PCTs: An unfinished agenda

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Introduction

Change has been a certainty for the National Health Service (NHS) in England over the last few decades. New structures, organisations and pathways have emerged, merged, disbanded, reformed and formed again as respective governments have attempted to grapple with seemingly infinite demands, limited resources, and ever increasing public expectations.

Growing inequalities in health outcomes, perceived under-funding, poor buildings and infrastructure had contributed to a widening gap between public expectations and actual NHS delivery. This, together with changes in population health, including a rise in the number of people living with chronic diseases, and increasing life expectancy, had created a number of complex challenges in delivering effective and efficient health services in England.

By the late 1990s there was an acute need to address these issues and to modernise services so as to close the gap between public expectations and system performance (Stevens, 2004). In its attempt to tackle these challenges, the current Government placed a primary care led NHS at the centre of its health policy. Primary care professionals were thought best placed to identify local and individual health needs. This was to be achieved through decentralisation in the form of creating Primary Care Groups (PCGs) which subsequently became Primary Care Trusts (PCTs). This approach aimed to provide local freedoms to enable innovations in service delivery; increase responsiveness to local priorities and patients; and build social capital through engaging with service users and the public in decision-making processes.

However, since the vision for PCTs was outlined, the broader policy agenda was changed. Some acute trusts gained foundation status and new forms of financial flows have been introduced. These changes have clouded the role PCTs are meant to undertake. The question is whether this health policy agenda has delivered and has it assuaged public concerns about NHS performance? Current public and media debate hotly contests the relative effectiveness of these reforms. The NHS remains centre stage.

It is within this context that the ippr held a series of policy seminars in 2003 and 2004 to examine the new NHS, decentralisation and how the NHS and patients might benefit from PCTs. Drawing on discussions from these seminars and current literature, this report examines PCT performance and makes recommendations for their best way forward.

In setting about its reforms of the NHS, the newly elected Labour Government inherited a number of different purchaser arrangements, such as GP fund-holding, from the internal market reforms of the previous Conservative Government. Far from abandoning these reforms, the Labour Government signalled their intent to retain key features, albeit with an emphasis on co-operation rather than competition. Arguably, the inherited arrangements paved the way for the new Government's call for a primary-care led NHS. It sought to integrate care, and balance efficiency and effectiveness with fairness. A duty of partnership was imposed and clinical governance used to drive up quality and improve accountability to local communities (DH, 1997). These new plans appeared to symbolise a shift in belief from one in which competing economic incentives create change in the NHS, to one in which cooperation and integration are the key drivers for change.

However, achieving sustained improvements in health service organisation and delivery comes at a price. Long term funding increases were promised. By 2007-8 public sector health spending will be 7.8 per cent of GDP, up from 5.5 per cent in 1999-00 (HM Treasury, 2004). These never-before-seen levels of funding increases are needed if the Government is to make good its promise of bringing UK spending on health as a proportion of GDP up towards the European Union average.

Developing a primary-care led NHS, in which patients are provided with rapid access to high quality health care in an appropriate manner, and at a place and time of their choosing, became, in principle, the central focus of health policy. The Government set out its plan for modernising the NHS and how it would achieve this whilst maintaining the NHS's overarching objective of equitable access to health services for all, free at the point of use (DH, 1997*).* In an attempt to win back the public's trust, lost as a result of a number of high profile inquiries into professional failures, such as the Bristol Royal Infirmary Inquiry (Kennedy, 2001), and to improve efficiency and quality of care, reform was focussed on two areas.

First, new forms of public service management were introduced with the public explicitly involved in decision making. A new era of evidence-based policy and decision-making in health began. National Service Frameworks (NSFs) and care pathways, based on current evidence and accepted standards of best practice, were designed to map out the types of care patients could expect. The National Institute for Clinical Evidence (NICE) was established to make recommendations and publish guidelines based on cost-effectiveness, expert and patient evidence. A new system of clinical governance was introduced to ensure clinical standards would be met and reinforced through continuous quality improvement activities. The Commission for Health Inspection (CHI),

now the Healthcare Commission, was set-up to monitor and inspect provider compliance with these requirements.

Second, in 1999 a more evolved form of primary care funding, Primary Care Groups (PCGs), was established. PCGs were responsible for a devolved budget to cover most aspects of care for their geographically defined populations. Contracts were replaced with longer term funding agreements. These funding agreements, along with NSFs, were intended to encourage health professionals to work with each other and with health interest groups and local authorities. Using a partnership approach, these reforms were intended to increase flexibility and improve integration between previously fragmented services, strengthen lines of accountability to the centre and to local communities, and attempt to lead the NHS from primary rather than secondary care.

In 2000, PCGs were superseded by PCTs. PCTs were charged with re-shaping services to meet local needs, and from April 2003 had responsibility for approximately 75 per cent of the NHS budget in order to achieve this. This decentralisation of financial decision making through budget holding was seen as an important instrument for making more cost-effective use of scarce resources.

However, what exactly did the Government mean by decentralisation in the NHS? Decentralisation has been used in different countries at different times to describe reforms in which a range of state functions are transferred from higher to lower political and administrative levels. As a concept, it is largely political in origin, predicated on a belief that some state functions are better situated locally, closer to the community, rather than centrally. Decentralisation encompasses a range of activities, from management and decision-making, to revenue raising and service delivery. Its breadth of functions make decentralisation multi-faceted in practice.

Despite wide ranging use of this term, and extensive scope of decentralised functions, the actual definition of decentralisation remains contested. Different definitions emphasise its different aspects. In an attempt to incorporate the widest sense of its meaning for the NHS in England, decentralisation is defined in this report as ‘the transfer of authority and power in planning, management and decision-making from higher to lower levels of organisational control’ (Bankauskaite *et al*., 2004). This definition explicitly omits the function of decentralising revenue raising activities, which, for the NHS in England, remains the responsibility of the centre and will do so for the foreseeable future.

A range of perspectives are used to analyse decentralisation. These include local fiscal, principal/agent and social capital approaches. Arguably, the most widely applied framework for analysing decentralisation in health services is the public administration approach. This framework describes four different forms of decentralisation as the transfer of responsibility: delegation to a lower organisational level; de-concentration to a lower administrative level within the same organisation; devolution to a lower political level; and privatisation when all assets and/or responsibility is transferred from public to private actors (Mills *et al*., 2001)

Clearly, decentralisation can mean different things to different people at different times. In England, decentralisation has been an important policy instrument in respective governments' health reform agendas, from the Conservative Government's internal market reforms of the 1990s to the current Government's attempts to establish a primary-care led NHS.

Recent rhetoric around decentralisation and responding to local priorities and communities is not new. A quick glance through recent history shows the Conservatives made similar claims in 1972, and again in 1979 (Klein, 2000). Decentralisation and centralisation are not mutually exclusive. Rather, they are two ends of the same continuum. At any given time, we can expect different functions of the health service to be more or less centralised, or decentralised. The debate of the day is centred on political disputes about where the balance lies between these two approaches.

Decentralisation, and to some extent recentralisation, in the NHS continues to take place in the context of strengthening central power to make it both more efficient and more responsive to patients (Klein, 2000). The existence of Public Service Agreement targets set by the centre is most symbolic of this continuing exercise of central power. This tension between devolving power and autonomy and central control is a key challenge.

Within this framework, PCTs are devolved bodies responsible for providing an efficient, equitable and responsive health service for patients, led from primary care. PCTs are accountable upstream, for meeting central targets, and downstream, by meeting the needs of their local communities. This report aims to evaluate how effective PCTs are at delivering their agenda. Having weighed up recent evidence, and in recognising the many complex challenges for PCTs, it makes some key recommendations.

PCTs in practice

PCTs need to deliver many activities that used to be higher up as well as lower down the health hierarchy. They superseded PCGs in 2000 and inherited some devolved responsibilities from health authorities. PCTs are differentiated from their predecessors and from health authorities by virtue of the fact they require mandatory membership of all general practices in England, are built on co-operative and partnership working rather than competition, and promote the involvement of all primary care professionals (Bond & Gunji, 2003). PCTs are free-standing statutory bodies expected to manage resources for primary and secondary care in the hope of improving efficiency; to shape prevention and treatment services to meet patient needs; and to improve quality through adhering to clinical governance frameworks.

PCTs have significant strategic and operational responsibilities for a broad spectrum of primary care. They have a duty to involve patients, carers and the public in service planning, and have the power to own and purchase property to ensure the appropriate infrastructure is available. PCTs are charged with three statutory functions:

- health improvement of the local population
- development of primary care and community services
- commissioning secondary care and community services.

For PCTs to fulfil these statutory duties, and ensure responsive, patient-centred services for their populations, a number of functions need to be fulfilled. They need to develop new and integrated services for their patients, and to work towards improving the health of their local population. Therefore, PCTs need to invest in health, social and community care, as well as work with social services, local voluntary and community organisations and local authorities.

PCTs control approximately 75 per cent of NHS funds. They do this through cash limited budgets which are broken into hospital and community health services, General Medical Services (GMS), and prescribing budgets. Importantly, PCTs may move money across these budgets. However, GMS budgets cannot be shifted unless local GP representatives agree.

Governance arrangements for PCTs involve a board and an executive committee whose membership composition is determined by the Department of Health. PCTs have some autonomy in determining the respective roles of these committees. In practice, the board is typically concerned with the PCT's accountability within the health system as a whole, and the executive committee concentrates on operational issues. Commissioning decisions are usually made by a commissioning sub-committee comprised of members of the board, executive committee and other health professionals. The modernisation agenda's emphasis on primary care clinicians being directly involved in decision-making creates unprecedented opportunities for them to be at the centre of determining the shape and delivery of services at primary and secondary care levels. Given their remits, PCTs have considerable powers and influence.

However, in the new NHS, market dynamics have evolved. In comparison to earlier forms of fund-holding, PCTs use one-year and three-year long service-level agreements. These are in line with budget allocations and based on quality and effectiveness. In the new mood of collaboration and partnership, moving contracts is not encouraged because of its potential to de-stabilise services. Rather, it is seen as a last resort and only if co-operative attempts to improve performance have failed (Wilkin *et al*., 2002). Compared with PCTs, secondary care providers have a strong historical relationship with health authorities, and a longer history of contracting, including necessary data and information systems. This may make it difficult for PCTs to exercise their powers in the marketplace and to learn lessons from previous experience, such as GP fund-holding.

If PCTs are, in theory, in the driver's seat for modernising and improving the NHS, we need to examine how far down the road they have come in practice.

PCTs' performance

Given the breadth of activities in their remits, and for the purpose of informing practical solutions, analysis of PCTs' current performance is grouped under functional headings.

Managing patients and reshaping services

PCTs need to re-shape services and provide more appropriate and patient-centred care. Evidence shows some PCTs are doing this. Some services are now provided closer to the patient, moving from their traditional base in secondary to primary, and primary to community care. As a result some patients are benefiting from faster treatment closer to home (Audit Commission, 2004a).

Most of the population accesses the NHS through primary care services. The Department of Health (2004a) argues 90 per cent of patients are satisfied with primary care. In 2003, 85 per cent of the population used primary care and were pleased with the service (CHI, 2004), suggesting people value their local health services. As encouraging as these statistics may appear, we do not know if these figures are higher or lower than previous years. As this was CHI's first survey of this type we do not have a comparable result, and comparing across unmatched surveys is difficult. Furthermore, for some patients access to primary care services remains problematic.

By the end of 2004 GPs will be required to offer patients the opportunity to see them within 2 working days. However, this is not yet always patients' experience. Patients have access difficulties despite a range of entry points, for example, in telephoning surgeries, obtaining appointments, and waiting times once these are arranged (Audit Commission, 2004b). Those enrolled in larger surgeries, with more than two GPs, often have to wait longer to see a GP than those enrolled in smaller practices (Campbell *et al*., 2001). Furthermore, if patients wish to see a particular GP they may have to wait longer still (Stanton, 2004).

A related issue in accessing GPs is that some people still have difficulty enrolling in a practice in their area. The NHS information service attempts to help by directing people to local surgeries who still have open lists. However, as there is still a shortage of GPs in England (DH, 2003a), the NHS information service will be limited in its effectiveness.

Attempts are being made to reduce these shortages and tackle inequities in access. Some GP surgeries have introduced initiatives such as telephone consultations, nurse triage, and extended opening hours in an attempt to meet Government access targets (CHI, 2004; DH 2004a). This has also benefited patients who need to juggle different demands, such as hours of work and child care, which often make it difficult to access surgeries between 9am and 5pm.

However, such reforms focus on traditional care pathways, with the GP acting as the gatekeeper to all primary and secondary care services. If this model is maintained, as more services move towards primary and community care settings, and as more people live with one or more chronic conditions, difficulties in accessing GPs will grow. This may increase inequities in access.

On the other hand, PCTs are supposed to redesign care delivery to provide more appropriate, patient-centred services, and should therefore simultaneously address access issues. Certainly, nurse-led consultations are becoming more common, but use of other health professionals, such as pharmacists and physiotherapists, as first contact practitioners remains limited. PCTs have the powers to address this.

A related issue is the extent to which PCTs are developing infrastructure so services can be delivered in new ways, for example offering a range of services not previously available at one site. Presently, over 40 PCTs have approved Local Improvement Finance Trust (LIFT) schemes. However, it is unclear how many of these, if any, are for new buildings and how many are for refurbishments. In addition, it is difficult to identify the extent to which this development is orientated towards new forms of infrastructure, or if they reflect more traditional buildings. Available land for new builds, and funding constraints, may also play a role.

Furthermore, less than a quarter of PCTs have effective systems of demand management in place (Audit Commission, 2004b; NHS Alliance, 2003). Reasons given include financial deficits, lack of information, and lack of management support. This makes it difficult for PCTs to control primary and secondary referrals, and the onward financial and non-financial costs for patients and themselves.

Whilst early attempts are promising, there is much to be done to resolve problems with accessing primary care services and managing demand for secondary care. At present, primary care services can only be patient-centred for patients who can reach them.

Managing the PCT

Managing a PCT effectively relies on a range of interrelated functions performing well. These include human resources, the workforce, financial planning, information collection and analysis.

Workforce

A key objective of The NHS Plan (DH, 2000) is to encourage employers and staff to support new ways of working in the NHS so as to benefit both staff and patients. This can include creating new roles, as well as matching skills and job requirements with staff needs. Theoretically, this objective provides PCTs with freedom to redesign staffing alongside their service innovations.

Staff often cite PCTs as examples of good employers operating in an open culture with visible leadership (CHI, 2004). However, most PCTs experience difficulty recruiting staff for both management and clinical roles. These difficulties are not unique to PCTs as they reflect wider staff shortages across the NHS (DH, 2003a; Royal College of Nursing, 2000). Extensions to the European Working Time Directive may magnify some of these shortages. These problems, coupled with an ageing workforce, makes it difficult for PCTs to ensure an adequately trained and supplied workforce.

There is little consistency in recruitment practices across PCTs. Over 75 per cent of those interviewed in one survey thought senior private sector experience was not necessary for financial management positions in PCTs (Hudson, 2004). It is important to ensure that people who may bring a range of beneficial skills from the not-for-profit and private sectors are not excluded from the recruitment pool.

Once recruited, senior management staff are often responsible for multiple tasks. CHI found 25 per cent of PCT managers had extensive roles across more than one area (CHI, 2004). Of the 50 PCTs where senior staff were interviewed, 40 per cent of financial directors had more than one role and found it difficult to meet all requirements and to keep up with new developments (Hudson, 2004). An informal support network across individuals working in similar PCT positions could be a beneficial first step.

A recurring criticism in the literature on PCTs, is the lack of use of human resource procedures. The majority of PCTs do not systematically use appraisal systems (CHI, 2004; Hudson, 2004). They lack knowledge about staff performance and satisfaction. By not systematically gathering this information through an appraisal system, PCT management is denied useful channels for identifying new and improved ways of working from those at the coalface. It also makes it difficult to obtain information on training and development entitlements and the funding necessary to pay for it. Resultant variation in the treatment of staff may contribute to staff confusion over entitlements, and lower morale.

A related issue is the implementation of clinical governance in PCTs. This is slowly but surely being undertaken by some trusts and early evidence is encouraging. PCTs are generally good at developing systems for monitoring quality and poor performance. However, matching this with supportive processes and resources, for example shared learning and staff support, rather than a culture of blame, is at best incremental (Audit Commission, 2004b; Stanton, 2004).

There is also a need to break down managerial perceptions that staff development opportunities must be traded-off against other targets managers are accountable for, such as waiting times. Managers should be encouraged to see these as a positive means to improving service delivery, staff morale and motivation.

Interestingly, those leading the pack in integrating clinical governance into PCT management strategies demonstrate associated improvements in strategic planning and capacity (Stanton, 2004). Although unforseen, this link is positive. Further research is needed to establish why this has happened and how such success could be replicated.

PCTs are in a position to mobilise resources towards attractive remuneration and retention policies and practices, including incentives and rewards, to address their more pressing staffing needs. Clearly, PCTs need to utilise these powers. Along with developing an adequately trained and supplied workforce, PCTs need to identify how staff are best deployed within existing and new types of services.

Information and communication technologies

Since it came to power in 1997, the Government has argued for greater use of information and communication technologies (ICT) in the NHS (NHS, 1998). Later publications placed effective use of ICT as central to modernising the NHS and developing patient-centred care (DH, 2000). In a wide-ranging review of the future of the NHS, Wanless (2002) made the case for doubling spending on ICT. In response the National Programme for IT in the NHS was launched, backed up by £2.3 billion of funding.

A number of projects are now running with still more in development, for example, NHS Direct Online and NHS Direct Digital Television. And the stakes have just been raised. The newly published NHS Improvement Plan (DH, 2004b) aims to have all patients accessing their own health records by 2008, with the potential to book their own appointments from home.

Yet despite these initiatives, access to and management of ICT is repeatedly cited as one of the biggest barriers facing PCTs (Audit Commission, 2004b; 2004c; CHI, 2004; Wilkin *et al.*, 2002). Of real concern is that four out of ten PCTs do not have an information technology director despite the NHS having a budget for new information technology (Hudson, 2004). There are seemingly numerous sources of data held within PCTs that could assist in planning and commissioning, but they are rarely used effectively.

The majority of PCTs are monitoring inputs and outputs well, such as waiting times, treatment numbers, and finances. This may relate in part to ease of measurement. It is much easier to link increased activity rates with a reduction in waiting lists, than it is to link resource allocations to prevention and improved health outcomes. We are not yet seeing data collected on more complex measures which affect health outcomes. Anecdotal evidence and reports suggest this is a result of poor planning about what the service is trying to achieve (CHI, 2004; Audit Commission, 2004c). It may also be linked to the low use of effective ICT systems for PCTs management, as well as for individual staff. However, it is unclear whether or not patients realise this information is used for management as well as treatment purposes. There will need to be more education and information on this as the ICT programme rolls out.

The potential benefits of more effective use of ICT cannot be underestimated. ICT can help map staff numbers and type to the actual patient care delivered and their progress, and to adverse events. This would help with staff and service planning, and with reducing adverse events and their financial and non-financial cost to patients and the service. It would also help reduce unnecessary and ineffective treatments, freeing up resources to be more

effectively directed elsewhere. ICT could help capture the costs and benefits of this.

ICT can facilitate communication between locations for different aspects of patient care. In this instance it could be used to prevent the current problem of patients falling through the gaps in service delivery and communication between health and social care (Rankin & Regan, 2004), and between different NSFs and care pathways.

To reach the Government's newly announced target of having all patients access their records by 2008 (DH, 2004c), and for this target to be meaningful to patients, a new culture will need to be developed in which patients actively seek out information on their health status and use ICT to book appointments. This is quite a shift from current practice, where patients receive information about their health status when they have contact with health professionals, and are told of specialist appointments in the post. PCTs have the opportunity to use ICT packages to develop this culture and move towards this new target whilst simultaneously meeting their own targets of personalised services and involving the public.

PCTs could also track patient adherence to their treatment programmes. Not only would this provide a pro-active approach to patients at risk, it would help staff establish which patients need follow up before they present with conditions that might have been avoided through effective monitoring.

The use of data and information should be seen as central to the organisation and delivery of PCT functions. Placing individual patients within an overall quality framework that supports patient self-care and management is important as 60 per cent of the adult population lives with at least one chronic condition (DH, 2004b). ICT is one means by which to achieve this.

Presently, large amounts of rich data sources remain untapped, their many benefits for PCTs, staff and patients unrealised. Developing staff information technology skills, as well as suitable ICT systems, will assist them in recognising and exploiting these benefits. Effective use of ICT could be translated into quantifiable savings and benefits. Furthermore, it would provide a continuously updated data-base from which to draw evidence on patient care and management, staffing, commissioning and care delivery, to identify what is working and what is not. This would help PCTs with making decisions as they commission services.

Commissioning

Commissioning was first introduced to the NHS in 1991, and thirteen years on expectations of what it can and should achieve have grown. With responsibility for commissioning now devolved to PCTs, who commission for their own population or jointly with other PCTs, the local level is expected to be the basis for increasing access to services, integrating care, enhancing responsiveness, and continuous quality improvements (DH, 2003b).

To fulfil their commissioning responsibilities, PCTs need to secure appropriate high quality care for their populations. These services do not have to be NHS services, and may be chosen from a range of providers, including not-for-profit and private sectors (DH, 2004b; Stevens, 2004).

However, the definition of commissioning is disputed. Some see it as needs-based purchasing whilst others understand it to be an overall function including activities such as contracting with providers (Bamford, 2001; James, 2001). Thus, the term 'commissioning' is used across the NHS with little functional consistency. This has implications for assessing the efficacy of PCT commissioning in terms of its objectives and impact on health outcomes.

A general consensus is now emerging around the components that make up the commissioning process. These include:

- assessing the health and social care needs of the target population
- priority setting and allocating resources to meet these needs in line with national and local targets
- contracting with providers or purchasing services to meet these needs and targets
- monitoring and evaluating outcomes.

In practice, the commissioning of services is usually defined by population or programme. Population-defined commissioning includes services for geographically defined, general practice, and/or hospital populations. Programme-defined commissioning includes services for specific conditions and care groups, for example diabetes (Chappel *et al.*, 1999). In England, programme-defined commissioning has come to be identified with integrated care pathways and chronic disease management programmes.

In order to assist PCTs with commissioning, the National Primary and Care Trust Development Programme publishes a web-based commissioning competency framework (www.natpact.nhs.uk). The NHS Alliance also offers tools to assist its members in their commissioning functions (www.nhsalliance.org.uk). These are designed to instruct PCTs and commissioners in how to commission effectively.

Despite these initiatives, a key concern drawn out in our seminar series, and a theme common to all independent reports and literature evaluating PCT performance, is a lack of commissioning capacity. This ranges from the need to develop the specialised skills of individual commissioners and carrying out effective needs assessments, to understanding the advantages and disadvantages of different commissioning models.

Charged with executing what is arguably the most important and influential aspect of a PCT's remit, it is essential that those that lead the commissioning process have the training, resources and full support of their PCTs. Yet this has been repeatedly shown to not be the case (CHI, 2004). If PCTs are to lead from the front, and not simply re-shape services at the margin, then supporting staff in this role must be a priority.

Encouragingly, a number of PCTs are integrating quality standards in contracts, and most use NSFs as the main source (Wilkin *et al.*, 2002). There are some signs that use of needs assessments is growing. Appropriate and comprehensive needs assessments can only be achieved when data is collected, interpreted and applied. Some PCTs are collecting data using audit tools, the national registry, NHS Trusts and Strategic Health Authorities (Audit Commission, 2002; 2004c). A number of PCTs have committees to assess clinical and outcome data, such as staff activity rates (Bond & Gunji, 2003). But often there is little translation of this activity into planning and commissioning decisions (CHI, 2004).

Furthermore, not all PCTs use a local needs assessment (Audit Commission 2004c; CHI 2004). A key challenge is for all PCTs to use a needs assessment of their local population to identify and drive changes to care models whilst managing local demand.

Evidence to date shows commissioning for chronic disease management remains problematic. Whilst some PCTs are managing to bring incentives into line with effective and efficient management, many are still struggling. Nine PCTs are currently piloting programmes. Findings from these projects might point to possible solutions.

Until recently, different forms of commissioning developed on an ad hoc basis, growing from perceptions of different models' relative successes and limitations, rather than any systematic monitoring and evaluation (Baker, 1998). Of late, the focus on developing evidence-based policy has brought closer attention to different models of commissioning.

Collaborative commissioning

Collaborative commissioning between PCTs, and with social services, is becoming increasingly common. Over 50 per cent of PCTs commission services on behalf of other PCTs, and approximately one third commission jointly with social services through Joint Investment Plans (Audit Commission, 2000; Bond & Gunji, 2003).

Yet some concerns remain. Significantly, only 81 per cent of PCTs which commission collaboratively consider it to be effective. Different funding streams and cycles for health and social care services complicate the process (Bamford, 2001) and a lack of co-terminous boundaries may add to this. In addition, health and social care professions have slightly differing, but not mutually exclusive, objectives which may influence commissioning priorities.

Commissioning for health services is largely focused on improving health outcomes, whilst social care is concerned with broader outcomes, such as an individual's ability to live in the community. As health and social care are interconnected, using a broader range of outcomes when jointly commissioning services could be equally beneficial for both, as well as for patients. It would assist PCTs in meeting their wider remits, for prevention and local community involvement, and augment the commitment to achieving social care outcomes. Importantly, it has the potential to be particularly beneficial for patients with multiple chronic conditions, and for people with complex health and social care needs, who come under health, social care and local government remits.

Collaborative commissioning may be encouraged to improve cost-effectiveness by benefiting from economies of scale, and/or to improve partnership working and integration, as well as patient outcomes. But, as yet we do not have all the evidence needed to back-up decisions to support this process, for example, the types of services and commissioning models best suited to collaborative endeavours. Another complicating factor is the potential for blurred lines of accountability and risk in different models.

Reconciling discrepancies and difficulties is an important first step to effective collaborative commissioning and ensuring the commitment to partnership working and integrating health and social care services is not lost.

Natural experiments

A range of natural commissioning experiments are taking place across England. This is decentralisation in action. Some aspects of commissioning are being re-centralised through collaborative efforts, some remain at PCT level, and examples of practice-led commissioning devolve it further still. Some PCTs commission from private providers, albeit at the margins, others do not (Goodwin & Smith, 2002). This range in commissioning practices across England reflects different responses to similar problems.

These different approaches to commissioning may be interpreted in two ways. First, they could reflect problems with management and capacity across the country. However, second, these differences could reflect the autonomous decisions made by PCT commissioners and boards based on their understanding of what will best serve their population's needs. Whilst the former may, to some extent, be the case, it is too early to identify if the second holds.

With commissioning now devolved to the local level, theoretically PCTs have freedom to commission services shaped to meet local needs. However, given the broader structures of accountability within the health system, this creates two conflicting tensions. First, the Secretary of State for Health has an inherent interest in monitoring commissioning on the ground and a temptation to strengthen central control. Second, the centre sends a number of directives to which PCTs and providers must adhere, for example targets, NSFs and NICE guidelines. Currently, PCT commissioning must take account of these central directives as well as meet the needs of their local population. There is some concern about the extent to which commissioning is steered by these central directives, particularly as targets have favourable incentives aligned with them. Targets have been criticised for distorting PCT behaviour (Wanless & HM Treasury, 2004). The centre is sending confusing messages. On the one hand, it provides devolved power and decision-making, on the other hand it places devolved bodies under central guidelines and target regimes. There is certainly room for clarity in this debate.

Added to this are recent calls either for practice-led commissioning (Lewis, 2004; Singh, 2004), maintain the status quo, or move commissioning a step higher up the health hierarchy than PCTs. Each approach has its own pros and cons.

Needs of the public and professionals

An important aim of decentralisation is to bring decision-making closer to the people. This has been an underlying theme of the Government and part of its strategy to make public services more accountable at the local level. Involving the public, patients and carers in decision-making about how health is provided in their communities is central to the modernisation agenda (DH, 2000; 2001). PCTs have a statutory duty to involve the public (including patients and health professionals) in these processes. In practice, this has taken a range of forms across PCTs, from public representation on commissioning boards to consultation processes.

There are some positive signs about the extent to which provider involvement in commissioning is taking place. Ninety per cent of PCTs seek the views of GPs. However, fewer PCTs consult with other front line clinicians. Only 45 per cent involve social services, 26 per cent community nurses, and 21 per cent include practice managers (Wilkin *et al.*, 2002).

Despite these arrangements, there is a strong sense that the entire process of service planning and commissioning is divorced from the needs of the public. Levels of GP engagement are falling well below previous levels and GP practices are still struggling to involve the public in these processes (CHI, 2004). In many cases other health professionals are not represented on commissioning boards at all, leaving them feeling disconnected with the process. Many PCTs use corporate bodies to consult with the public (Bond & Gunji, 2003). It is more difficult to assess the extent to which non-expert members of the public are involved in decision-making about health and health services.

Of real concern is the perception of the impact of provider and stakeholder input. One study found 65 per cent, and another only 44 per cent, of PCT commissioners considered this contribution to be effective (NHS Alliance, 2003; Wilkin *et al.*, 2002). If the very people responsible for taking forward input from those delivering services don't recognise it as important and act on suggestions, there is little opportunity for health professionals to re-shape services in response to patient needs, let alone there being real opportunities for patients to influence decisions. Alienating the very people responsible for implementing, receiving and evaluating new and existing forms of service delivery is a disturbing trend.

Furthermore, consulting with the public may merely involve seeking comment on a number of suggested improvements once the direction and re-design of these has been decided. They may have little or no involvement in deciding priorities. Involving the public in developing ways to re-shape services from existing provision, and deciding priorities between services, is an entirely different process. If we are to develop truly patient centred and responsive health services it is important that the public's suggestions are listened to and acted on, not just heard. Clear mechanisms to resource, plan, support and follow up these processes are needed.

Drawing lessons from PCT performance

Drawing meaningful, evidence-based lessons from PCT performance to identify the best ways forward relies on obtaining enough accurate and valid information to do so. At this early stage it appears that, to some extent at least, this task is constrained by PCT's own limitations in information collection and management systems. The evidence we do have shows that, whilst in theory PCTs have enormous power to reshape local health services, this is not happening in practice.

Current evidence shows they are not fulfilling their commissioning and public involvement responsibilities, and practice management and commissioning is underdeveloped. It highlights the management and capacity concerns, both in terms of involving health professionals and the public, and in exercising commissioning as a lever to reshape and improve services, arguably the most powerful tool PCTs have to achieve this.

Nonetheless, evidence of major improvements in primary care is growing. Chronic conditions are being better managed and there are more examples of integrated approaches to patient care. GPs with special interests are beginning to lead provision for some patient groups at primary rather than secondary care and nurse-led care is at its highest ever levels. However, these examples are just that. They are not representative of care across the NHS, nor is there any evidence to show they are infiltrating care delivery where most needed. The NHS itself needs a holistic approach to this problem.

Passing on lessons learnt

Initial literature and reports on PCT performance all make a similar recommendation, that in order to improve their performance, PCTs should learn from examples of good practice. This suggestion relies on the belief that examples of best practice can, and should, signal the way forward for poor performers. It therefore follows that to be effective in improving PCT performance across England all that is required is to make known the appropriate best practice example to the relevant poor performing PCT, this PCT will then import the best practice example and thereby achieve the necessary improvements. Whilst there are indeed many examples of good practice across PCTs in England, there are not necessarily examples of good practice in transferring this across, or even within, PCTs. What works in one place will not necessarily work in another.

It is one thing to identify and highlight areas of good practice, quite another to effectively promote these to their intended audience, to develop mechanisms by which they may actually be taken up, and ensure they will attain their hoped for goals in new and different settings. Indeed, the CHI report was concerned that innovative practices occurring in parts of some PCTs were not being transferred across the same organisation (CHI, 2004). If best practice transfer is desired, and if this is not occurring within organisations, then it is rather optimistic to expect these to travel between PCTs if they cannot travel within.

Evidence from the policy transfer literature shows that transferring policies across similar institutions can, at best, illuminate what works and why, or what does not work and why (Marmor, 2001). It does little to embed effective change and achieve hoped for gains. Furthermore, the current approach relies on PCTs themselves, the very organisations with managerial limitations, to utilise effective management to improve their practice. Whilst there has been some success in promoting examples of best practice, there is a need to shift away from the rather optimistic belief that pockets of best practice will gather steam and spread throughout England.

Weighing up the pros and cons

PCTs are, in reality, semi-autonomous organisations. Therefore, much of their ability to meet expectations, such as performing on central targets whilst delivering locally determined commissioning and reshaping services, relies on their relative market position. However, PCTs are squeezed between the Government's decentralisation agenda, the incoming choice agenda, and traditionally stronger, more established and market savvy secondary care providers. It is perhaps at PCTs' abilities to exert power and influence in the marketplace that efforts need to be concentrated. The reality may not match the rhetoric.

Recent focus on integrating care requires coordination with a range of providers. This can include local authorities, voluntary and private (including international) organisations, whose priorities, visions, and lines of accountability may not be closely aligned. New ways of commissioning and working need to be developed to align these incentives.

However, we do not yet fully understand the current marketplace in which PCTs operate, nor the impact of new policies as they roll out, in particular the new forms of financial flows and patient choice. As capacity increases along comes the temptation to lower treatment and referral thresholds. The NHS Improvement Plan (DH, 2004b) argues that PCTs are well placed to manage this risk on the basis of their controlling 80 per cent of the NHS budget.

A key to unlocking this challenge lies in the proportion of PCT budgets that is truly discretionary. That is, the resources available for new and desirable forms of service provision. However, the discretionary budget is squeezed between funding committed to payment-by-results, funding following the achievement of central targets, funding following the patient as the choice agenda rolls out, and servicing debt. Thus, a PCT's discretionary budget is actually quite low. New forms of financial flows can be used to enhance the discretionary budget if PCTs create favourable financial incentives.

Payment-by-results is an important first step (DH, 2002). PCTs are moving to commissioning services on a cost-per-case basis using regional tariffs, which removes disincentives with differential provider pricing (Goodwin & Smith, 2002; Lewis *et al.*, 2003).

If PCTs are successful in using new forms of financial flows to design effective strategies around public health and chronic disease management, then resources can stay within their budgets. PCTs have an incentive to keep people out of hospital. This could lead to effective demand management, including a reduction in hospital stays and length of stay. Favourably manipulating financial flows may also ensure the discretionary proportion of their budget is not narrowed to care provided outside of that listed for tariff prices.

The first two waves of Foundation Trusts (FTs) are now on-stream and more are set to join. This brings an even stronger need for the centre to balance a loosening of the reins with monitoring and accountability to the centre, as PCTs will become the solitary link between the Government and hospitals.

Practice-led commissioning could assist in positioning primary care as the visible lead in the community and facilitate use of patient level data to prioritise and meet local need. Evidence suggests this is reinforced with devolved budgets (Goodwin & Smith, 2002). However, practice-led commissioning has higher transaction costs and can lack a broader population perspective (Chappel *et al.*, 1999). On the other hand, higher level commissioning could help standardise variations in care, integrate primary and secondary services, ensure broader population characteristics are taken into account, and lower transaction costs. However, information used to set priorities at higher levels may not translate to need at the local level and it is one step further removed from the public. PCTs freedoms are already influenced by the need to meet a number of centrally determined targets.

There will inevitably be tensions between these two approaches, and the added perception of them leaving PCTs as, essentially, performance managers. Monitoring and evaluating different commissioning models would improve our evidence-base and assist in clarifying risk management and accountability. Furthermore, identifying factors inherent to successful commissioning could help improve commissioning outcomes.

What is important in the current climate is that Government should monitor and evaluate current forms of PCT commissioning, and those forms that develop in light of recent policy developments, rather than shift the goal posts again. Commissioning with private providers may become more widespread and it will be possible to monitor how indicative commissioning budgets for GP practices from 2005 will impact on efficiency (DH, 2004b).

An evidence base could be identified through PCTs evaluating what types of care should be delivered at what level, and by whom. This will require investigating care delivery at the team level as traditional professional boundaries are blurring. Thus, PCTs can use their commissioning powers to break down traditional forms of care delivery to ensure care is delivered by who is best for the patient. This will assist in making planning decisions about staff supply and training.

Evidence shows that PCTs still need to re-shape services. They need to use more foresight in order to match future demands and expectations. A lot of attention has been given to examining packages of care, such as chronic disease management, in other countries and the lessons these might bring to the NHS (Dixon *et al*., 2004; Feacham *et al*., 2002). Whilst this is important in informing ideas for patient management in England, given difficulties in transferring policies, its importance should not be over-stated.

What is surprising perhaps, is that these studies have paid little attention to where services are situated within health care. Services that traditionally have their home in secondary care in the NHS, such as diagnostic and pathology laboratories, are often located in primary care in other countries. PCTs should look beyond the traditional models of care delivery in England to innovate.

PCTs need to be encouraged to commission care provision away from its traditional home in secondary care to a new home in primary care. As an example, some types of post-operative rehabilitation could be routinely provided in primary care, and thus de-commissioned from secondary care. This would serve a dual purpose for PCTs as they can negotiate to keep that proportion of the tariff price within their budget whilst also benefiting patients by providing services closer to their local communities.

Developing new ways of working and delivering care will bring direct challenges to existing traditional boundaries of primary and secondary care. PCTs need to be supported in implementing initiatives that encourage improvements in existing working patterns. Furthermore, if recruitment lags behind the need for care delivery, staff at the coalface should jointly make decisions with managers on how new ways of working might solve current problems.

As the patient choice agenda rolls out, the importance of first contact practitioners in primary care acting as gate-keepers will grow. Contrary to a lot of current practice, these do not have to be GPs; other health professionals working in primary care may carry out this function, for example nurses, pharmacists and physiotherapists. They will be best placed to manage demand, to influence primary care provision, and secondary care waiting lists and times, through their referral patterns. Thus all primary health care professionals are key instruments in the success or otherwise of PCTs' modernisation agendas.

At present PCTs are struggling to meet their statutory duty in involving the public. This is complicated by a general disillusionment amongst PCT decision makers that this process adds value. A tick box system is not enough. If the public are to be an integral and influencing voice in PCT decision-making there needs to be a clear understanding of their role in this process. This understanding needs to travel in both directions.

A key issue is determining the nature of this public involvement. The ippr has previously argued that the bare minimum of public involvement to meet statutory requirements is not sufficient in developing a new and beneficial democratic relationship with local people (Clarke, 2002). PCTs could elicit information on what aspects of their remit the public would like to be involved in, not just those the centre determines as appropriate. They need to engage the public in decision making about how services might be changed, about the types of services they would like to be available for their care, and their families and dependents. This might also help PCTs connect with their local communities.

The lessons we can take from PCT performance and our knowledge of spreading good practice to apply to identifying the best ways forward for PCTs are by no means exhaustive. Rather, they are designed to reflect emerging themes from the literature and policy seminars we held at ippr. If PCTs are to be successful in shaping services that match current, as well as projected, future expectations and demands, these challenges need to be faced now.

The success of our recommendations relies on effective incentive strategies, some from the centre, and some from within PCTs themselves. PCTs need to exercise their political clout and authority to realise the powers they have been given in legislation, to ensure contestability in the market, and to drive through and secure change.

Ways forward for PCTs

PCTs face many challenges in their youth. They are complex organisations charged with a multitude of tasks and responsibilities. Decentralisation in the NHS has shifted some of the balance of power towards primary care and the needs of those working in primary care now have a collective voice. Whilst PCTs are on the road to leading the NHS, there is still a long way to go.

However, a new direction of travel has been signalled. The Government has just published the next stage of its health service reform (DH, 2004b). Building on its earlier developments, The NHS Improvement Plan focuses on high quality personal care, improving patient choice and support. Using stronger market incentives it lays the platform for further diversity in provision.

It is probable that this plan will facilitate the roll out of different models of chronic disease management provided by a range of organisations, not only reflecting the centre's encouragement for diversity of care, but where the public purse is targeted. However, in light of renewed contestability in the market, PCTs will need to ensure their commissioning is based on sound evidence of quality and efficiency, and not marketing techniques. In theory, PCTs have the power to ensure they align incentives to achieve this. It remains to be seen if they will do so in practice.

As we move to an era of greater patient choice and personalisation of services a one-size-fits-all model will not be possible. We are likely to see new provider organisations and their models of care delivery enter the market, including international companies. PCTs and patients alike will need to have good information to make their choices. Change remains constant in the NHS.

There is a renewed emphasis on empowering local communities and public involvement is moving up the political agenda, however, its practice on the ground remains inconsistent. Public involvement in primary care needs to be a vehicle for actively involving citizens in improving health in their local communities in a way that is meaningful and responsive to their needs. PCTs could move from a practice of inviting participation on their terms at their premises, to seeking out successful existing forms of community involvement and participate within these, or develop new types of engagement on the public's turf.

Responsiveness to local need means differences in practice. There is a shifting line between comfort with diversity and gross variations between local populations. Inequities may develop. But these may not be as problematic as they seem. What will matter perhaps, is the amount of emphasis put on this variation by the public. Or, in populist language, to what extent will this be tolerated, and to what extent will it be considered a return to a post-code lottery.

PCTs require investment channelled towards their development as organisations so they can become the organisations they were intended to be; those that can bring about changes to improve services and patient care. The pledged increase in NHS resources to 2007-8 will need to be used strategically and effectively if this is to be achieved.

There are a number of areas where PCTs need to be supported to improve performance. Developing commissioning and management skills and capacity, effective and efficient management of patients with chronic diseases, and engaging the public, remain key concerns. Evidence shows there is no single solution. To improve their performance we need to target incentives and support PCTs across all aspects of their activities, from finance to leadership to ways of effectively spreading best practice. Given the new agenda, the following proposals offer an interim measure to work towards improving PCT performance so as to achieve sustainable improvements in a primary care led NHS.

The key recommendations for developing PCT performance are:

No further structural reform
There was a general consensus that PCTs should not be swept away in yet another round of reforms. PCTs need time to mature as organisations and identify how they can effectively and efficiently achieve their desired policy outcomes.

Establish an adequately trained and supplied workforce for PCTs at all levels
Steps to achieving this include:

- *Establish recruitment schemes targeted at the public and private sector* – to recognise contributions of both workforces to PCTs

- *Practice staff involvement at all levels* – so that workers at the coal face can bring their experience to decision-making about new ways of working and shaping services, which could include input from secondary care sector staff

- *Promote clinical governance as a supportive process to improve performance and introduce effective staff support strategies alongside* - should include use of appraisals and schemes for staff development as well as complaints procedures, thereby strengthening accountability whilst moving away from a culture of blame. This could be facilitated by quality inspection at GP practice level

Monitor and evaluate current commissioning experiments
This could provide evidence to inform decisions on which types of services are best commissioned at which level and by whom.

- *Supporting PCT commissioning leads should be a priority* – including adequate training, resourcing and remuneration

- *PCTs need to drive the NHS* – they need to assert their power in the marketplace and ensure they drive the NHS, not Foundation Trust's or new providers

- *Identify and publish critical factors of success* – these could include capacity, stakeholder support, and positive working relationships with providers and the public

Enhance the role of information and communications technologies
Develop a system of monitoring and evaluation to inform future practice and manage demand and risk. This can include what is clinically effective care, links between staffing and patient safety, and service requirements and innovations

- *Establish and collect the level of information needed for organisational, management and inspection functions*
  Effective ICT programming could ensure data required for management and inspection functions is collected alongside patient information. This could ease resource requirements when preparing for inspection as well as facilitating a culture of ongoing information collection and eliminate any duplication

- *Make patient access to records meaningful for NHS development*
  As patients will be able to access their records by 2010, the sites could be designed to include feedback forms. This could help to engage people in service development as well as offering an access point for complaint reporting

For a comprehensive assessment of the use of information and communication technologies in health see ippr's new publication: *Public Value and eHealth* by J. Bend (2004).

Key recommendations:
- Procurement processes should be subject to evaluation in order that the lessons from them are properly learned
- New, innovative procurements should be trialled
- ICT projects seeking funding should demonstrate that they have considered and will continue to examine the acceptability of proposed services to patients and the public

Shape services creatively to meet public need

- *Design targets to reflect what PCTs could and should be doing* – This can include developing targets around local implementation, including where care should be delivered and by whom. It could include PCT performance assessment of all aspects of their remit by the Healthcare Commission

- *Extend primary care services to include some previously sited in secondary care* - for example some diagnostic and laboratory tests, relocation of some consultancy work such as dermatology clinics

- *Out-of-hours services* – these should be targeted at avoiding unnecessary and inappropriate admissions

- *Be creative in canvassing public opinion* – Instead of expecting the public to come to health services to discuss and offer opinion on services, PCTs should reach out to established community forums and groups to garner public opinion and suggestions on their turf

- *Developing a formal structure for up-take of patient and public suggestions* – adhering to minimum standards of consultation developed and agreed with patient groups to ensure services are shaped to meet public need and expectations. These need to be backed up with lines of accountability. More sophisticated methods of measuring ways of patient satisfaction need to be developed.

PCTs are still relatively new organisations, so it is perhaps not surprising that they still fall short of the expectations that many had of them leading a primary-care led NHS. If they can develop their commissioning role, involve a wider range of practitioners and the public more effectively, resolve the dilemma of meeting central targets and local needs, they may be able to overcome the historical dominance of the acute sector in the NHS. However, their success in rising to this agenda is not yet assured.

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