


Primary Care Trusts

Tailoring commissioning

An NLGN White Paper by **Dr Victoria Barbary**



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1 *Primary Care Trusts: Tailoring commissioning*

Introduction

Primary Care Trusts (PCTs) were created by the Department of Health (DH) in April 2002 to oversee the commissioning of primary care. As such, they commission 80 per cent of healthcare, covering the services of GPs, dentists, opticians, pharmacists and NHS walk-in centres.¹ Their purpose was to achieve a greater degree of local freedom and decision-making power in health and well-being provision, to reduce health inequalities and improve the health of the community.

However, many PCTs have struggled to fulfil these criteria for two main reasons. Firstly, their ability to perform has been challenged by frequent restructuring since they have never experienced a period of more than two years' uninterrupted growth without some form of reorganisation. As the House of Commons Health Committee noted in 2005, this can be disruptive as it takes eighteen months for organisations to 'recover' and bring their performance back to previous levels.² Secondly, PCTs are part of a centrally-accountable NHS structure. They receive budgets directly from the DH, and ultimately financial and organisational responsibility lies with the Health Secretary. PCT management cannot, therefore, adapt fully to local conditions. PCTs thus risk being in a weak position, which can result in poor financial management, inefficient commissioning practices, and dysfunctional relationships with their local partners.

The government has recently begun to address the centralised structure of healthcare delivery, seeking to empower local communities to take control. In

¹ House of Commons Health Committee, 'Changes to Primary Care Trusts': second report of session 2005-06, 3

² *Ibid*, 4

its White Paper, *Our health, our care, our say: a new direction for community services*, published in January 2006, the DH mapped out a new vision that not only concentrated on treating ill-health (increasingly at home and in the community), but also promoted healthy living and well-being. This was further developed in a new Commissioning framework for health and well-being, issued in March 2007, which established a vision that increased co-operation between the NHS, local authorities, businesses and voluntary-sector organisations.³ This has been complemented by the White Paper on Local Government – *Strong and prosperous communities* – published by the Department for Communities and Local Government (DCLG) in October 2006.⁴ Influenced by the interim reports of the Lyons Inquiry, the White Paper outlined a more accountable system of local government, and sought to allow communities to take control of their own governance through widespread multi-sector collaboration. These departmental initiatives have been consolidated in the current Local Government and Public Involvement in Health Bill, which proposes strengthening the role of Local Strategic Partnerships (LSPs) and Local Area Agreements (LAAs) in public health policy.

The move towards devolving power is a step in the right direction. However, this paper questions whether these developments go far enough to solve the problems of PCTs, which remain locked in a centralised structure, and thus committed to achieving national objectives. Challenging the centralist construct of the NHS is particularly pertinent in light of the row over the NHS £500m underspend for the 2006/07 financial year.⁵ Apparently to achieve national objectives, the delivery of community healthcare suffered. Unison and the Royal College of Nursing claimed that local trusts were pressurised to squeeze ‘soft targets’: mental health budgets were cut, funding for voluntary

3 Department of Health (2007), *Commissioning framework for health and well-being* http://www.dh.gov.uk/prod_consum_dh/idcplg?ldcService=GET_FILE&dID=134031&Rendition=Web
Department of Health (2006), *Our health, our care, our say: a new direction for community services*, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_5656077

4 Department of Communities and Local Government (2006), *Strong and prosperous communities: the Local Government White Paper*, <http://www.communities.gov.uk/index.asp?id=1503999>

5 Department of Health (2007), *NHS Financial Performance Quarter Four 2006-07*, 1

organisations was cut back and staff training was axed.⁶ This highlights that PCTs require more autonomy if they are to consistently deliver high-quality services.

Here, it is argued that PCTs should be freed from central management control and national targets relaxed, in order to empower local communities to play a greater role in defining the structure and priorities of their healthcare services. This would enable PCTs to make managerial and clinical decisions that would best benefit the patients they serve, including the option to work more closely, or merge commissioning structures with local authorities. This echoes the leadership options given to councils both in the 2000 Local Government Act and in the new Bill. It is not to suggest that a top-down devolutionary framework should be imposed, but that each PCT should be allowed to define its relationship with local partners and its own goals. This would create a locally-defined and locally-responsive system, which would empower local authorities and citizens to tailor goals to local needs.

Devolving Power

Financial Management

At the end of the 2005/06 financial year, the NHS had accumulated a net deficit of £547 million. In the Audit Commission's Auditor's Local Evaluation (ALE) 2005/06, nearly 40 per cent of PCTs were deemed to have an 'inadequate' financial standing, with only 20 per cent having a financial position that 'met minimum requirements'.⁷ By the 2006/07 financial year, PCTs accounted for 69 per cent of the gross NHS deficit (£633 million), compared with 47 per cent (£616 million) for 2005/06.⁸ This was generated

6 J Carvel, 'Audit Office asked to investigate record £500m NHS underspend', *The Guardian*, 30 May 2007; idem, 'NHS cutbacks leave £500m unspent' *The Guardian*, 29 May 2007; Unison Website, "'Pay up" says Prentis', http://www.unison.org.uk/news/news_view.asp?did=3300

7 Audit Commission (2006) *Auditor's Local Evaluation 2005/06: Summary Results*, 20

8 *NHS Financial Performance Quarter Four*, 9-10

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_075230

by 41 PCTs (27 per cent of the total). In contrast, there were only 36 NHS Trusts (19 per cent) in the red, with a deficit totalling £269 million.⁹

Clearly, in some PCTs there have been serious financial problems, and it was noted by the House of Commons Committee of Public Accounts that there was 'a lack of financial management expertise in the NHS'. Additionally, errors in costing the Agenda for Change pay initiative, GPs' and consultants' contracts in 2005-06 had increased the pressure on NHS bodies, leaving them to fund a £560 million shortfall in resources.¹⁰ To rectify these difficulties, the Public Accounts Committee recommended the need to 'strengthen communication between those responsible for the finances and for the delivery of local health services', as too often PCTs focus on their own financial complications rather than working with their providers to overcome them.¹¹

Those responsible for the delivery of many local health services are local authorities, whose financial record is the antithesis of the PCTs'. The Audit Commission's 2006 Comprehensive Performance Assessment of 150 single-tier and county councils revealed that all met the minimum requirements in their use of resources; furthermore, 79 per cent were either 'performing well' or 'performing strongly'.¹² Local authorities have also demonstrated their institutional effectiveness in financial management, handling budgets greater than those of PCTs, and have responded well to the demand for efficiency savings since the Gershon review. Savings include £1.2 billion during 2005/2006 – almost double that of PCTs' net deficit for the same period.

The strength of local authorities' financial performance is key to improving the cost efficiency of local healthcare. In many areas, councils are better

9 *Ibid*, 15

10 House of Commons Committee of Public Accounts, 'Financial management in the NHS': seventeenth report of session 2006-07, 5

11 *Ibid*

12 Audit Commission (2006), CPA – *The Harder Test: Scores and analysis of performance in single tier and county councils 2006*
<http://www.audit-commission.gov.uk/Products/NATIONAL-REPORT/1ECBC9FA-6F4A-471c-82D2-E087437925CC/CPATheHarderTest2007.pdf>

placed to manage the finances of public health. Consequently, where local authorities perform well and PCTs poorly, there is an opportunity to help PCTs by tapping into councils' managerial, commissioning and financial skills. Involving local authorities in healthcare procurement would offer the possibility of joined-up commissioning across a range of cross-cutting policy areas. Funds could also be moved between services to tailor them to local needs. PCTs and town halls could thus be freed from much central government control, rehabilitate healthcare finances and tailor services to fit local needs.

Commissioning

In the NHS, commissioning managers are responsible for service redesign, contract development and monitoring. Few have specialist procurement skills, however, and frequently appear to commission services on a 'one size fits all' basis, which is insufficiently flexible to meet patients' needs and preferences.¹³ In contrast, councils are closer to the community and often have a more advanced insight into the needs and preferences of local citizens. The data that unitary, county and metropolitan borough councils already hold is often a stronger foundation from which to construct health procurement. Political accountability encourages councils to decide and act on local changes as they arise. This has resulted in the development of effective commissioning frameworks, which delivered savings of £106.7 million in the 2005/06 financial year. Many PCT commissioning managers would thus benefit from working with local authorities who have competency in procurement processes, with access to in-house legal advice. By so doing, services could be improved, as local authority commissioning managers would pass on the experience and skills to their PCT counterparts, such as providing advice or delivery of support around the tendering process, contract writing and monitoring support.

There are also valuable opportunities for shared service delivery. The NHS Commissioning Framework and the Local Government Bill provide for a Joint Strategic Needs Assessment as the means by which PCTs and councils

13 *Commissioning framework for health and well-being*, 18

describe the future health, care and well-being needs of local populations, and the strategic direction of service delivery to meet those needs.¹⁴ This could, however, be taken further where PCTs fail to deliver effective services. Integrating local authorities into the commissioning process would help to orientate services towards the recipients, rather than the suppliers of care. For instance, shared business planning cycles and a joint performance management framework would enable greater collaboration between PCTs and local government, while facilitating more responsive, flexible, seamless and efficient provision.

Creating a single set of supply objectives for local authorities and PCTs would also avoid frequently-fraught commissioner-provider relationships in areas such as children's services, mental health, and the care of older people, where frontline PCT and local partner employees work together closely. In a survey conducted by the NHS Confederation, nearly two fifths of respondents (39 per cent) had been forced to reorganise a partnership project by their financial situation; 29 per cent claimed that their local authority had also restructured joint schemes due to budgetary constraints.¹⁵ By integrating business plans, however, a consensus would be reached on the allocation of resources and thus transcend existing tensions between the distribution of the two bodies' capital.

Accountability and Empowerment

By design, the NHS is centralised. Established by Aneurin Bevan in 1948, at a time when the role of central government was being expanded by Clement Attlee's Labour government, the NHS has remained accountable to the Health Secretary since its inception. In the last sixty years, the NHS has changed beyond all recognition, reacting to technological advances and providing ever more comprehensive services in an increasingly complex system. Currently, as the world's third largest employer, it employs 1.3 million people, all of whom are ultimately managed from Whitehall.

Since the 1980s, the NHS has undergone a series of institutional changes aimed at making it more efficient and cost-effective, but the accountability

14 *Ibid*, 64-70

15 NHS Confederation (2007), *Partnership working: the facts*, 6

structure has rarely been challenged. However, during the last seven years, services have been devolved to help meet the challenges presented by the 'choice agenda', which sought to increase the number of providers in public services to improve quality by competition. There have been concerns that these market-driven public service reforms has confused and alienated both staff and the public.

In 2007, however, a new prime minister presents a rare opportunity to improve accountability and encourage personalised healthcare services. Local commissioning could empower communities to define locally-relevant health and well-being services, and align them with local social and cultural aspirations. These reforms would advance the Government's localism agenda, as outlined in the DCLG White Paper, recent DH policy and the Local Government Bill.

The focus on choice of public service providers has overshadowed equally important questions of voice, reliability, equity and accountability. It is, therefore, vital to develop a more sophisticated model, with a clearer relationship between individual and collective choice. Many decisions balance individual choice in the short term in order to increase long-term options for all and there must be greater accountability to local people where these judgements are made. But such trade offs can only happen if power is devolved, and local public agencies are empowered to engage in decision-making. In other words, accountability needs to rest not in Whitehall, but with local agencies.

Devolving responsibility to local government would not only empower users of care, but also its providers. Clinicians have long been concerned that the current emphasis for commissioning is to achieve immediate and short-term financial and political aims. This has led the British Medical Association (BMA) to insist that a demand management or 'rationing' mechanism is 'inevitable' in the NHS, as some treatments will have to be sidelined in order

to achieve national targets on others.¹⁶ Doctors have, therefore, felt that their professional opinion on clinical need has become increasing undervalued as the NHS struggles to achieve politically-motivated targets. With devolved accountability, local healthcare professionals will be able to make the clinical decisions informed by local need and involvement, thereby ensuring procurement is tailored to community requirements as they evolve over time. This would re-engage medical staff and encourage them to play a more active role in the commissioning process.

This provides the option for developing local control over healthcare and well-being services. Where PCTs are failing to meet the needs of the recipients of care, and not delivering personalised services, integrating PCT and local authority commissioning frameworks would empower service users and providers. Local authority procurement structures are more efficient, and since those responsible for them are democratically elected, more responsive and transparent. Their involvement in commissioning healthcare and well-being services would, therefore, give more control to citizens and drive up standards. By so doing, it would be possible to re-engage those on low incomes who have been alienated by the government's treatment of individuals as consumers, and empower them as citizens.

Action

Enhancing local government involvement in commissioning health and well-being services could, therefore, improve the delivery of community healthcare without the need for further disruptive and expensive top-down restructuring. In some areas, there is a clear need to address shortcomings in healthcare procurement, but circumstances vary from location to location, PCT to PCT. Necessary changes should be triggered locally, enabling healthcare commissioning frameworks to develop organically to fit their individual circumstances.

Where a PCT struggles to meet its financial targets and performance

16 British Medical Association (2007), *A rational way forward for the NHS in England: A discussion paper outlining an alternative approach to health reform*, [http://www.bma.org.uk/ap.nsf/AttachmentsByTitle/PDFrationalwayforward/\\$FILE/rationalwayforward.pdf](http://www.bma.org.uk/ap.nsf/AttachmentsByTitle/PDFrationalwayforward/$FILE/rationalwayforward.pdf)

objectives, and there is organisational and popular consent, the PCT and unitary local authority, or county council, should be allowed to appoint joint posts on the senior management team. For example, a single chief executive would oversee the PCT and the local authority, with a joint head of finance and director of public health. Moreover, to ensure full democratic accountability, the PCT board could be constituted with a majority of councillors and chaired by the leader of the council or mayor. This arrangement would enable democratically-elected representatives to work closely with incumbent specialists, which will help assuage tense commissioner-provider relationships. As a result, the local delivery of healthcare services would be improved by amalgamating expertise to develop a more efficient and effective commissioning framework.

By creating an overlap between council and PCT personnel in health-services management, a direct link will be established between clinicians and democratically-elected managers. Medical professionals will thus have greater influence over commissioning processes. Where doctors make a case to the newly-constituted PCT board for tailored procurement to meet local requirements, a body with a significant elected component will be more inclined to implement such requests as they are locally accountable, and not driven to meet central targets. Doctors may, therefore, be better engaged with commissioning, resulting in local services more likely to be obtained on the basis of the community's clinical need.

Such integration is already happening in some areas: Bristol PCT's public health management structure is currently 'changing because of close work with the council'.¹⁷ Herefordshire has recently established a Public Service Trust, which consists of integrated commissioning teams, accountable to a Board, which is answerable to both the council and the PCT.¹⁸ Nevertheless, these arrangements will only work effectively if the PCT's bonds to central government are loosened and commissioning frameworks allowed to become

17 Bristol Primary Care Trust website (2007), Bristol PCT Management Structure, <http://www.bristolpct.nhs.uk/theTrust/Bristol%20PCT%20Management%20Structure.pdf>

18 Herefordshire Primary Care Trust (2007), *The Future of Public Services in Herefordshire*, 18, http://www.herefordshire.gov.uk/publicservicetrust/herefordshire_pct_web.pdf

more responsive to the local community's needs through collaboration and shared objectives.

This process, however, needs to be stabilised by a firm commitment from central government. The Health Secretary must allow for the relaxation of national targets where LAA provisions fit the objectives laid out in the Treasury's Local Public Service Agreement requirements. Moreover, there needs to be a public statement from the government that PCTs undertaking this procedure would not be subject to future top-down re-organisations. This will allow the new framework to evolve and settle after the changes are implemented. Alternatively, the government could provide for pilot schemes where the PCT and council believe services would benefit from this arrangement; this would allow the performance of the new structures to be reviewed over time, and incorporated into legislation when appropriate.

Conclusion

This paper has outlined the current status of healthcare provisioning frameworks, highlighting the shortcomings of the current system of commissioning health and well-being services in local communities. It has argued that while the framework of LSPs and LAAs provides a vehicle for increased co-operation between PCTs and local authorities, the centralised NHS structures in which PCTs function prevent more extensive local-level co-operation. The result is that PCTs sometimes encounter difficulties creating functional relationships with their partners as they are constantly being forced to meet national financial and treatment targets, which are often inappropriate for the local area. In turn, this could undermine health and well-being provision as clinicians are less able to prescribe the treatments most appropriate to the community.

Personalisation and choice require more stable and effective commissioning arrangements and clear lines of local accountability, which will empower local communities. Presently, the procurement framework does not fulfil these conditions as it draws accountability towards centralised national NHS structures. Here, a better framework for delivery has been proposed, which

would enable existing engagement systems, primarily LSPs, but also Drug and Alcohol Action Teams, and Youth Boards, to be used more effectively to delivery health and well-being services.

Where PCTs struggle to deliver effective services, the commissioning frameworks of PCTs and local authorities should be brought together under a single management team consisting of members of both executives. Through this, councils' procurement expertise and the specialist clinical knowledge of PCT personnel can be amalgamated, resulting in more personalised, efficient and cost-effective services for the customer. In some parts of the country this is already happening, and it is widely held that local government needs to play a more pronounced role in health services to raise standards. However, in order to achieve this, it is vital that PCTs are loosened from their centralised framework, so that targets can be tailored to the needs of localities and financial management of health services improved.

