www.statistics.gov.uk/pdfdir/can0410.pdf)

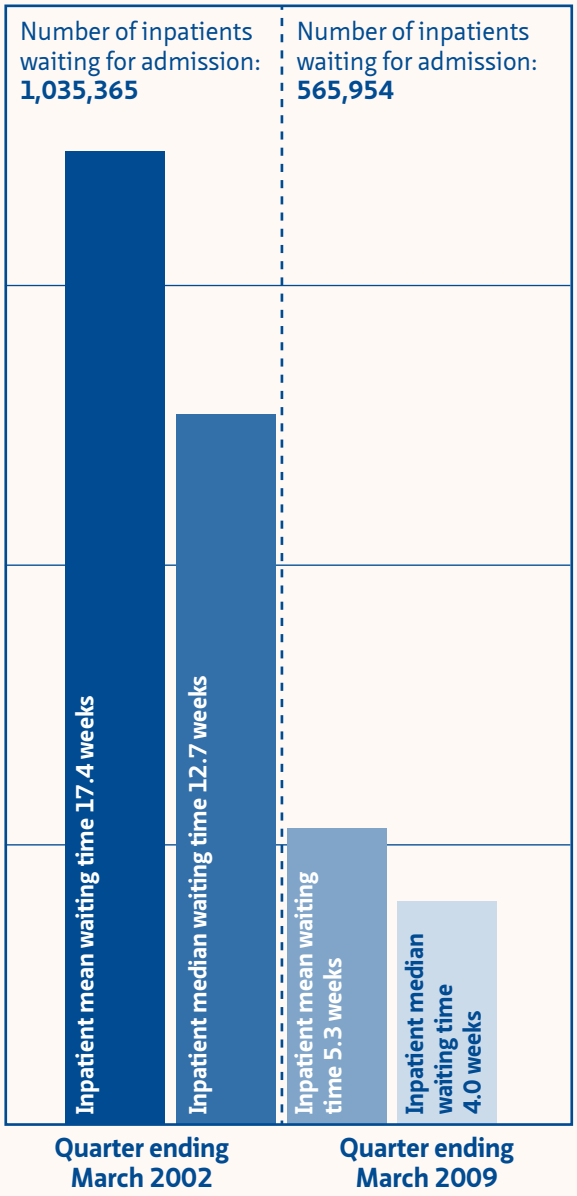
Securing the provision of high-quality services

Much of the last Government's focus on improving quality focused on improving patient experience (and, in some cases, clinical outcomes) by reducing waiting times. PCTs, as system managers, led the implementation of these improvements, including reducing waiting times for inpatients, outpatients and in A&E services. They also helped speed up cancer referral times. More recently, the quality focus widened to include a number of clinical quality measures which again were successfully delivered, including MRSA and C. difficile rate reductions (see Figures 2 and 2.2).

While these achievements relate to national targets, all PCTs have focused on and have played a significant role in delivering this work. A recent analysis of the World Class Commissioning assessments also demonstrates that where PCTs have focused on local priorities, this focus has led to improved performance in those areas.[4]

Figure 2. The provision of high-quality services

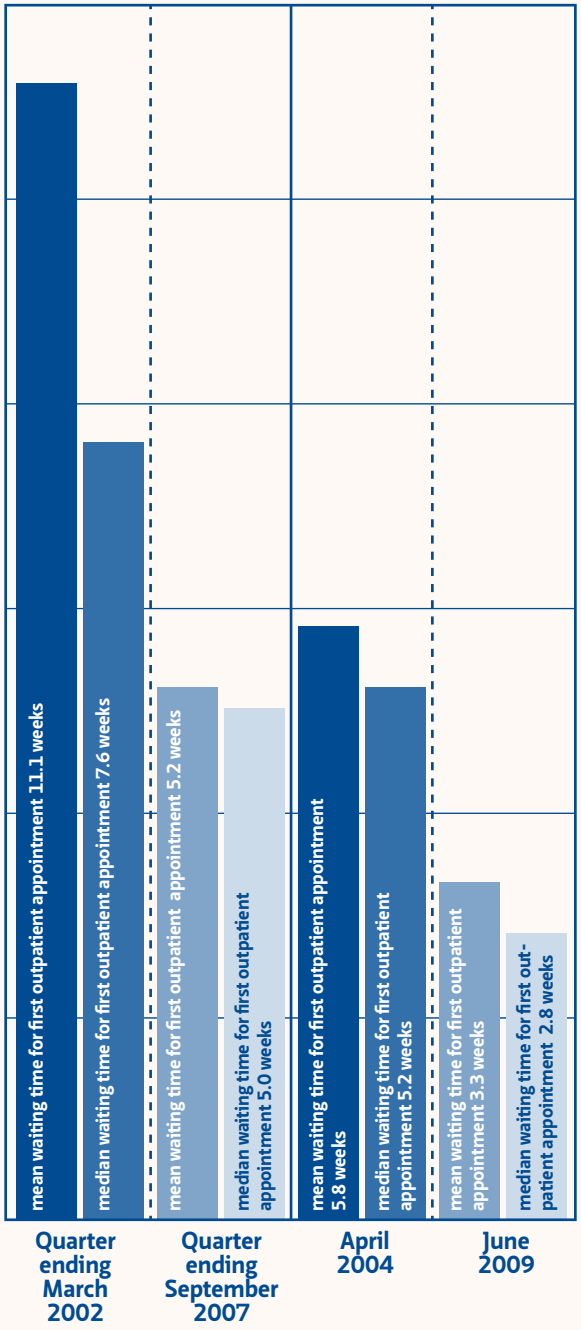
Inpatient waiting times, England



Source: Health Select Committee, *Public expenditure on health and personal social services 2009*.

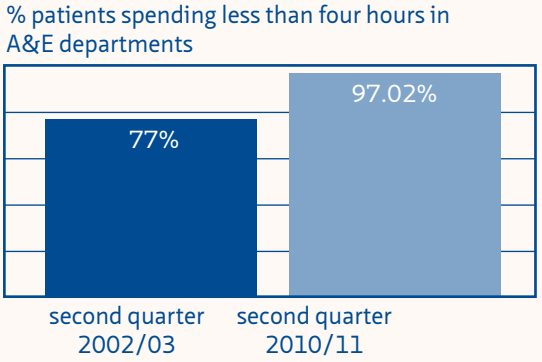
Figure 2.2. The provision of high-quality services

Outpatient waiting times, England



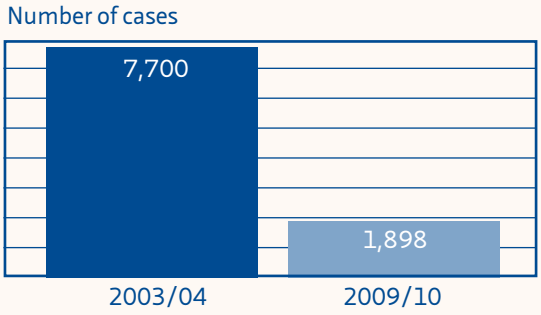
Source: Health Select Committee, *Public expenditure on health and personal social services 2009*.

A&E waiting times, England



Source: Department of Health, A&E waiting times

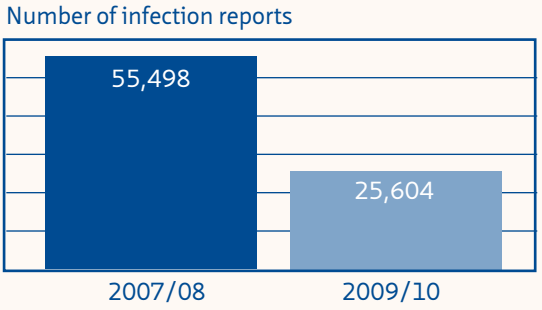
MRSA infection rates, England



Source: HPA

C. difficile infection rates, England

Mandatory surveillance has been in place since April 2007.



Source: HPA

Achieving financial balance and value for money

Value for money is difficult to measure in the NHS. A number of reports have questioned the value for money achieved by the NHS in recent years because its many achievements have been made in an era of significant financial growth. According to a report by the Public Accounts Committee in March 2011, over the decade from 2000/01 NHS spending increased by 70 per cent but productivity fell by an average of 0.2 per cent a year, and by an average of 1.4 per cent a year in hospitals.[6] However, it has remained difficult to find reliable measures of health service productivity, and others would argue that conventional indicators do not take into account changes in models of service delivery and quality.

What can be clearly demonstrated, however, is that PCTs have achieved significant improvement in maintaining financial balance in recent years. By 2005/06, a number of PCTs had fallen into financial difficulties, but by 2009/10, figures show that PCTs' financial management was steadily improving.[5]

In 2005/06, 35 per cent of PCTs were in deficit, with a gross deficit of £616 million and a net deficit of £492 million. By 2009/10, only 3 per cent of PCTs were in deficit, with a gross deficit of £39 million and a net surplus of £1,274 million.

Audit Commission figures also show a significant improvement in the financial capability of PCTs. Its Use of Resources scores for 2009/10 showed a significant improvement in PCT performance, with 96 per cent of PCTs at or above minimum requirements for managing finances. As the previous section demonstrates, this has been achieved at the same time as the NHS has seen improvements in health outcomes and while most government targets have been delivered.

Case study: PCTs improving the health of the local community – NHS Cornwall and the Isles of Scilly dementia strategy

NHS Cornwall and the Isles of Scilly began to prioritise improving its dementia care following a county-wide review of services in 2007. The PCT put in place a three-year strategy to improve dementia care, established a programme board, and made dementia one of its World Class Commissioning priorities.

NHS Cornwall and the Isles of Scilly used high-quality commissioning to improve dementia services without increasing funding, by decommissioning services such as homeward-bound unit beds and reinvesting the funding in a dementia liaison service, an arts for homes scheme for care homes, advocacy, and care and support services. The PCT also redesigned services without increasing expenditure by being very clear with providers about service specifications and setting out delivery plans.

By spring 2010, following on from a range of other initiatives to help tackle dementia, chronic disease registration for dementia stood at 68 per cent in Newquay and 39 per cent in the rest of the county. This compared with a national average of 33 per cent. NHS Cornwall saw this as proof that the approach being used in its Newquay integrated care pilot, and more widely in the county, works.

Source: www.nhsconfed.org/pctn

Provision of services – community services

Most PCTs were responsible for directly providing community services until the recent deadline to transfer management of these services to alternative providers by April 2011.

The range of community services that PCTs were responsible for varied widely. Community services also lacked national policy direction until relatively recently, and there has been an absence of consistent measures of quality or performance. For example, there were no community-specific performance measures in the Care Quality Commission's Annual Health Check, unlike for all other types of NHS provider. This has meant community services have developed very differently across England and there has been an absence of comparative performance data.

However, there is some evidence that PCTs have outperformed other types of NHS providers. The 2008/09 Care Quality Commission ratings comparing the performance of providers against core standards (which apply to all types of providers) showed that 94 per cent of PCT community services fully or partially met core standards, compared to 90 per cent of non-PCT providers.

After many years in the policy 'desert', community services started to feature in health and care policy with the publication of the 2006 white paper, *Our health, our care, our say*, which set out plans for a radical and sustained shift in the ways in which services should be delivered. The strategic direction was to:

- deliver more services in local communities – closer to home
- support independence and well-being
- support patient choice
- deliver a realignment of the health and social care system.

PCTs responded to this by differentially increasing spend on community services by 27 per cent between 2007/08 and 2009/10, compared to an increase of 17 per cent in spend on other services.[7]

A renewed focus on community services emerged in January 2009 with the revised Transforming Community Services programme. The sector welcomed the attention, but the subsequent focus was on the organisational form of community services, and changing requirements around the timetable for separation from PCTs. This has tended to take the focus away from the transformation of services.

Services context

Community services could be regarded as the glue in the health and care system – working closely with many other agencies, including local government, social services, education, primary care teams, and voluntary sector services, as well as the acute sector.

There is no single national model for the configuration and range of community services. Patterns of provision depend on the characteristics of the local population, geography and nature of services provided by other sectors, including health and local authorities. The wide range of diverse services provided in an equally diverse range of configurations has made it difficult to measure the performance of providers.[8]

This diversity of community services has had both strengths and weaknesses. Diversity has allowed teams, models and systems to develop according to local needs, skills, resources and policies. However, as some commentators have noted, this has sometimes resulted in an ad hoc development of services, resulting in very dissimilar provision in different geographical parts of the same region.[9]

Case study: NHS East Riding of Yorkshire – neighbourhood care teams

NHS East Riding of Yorkshire released nearly £600,000 of savings by improving community provision for patients with long-term conditions while still running community services for the local population.

The PCT piloted a model of neighbourhood care teams – extended community teams which aimed to provide multi-disciplinary, integrated and streamlined care closer to local patients' homes. Through extended hours, the team aimed to reduce emergency admissions, support earlier discharge from hospital, increase rehabilitation provision, and enable patients to manage their conditions in their own homes – all central features of the PCT's commissioning strategy for community services, health strategy and Quality, Innovation, Productivity and Prevention (QIPP) plan. Under the pilots, additional investment was made to provide extended community nursing teams and therapy support. Led by community matrons and therapy staff, the teams focused on patients with long-term conditions, providing an enhanced level of care up until 11pm on weekdays and for extended hours at weekends.

The teams maintained close links with local authority social services and shared boundaries with social services care management teams, enabling them to provide joined-up care. The teams were also aligned to local GP practices and worked closely with primary care. They were supported by more specialist teams who worked across the patch such as the respiratory team and specialist therapists.

An analysis of the Bridlington pilot, which was carried out over a period of eight months, showed a reduction of 256 acute spells, 159 GP appointments and 247 A&E attendances. This generated a saving of £589,000.

The future – community services are the solution

After years of being absent from policy, the Transforming Community Services programme was long overdue. But the changing nature of the timetable, with the eventual extremely tight timetable for separation, meant that PCTs and community service providers focused much attention on organisational structures and not on transforming services to meet the integration and care closer to home objectives.

The late attention to IT and quality measures for community services before their separation from PCTs means that these services continue to lag behind.

From a system perspective, if community services are transformed to provide the best possible services, other parts of the system will be enabled to provide the best possible services.

Looking to the future, if new momentum can be brought to the transformation of community services, there is potential for delivering service improvements across the whole health and social care system. This will require:

- strong leadership
- maximising opportunities for synergy in newly merged organisations
- engaging with primary care as providers and commissioners. GPs and primary care need to be part of the system transformation
- adopting more business-like approaches to maximise the potential of working in a competitive market environment
- technology, data capture and performance measures.

PCTs – answering the critics

The analysis in this paper shows PCTs have had consistent success collectively in delivering improvement in most of the areas the Government asked them to focus on.

It is widely acknowledged that the management and administrative costs of PCTs have risen since they were first established.[10] But what is less often acknowledged is the increase in the duties and responsibilities of PCTs in the same period. Similar increases in investment in management in NHS provider organisations have been hidden by the establishment of foundation trusts, which do not collect comparable information.

However, the most important question is not how much we spend on management, but whether it is value for money. Recent research has shown that investing in management leads to improved quality of service.[11]

There is little doubt that PCTs' power as commissioners has been relatively weak compared to the power of providers. However, many healthcare systems with a payer/provider divide face similar challenges. Evidence shows that in no system is commissioning done consistently well. The reasons for this centre on the complexity of healthcare and the inherent difficulty of commissioning health services in publicly financed systems.[12] Furthermore, in England, a large part of the power dynamic is the result of the design of the healthcare system, which has tended to focus until very recently on provider interests.

It is unreasonable to blame PCTs for the constraints of the system within which they work. But despite these constraints, PCTs have delivered significant improvement in the NHS in the areas they have been asked to focus on.

> "In my time with NHS Birmingham East and North, I have worked with an exceptional and highly motivated senior management team, clinicians and staff. Our staff, working with health and social care partners have been totally focused on high-quality, patient-centred healthcare, and improving the health and well-being of our citizens, making huge advances in smoking cessation and integrating health and social care for mental health and learning disability for the city."
>
> **Paul Sabapathy CBE**, chair, NHS Birmingham East and North

There continues to be a range of challenges commonly put to PCTs, including suggestions that they are too bureaucratic, too managerially-led and would be unable to deliver the productivity challenges faced by the NHS over the next few years. Are these views fair?

Are PCTs too bureaucratic?

It is easy to accuse public organisations of being overly bureaucratic without any real analysis of what is meant by this. Any publicly accountable organisation needs a degree of bureaucracy, in the sense that they need clear, transparent and consistent decision-making processes, schemes of delegation, standing orders, and so on. Without such rules and procedures, public bodies can quickly find themselves being challenged. In that sense, PCTs have been appropriately bureaucratic.

Where there has been frustration both among PCTs' own staff and their partners such as GPs, it has often related to the degree of central control from the Department of Health and SHAs. This has led at times to a feeling that PCTs have been too focused on 'feeding the beast' rather than on genuinely driving local improvement. However, despite this concern, PCTs have managed to make real improvements to health services and health outcomes, both individually and collectively.

Are PCTs too managerially-led rather than clinically-led?

On each board, the majority of executive directors for PCTs are clinicians, with three clinicians (including at least one GP) drawn from the professional executive committee, and a director of public health who is either a clinician or trained in public health. The other required executive directors are the chief executive (who in some cases is also a clinician) and the finance director.

So, PCTs are in fact more clinically led than other parts of the NHS. The perception of being managerially-led may derive from the fact that commissioners do not deliver frontline services, and the decisions they make are inevitably unpopular with some due to the nature of the role, rather than any serious analysis of leadership.

Could PCTs deliver the necessary £15–20 billion productivity gains?

The objective evidence from two years of the World Class Commissioning programme showed major improvements in PCT capacity and capability, including improvements in stimulating the market, and improving their procurement skills. There were definite signs that PCTs were starting to mature as commissioning organisations.

The productivity improvement requirements facing the NHS over the coming period are undoubtedly more challenging than any delivered by PCTs to date or indeed by the NHS at any time in its history. When the Government announced that PCTs were to be abolished, PCTs were gearing up for this challenge and will be responsible for delivering the first two years of the £15–20 billion programme up until 2013.

The disruption caused by the clustering of PCTs and the move to the new commissioning environment set out in the Health and Social Care Bill, undoubtedly adds to the challenge. But the legacy that the clinical commissioning groups will inherit relies on existing PCTs delivering effective productivity gains.

"While there have been many challenges, we have strengthened commissioning skills and built a strong foundation for the future, working with clinical commissioners. Effective financial stewardship has ensured a sound financial position and this will support the Somerset community in meeting the QIPP challenge."

Jane Barrie, chair, NHS Somerset

How could PCTs have done better?

Could PCTs have done a better job?

Undoubtedly, PCT performance has varied, as it does in any industry. One of the biggest factors for predicting success was almost certainly the quality of the leadership, not just in the PCT but of local partners, including provider organisations and local authorities. Without strong local leadership there was a greater risk of PCTs focusing too much on central requirements from the Department of Health or SHAs and too little on the needs of the local population.

However, there were also a number of external factors which limited the effectiveness of PCTs. These included:

- the frequent reorganisations of PCTs – there is evidence from Healthcare Commission assessments that the performance in recently reorganised PCTs was worse than the ones which had not changed structure
- the policy focus in the Department of Health too often favoured the interests of retaining stable providers rather than supporting commissioner-driven service improvement
- even with the introduction of Payment by Results and primary care contracts, the commissioning levers remained relatively weak
- the status of commissioning organisations, as measured by senior salaries, remained lower than provider organisations.

Despite the frequent re-structuring of commissioning organisations in the English NHS over the last two decades, it is arguably only in the last three or four years that proper attention has been given to the policy and implementation framework required for commissioning to be effective.

As this paper highlights, during this more recent period, PCTs have demonstrated both their ability to deliver on a range of national priorities, and their capacity to improve given some stability, focus and clarity of purpose. They have done this while also overseeing a series of complex, large-scale organisational changes including the transfer of community health services to NHS or foundation trusts or to new independent organisations.

One of the objectives that PCTs collectively have not achieved is the reduction in health inequalities within and between areas. With targeted funding and support having been made available to tackle this as a priority, this could be identified as one of the failures of the system. However, this is also one of the areas where PCTs were most reliant on partnerships with and effective action from local and national government and other agencies.

With no direct comparators historically, in other parts of the UK or internationally, it is impossible to compare the performance of PCTs with that of other organisations with an equivalent set of responsibilities or facing equivalent conditions. We will also now never know whether PCTs would have continued to improve their capability, influence and outcomes had they been given the opportunity to develop as commissioner-only organisations focused on long-term local health improvement objectives.

It is undeniable that there are things that PCTs could have done better both individually and collectively. However, the evidence set out in this paper suggests that they were heading in the right direction in terms of both their internal skills and competence and their impact on the health of local communities.

Conclusion – looking forward

Despite frequent changes in responsibility and a major reorganisation, the evidence shows that PCTs have overseen the delivery of significant improvements in health and the quality of health services, particularly in the areas the last Government required them to focus on.

PCTs collectively delivered what was asked of them in almost all major policy areas.

There was good evidence that PCTs were becoming more sophisticated and effective in their approach to commissioning before the announcement of their abolition. We hope that this legacy will be passed on to the new commissioning organisations which will be established over the next few years, so that the momentum for improvement is maintained and the challenges ahead are met as effectively as possible.

"I am proud to have been a PCT chief executive. My organisation and the people in it made a difference to the health and lives of people in Calderdale. Services became better and safer. We listened more to the public, patients and clinicians, and we were a good partner with a good reputation. And staff punched well above their weight and had a genuine passion for what they did.

"I hope that future commissioners succeed. To do so they will need to embrace the clinical voice; always seek the patient and carer viewpoint; and make relationships their biggest priority. In the times of radical change ahead, they will need this more than ever."

Rob Webster, former chief executive, NHS Calderdale (current chief executive, Leeds Community Healthcare NHS Trust)

PCTs have continued to perform well despite the challenges arising from the Government's health reforms and the £15–20 billion QIPP efficiency challenge.

They have succeeded in maintaining their core commissioning activities, and have also been able to progress complex plans to transfer their community services to other organisations while ensuring the provision of these services is maintained. This is a testament to PCT staff given the reductions in these organisations' management capacities, which continue steadily as PCTs continue to 'cluster'.

It is important to take a realistic and balanced view of the achievements of PCTs if we are to learn the lessons for the future of commissioning.

Evidence of the progress made by PCTs should be acknowledged so that future commissioning organisations and policy-makers learn from good past practices.

It has been made clear that the new system of commissioning cannot simply be a replication of the work PCTs currently do. However, clinical commissioning groups recognise that there are many skilled managers in PCTs who can help with implementating the commissioning reforms. As the NHS enters its most financially challenging period, difficult decisions will need to be taken about the funding and provision of certain services. This will require close working between those in clinical and managerial positions as the responsibility for commissioning moves over to clinical commissioning groups.

For further information on the issues covered in this paper, please contact David Stout, PCT Network director, at **david.stout@nhsconfed.org**

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The legacy of primary care trusts

Primary care trusts are currently responsible for managing around 80 per cent of the NHS budget. Since their launch, PCTs have often been subject to considerable criticism, culminating in the Government's proposal to abolish PCTs in April 2013. This paper sets out a more considered assessment of the performance of PCTs since their establishment. It examines how effective they have been, as assessed against what they have been asked to deliver. It also examines how their role has changed, as both provider and commissioner, since they were initially established.

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The NHS Confederation
29 Bressenden Place London SW1E 5DD
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