Primary care trusts: the way forward?

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Primary care trusts must become genuine public health organisations by maintaining their focus on key public health principles and developing meaningful partnerships

The All Party Parliamentary Group on Primary Care and Public Health states that “being charged with the strategic responsibility to improve the health of their populations is one of the greatest opportunities facing PCTs [primary care trusts], and a perspective that is a relatively new phenomenon in primary care”.¹ This emergence of the PCTs as health improvement organisations has a major impact on its other two core functions, namely the development of primary care and the commissioning of services—or rather described as the shaping of services jointly with other agencies in response to patient need. While primary care development and the design of services are crucial roles for the PCT, the most important conceptual shift is arguably the change to ensuring that the public health agenda sets the direction for the PCT and its partners.

The “new public health” stresses that common measures to protect the health and safety of communities, and individuals within them, are central to its endeavours. The realisation that health is created and maintained through reciprocity at various levels—organisational, community, and personal networks—emphasises the importance of interdependence, that is, PCTs are only able to pursue their public health goals in concert with others. Thus, these ideas are influential for the philosophy underlying the work of PCTs. First, primary care has to shift from an individual, disease focus to embrace a population and comparative approach. Second, PCTs have to establish robust needs assessment methodologies that can form the basis for health care decision making and designing services. Third, wide ranging partnerships involving other organisations and local communities are crucial to developing appropriate delivery processes and outcomes.

The above challenges for the new PCTs should not be underestimated and fears have been voiced that PCTs do not have the capacity to deliver such a demanding brief. Although it cannot be denied that the high expectations of PCTs present real dangers, there is also cause for optimism that this reorganisation has the potential to address long standing problems of inequalities in health. If public

health is placed at the centre of PCTs it is possible to articulate a number of key principles that will help in making this a reality:

- **Equity:** this implies that the PCT aims to maximise the welfare of individuals and communities most in need with the resources available.
- **Responsiveness:** the PCT delivers or commissions clinically effective services that achieve outcomes that are valued by its recipients. Therefore, the emphasis shifts from output measures such as number of patients treated, to outcome measures that offer information on whether and how people's quality of life has improved.
- **Cost effectiveness:** the PCT will not only assess whether it has achieved desired effects through its provision of primary and community services, or its commissioning of hospital care, but also whether it has been delivered in an efficient and best value manner.

Operating with this set of principles creates the conditions to make decisions more explicit and grounded within the local context. The involvement of various stakeholders, such as local authorities, voluntary and community organisations, patients, and the public is important. It is noteworthy that PCTs are structured around the involvement of local clinicians, principally through the creation of a professional executive committee (which consists of a majority of general practitioners, with further membership drawn from nurses, allied health professionals, other independent contractors, and managers). The opportunity for the PCTs to formulate a shared framework for decisions is an important step forwards. The making of choices has been fudged for too long, and because the pressures on the health and social care systems are increasing—despite the influx of more resources—it is becoming inevitable that more explicit choices will have to be made. PCTs are placed in the forefront of this debate. Rather than muddling through PCTs have to state their values and principles openly so that proper alliances between clinicians, policymakers, managers, and other partners can be forged. The essential issue is not

primarily “how money should be spent” but what quality of life communities and individuals aspire to and therefore, what contribution the PCT chooses to make to their wellbeing.

What does all this mean in practice, and what chances of success do PCTs have? The first step is for the PCT board and the professional executive committee to have an agreed approach to describing and analysing the ethical issues that lie at the heart of public health policymaking. Roberts and Reich offer a helpful overview of the main approaches, and argue that operationalising ethical theories by asking “real life” questions will clarify how ethical debate can be advanced.² Thus, the PCT could sharpen its decision making process by asking questions such as:

- Are we delivering services that patients need? Which groups or who have been involved in the debate? How robust was the process for involvement?
- How have the needs been assessed? Have we taken into account the various perspectives on need (clinical, patient, comparative)? What are our gaps in knowledge? Do we have ways in which to fill those gaps?
- How is high quality defined? What sources of evidence have been used? What checks have been put in place to ensure standards?

In short, the PCT has to define a framework that allows for the process of decision making to be assessed against the core public health principles that set its direction. As a result the performance management regime has to change fundamentally so that PCTs can create real pressure for improvement, support innovation, and develop meaningful collaboration on a small number of shared targets.³ Three preconditions have to be in place: first, clinicians need to be at the heart of the PCT's policy making. Thus, the professional executive committee must develop into a body that understands and activates strategy, leaving behind professional boundaries and allegiances. The difficulties of overcoming the management-clinical dichotomy have been well documented, especially when it involves changing professional practice.⁴ Therefore, the role of the professional executive committee in showing clear and unified direction is crucially important. Second, overall organisational change is important in order to create the context where innovation, risk taking and learning from mistakes are commonplace. This cultural shift has to be led by the board and the professional executive committee, visibly demonstrating that they are operating “as one” and behave in ways that are consistent with what is espoused. Thus,

slogans such as “we value our staff” should not be platitudes, but grounded in reality with tangible achievements on the “Improving Working Lives” agenda. In this way the PCT becomes an example for improving the health of its workforce. Third, progress must be made on partnerships with communities and relevant organisations. The recent literature on social capital emphasises the importance of building wide and varied networks, increasing trust and shared norms.⁵ Therefore, it is not only important for PCTs to develop collaboration with relevant organisations through setting shared goals, but also to find ways in which its own institutional design facilitates the creation and mobilisation of social capital among traditionally excluded sections of society.⁶ The barriers to working in ways that allow genuine engagement are legion, but current action research commissioned by the Department of Health points towards possible effective strategies, including:

- Managing conflict (between communities and organisations, or between organisations) more constructively.
- Developing more sophisticated skills and techniques for engaging with communities.

- Changing the professional culture towards one that respects lay views and the capacity of communities to improve their own health.

- Developing a more participative organisational culture—both for staff and other stakeholders—through encouraging innovation and risk.⁷

The challenges for PCTs to become genuine public health organisations are formidable, but realising this vision is the only way forward if they are to achieve what they are designed to achieve. The opportunities to succeed lie in the way clinicians are structurally tied into the policy process, in the awareness that health improvement (rather than just focusing on health services) depends on meaningful partnerships with communities, patient groups, and a wide range of statutory and voluntary organisations, and in the understanding that organisational cultures have to change to release the capacity of staff so that they can engage with an agenda that emphasises health outcomes and quality of life. Only if PCTs can maintain their focus on the key public health principles and work innovatively within and beyond their organisational boundaries will they

fulfil their promise.

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