NEWS FEATURE

Talk of primary care trusts separating their commissioner and provider functions is nothing new but it might be something that many pharmacists not working in PCTs do not fully understand

Why PCT commissioner and provider functions have split

By **Gareth Malson**, MRPharmS

At the beginning of last month, *Clinical Pharmacist* spoke to a primary care pharmacist who we believed to be running a PCT diabetes clinic with a specialist nurse. (We were hunting for someone to write an article for our **IN THE CLINIC** series.)

Unfortunately, we were told, the clinic is no longer in operation because the PCT has had to "separate its provider and commissioner functions". This phrase has been bandied about by primary care pharmacists for several years but we found ourselves wondering whether this process was done and dusted or whether it was still work in progress. It seemed a fair bet that many pharmacists, particularly those working outside PCT land, were probably wondering the same. So we asked Jonathan Mason, national clinical director for primary care and community pharmacy in England, to fill in the blanks.

Divide and conquer

"Alongside the introduction of world class commissioning was a requirement from the Department of Health to make PCTs focus more on commissioning rather than providing services," explains Mr Mason, who is also head of prescribing and medicines management at NHS City and Hackney. By separating PCT functions in this way, the DH believes conflicts of interest will be avoided since PCTs will no longer be commissioning services directly from themselves. Mr Mason adds: "In its broadest sense, this came about to prevent PCTs from getting drawn into managing community services."

So what will happen to the services currently being provided by PCTs? Essentially, those who deliver these "provider" services (see below) can no longer be employed to do so directly by a PCT. "There needs to be a clear separation of the commissioning function and the provider function," Mr Mason points out. "How you do it is up to you as a PCT — whatever fits in your locality."

All PCTs were expected to have undergone this separation, at least internally, by April 2009. In January 2009, the DH published "Transforming community services: enabling new patterns of provision". This document suggests several options for how the provider "arm" of each PCT might evolve in the future. For example, it could:

- Become an NHS trust in its own right
- Become a social enterprise — an arm's length body, akin to a charity, that would be commissioned to provide community services
- Transfer its staff to a local acute or mental health trust, or some other existing organisation, which would provide its services

"Most PCTs have . . . a provider organisation that is still subservient to the PCT board," says Mr Mason. "[The organisation] has its own shadow board but it is not a legal entity in its own right." He adds that until such organisations have the ability to become legal entities — ie, once they have been defined in legislation — PCTs will remain accountable for their actions.

Another option is for GP practices or practice-based commissioning consortia to employ provider arm staff directly. However, as Mr Mason points out, having a central organisation makes the division of case loads and cover for illnesses and holidays easier to manage. So this option will not be suitable for all services.

Since the aim of the separation was to prevent conflicts of interest between commissioners and providers, will these new provider organisations have to compete with

other service providers to continue doing what they have been doing? "That is the $64,000 question," says Mr Mason. "However, at the moment, the NHS remains the preferred provider [of services commissioned by PCTs]."

Provider functions

Historically, some of the healthcare services provided by PCTs for their local populations have been delivered by PCT employees. These are not services provided by traditional contractors, such as community pharmacies, dentists and optometrists, nor are they among the acute healthcare services provided by hospitals. Examples include district nursing, health visiting, podiatry, physiotherapy and dietician services.

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"Personally, I think there could be some misunderstanding over what constitutes provider functions and what is purely commissioning," Mr Mason suggests. "The difficulty in understanding arises around those things that do not fit into a specific service, like prescribing advice and support. You could argue that this is a provider function because you are providing a service. Or, you could argue that a lot of the work involves supporting practices to become better providers themselves. Commissioners should be supportive and there's nothing wrong with helping your providers become better providers of services.

"The upshot is that most PCTs are looking at prescribing advice functions and stripping out some of the things that we've traditionally done in prescribing teams — in particular medication reviews, auditing and [support for medicines] switching."

In London, a team of independent pharmacists, many of whom are former locums, are commissioned by practice-based commissioners or several PCTs (including Mr Mason's stomping ground) to provide such prescribing support. Mr Mason is a staunch supporter of GP practices commissioning pharmacists in this way. The arrangement, he says, allows PCTs to provide strategic direction for the pharmacists' work, such as specifying which medicines should be switched, but shifts the financial onus onto practices. "Out of savings they make from the switches, practices use some of that money to fund pharmacist support."

New pharmacy roles

As PCTs strip out the hands-on prescribing support they have traditionally offered to practices, their commissioners will be giving GP practices targets to meet in terms of prescribing, says Mr Mason. He believes that practices will require support in meeting these targets and recommends that pharmacists interested in providing such support should contact practice-based commissioning consortia and local medical committees directly.

What's in a name?

Over the past year or so, many PCTs have undergone a name change. Names in the format of "City and Hackney Primary Care Trust" have been replaced by "NHS City and Hackney".

"This helps to identify the commissioning arm of the PCT as the local leader of NHS services locally, which is what world class commissioning is all about," says Jonathan Mason, national clinical director for primary care and community pharmacy. Provider organisations that have emerged from the PCTs are then given separate names, such as NHS City and Hackney Community Health Services.

"Whereas in the past PCTs would have said 'this is what we want you to do and we can help you'," he explains, "it'll be a shift to 'this is what we want you to do, this is what we're going to monitor and these are the people who could help you — if you want to pay for it'."

Although he admits that not all PCT medicines management teams will relinquish this role, Mr Mason believes the workload for most pharmacists in these departments will evolve. "We'll move away from the direct provision of switching services and medication reviews to doing more performance management of practices, target-setting and looking at how we manage the prescribing budget and pharmaceutical services."

Help is at hand

Going back to our pharmacist in the diabetes clinic — what does Mr Mason suggest for this situation or others like it? "What the PCT could do, as a commissioner, is approach its provider arm and say 'this is the service we want, we will commission it and, by the way, this is a person who has been providing it'." Then, in theory, the pharmacist who had been working in the clinic could continue to do so by being employed, part-time, by the provider organisation.

Mr Mason adds that guidance is being filtered down through strategic health authorities about which services PCT commissioning bodies are allowed to provide. He suggests that PCT pharmacists who are unsure of how to deal with a problem of this nature should contact their SHA adviser.

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