PCGs
an early view of primary care groups in England

This paper draws on the results of a survey of all health authorities, collected when PCGs were being established. It contains key messages, particularly for NHS and other staff involved with PCGs.
Introduction

1. Primary care groups (PCGs) form a key element of the Government’s plans for improving health and health services in England. They have very broad areas of responsibility (Exhibit 1, overleaf). These include:
   • promoting the health of the local population in partnership with other agencies and contributing to a local health improvement programme (HiMIP);
   • commissioning hospital and community based health services within the framework of the HiMIP; and
   • developing the quality of primary healthcare received by patients through investment, joint working, sharing skills, professional development, audit and review.

2. The PCG concept is radically new in that:
   • the multi-professional board brings together GPs, community-based nurses, social services, a lay local resident and others, with powers to manage budgets and contribute to wider service plans; and
   • all GP practices are included in PCGs, although GPs, as independent contractors, can decide whether, and how much, they want to participate.

3. PCGs can thus represent all those primary care staff who routinely assess patient needs and arrange referrals. This gives them the potential to provide a fresh approach to addressing important issues such as:
   • the need to co-ordinate activities between primary and secondary care, and between health and social services staff;
   • the inequalities in patient care, of which primary care staff may be particularly aware, such as pockets of poor health status, poor access to services, and below-average standards of care; and
   • the professional isolation that has sometimes arisen within primary care.

4. This approach should enable PCGs to:
   • reduce inequalities in access to local health-related services;
   • ensure that good ideas are shared between GPs and that peer pressure to root out unsatisfactory practice is strengthened;
   • ensure that developments are targeted around national and local priorities and are supported by investment, training and audit;
   • co-ordinate the planning and delivery of all services that may impact on the health of the local population; and
   • improve public participation in decisions about local services.
PCGs have very broad areas of responsibility.

Source: Audit Commission
5. Initially, however, the major task has been an organisational one. Since the PCG concept was first announced in December 1997 (Ref.1), health authorities have had much to do in setting up the 481 groups that cover England (Exhibit 2). This paper describes some of the main characteristics of these new bodies. It is based largely on a survey of health authorities (HAs), which was carried out just prior to the formal establishment of PCGs in April 1999. This showed important differences between PCGs:

• some in size, previous experience of commissioning, and relationships to be built ('Initial PCG configurations' – Section 1); and

• others relating to PCGs' managerial capacity, and the problems that they have to address locally ('PCG responsibilities, governance and management' – Section 2).

The final section (Section 3) of the paper sets out some challenges for the immediate future, with examples of how they are being addressed.

Exhibit 2

The timetable for setting up PCGs

Health authorities have had much to do in setting up their PCGs.

Source: Audit Commission, based on NHS Executive guidance during 1998
1. Initial PCG configurations

6. Primary care groups were initially established at one of two levels of responsibility:
   • 17 per cent of PCGs (Box A) started at level one, acting in an advisory role; and
   • the other 83 per cent have started at level two, still subcommittees of their HAs, but with
     substantial delegated authority over budgets, commissioning and investment decisions.

Subject to legislation, PCGs will be able to proceed to levels three or four in April 2000. At these levels a
PCG will attain primary care trust (PCT) status. All PCTs will be free-standing bodies that are responsible
for commissioning care, and, at level four, will also be responsible for providing community health services
for their populations. Progress to levels three and four will be subject to approval from the Secretary of
State. HAs report that at least 50 per cent of PCGs aspire to reach these higher levels by April 2002.

7. The number of PCGs, and the population that each covers, varies between HAs. Most HAs have
divided their area into between three and six PCGs that average 75,000 to 150,000 registered
patients (Exhibit 3). But some (mostly with large populations) have formed up to 12 rather small PCGs,
while a few (with small populations) have set up only one or two unusually large PCGs.

Box A

Key facts about primary care groups

<table>
<thead>
<tr>
<th>Patient population(^1)</th>
<th>Minimum</th>
<th>Average</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of practices per PCG</td>
<td>5</td>
<td>19</td>
<td>66</td>
</tr>
<tr>
<td>Number of GPs per PCG</td>
<td>21</td>
<td>55</td>
<td>141</td>
</tr>
<tr>
<td>Percentages of practices that were formerly fundholding</td>
<td>0%</td>
<td>47%</td>
<td>100%</td>
</tr>
<tr>
<td>Percentages of practices formerly involved in some form of joint commissioning</td>
<td>0%</td>
<td>38%</td>
<td>100%</td>
</tr>
<tr>
<td>Number of PCGs per HA</td>
<td>1</td>
<td>4.8</td>
<td>12</td>
</tr>
</tbody>
</table>

Note: The minimum and maximum values for each of the above categories do not occur in the same PCG
or HA.

Approximate expenditure of an ‘average’ PCG (if 100 per cent of eligible funds were to be
delegated):

- Hospital and community health services: £50m per year
- Prescribing: £10m
- Practice infrastructure (GMS cash-limited): £2m

Note: These figures exclude funding of HA functions and of specialist services which cannot be delegated
to PCGs.

Source: Department of Health and Audit Commission surveys

\(^1\) Defined as the total number of patients registered at the constituent practices. This may differ slightly
from the true population, because some people are registered at more than one practice (‘list inflation’) while
others are not registered with a GP at all.
Exhibit 3

Number and average size of the PCGs in each HA

Most HAs have three to six PCGs that average between 75,000 and 150,000 patients.

Note: Each diamond symbol represents one HA.
Source: Data provided by Department of Health

8. Individual PCGs vary greatly in size: by a factor of 6 in terms of population list size, and by a factor of 13 for the number of GP practices (Box A). The consequences of such variations may be important:

- Small PCGs may lack the 'purchasing power' to influence trusts unless they commission services jointly with other PCGs. It is also harder to staff a small PCG within management cost limits (paragraph 12 below).

- Conversely, the larger the PCG, the more varied the communities it is likely to contain; thus, large PCGs, especially, will need to find ways of becoming aware of all local needs and of responding to them. Involving all the GP practices may also be more difficult in the larger PCGs. To improve communication and encourage development, some (predominantly larger) PCGs are defining smaller area subgroups; (three-quarters of those with over 100,000 patients are adopting this approach, compared with one-quarter of the smaller PCGs).

- HAs will be able to provide more focused support if they are responsible for fewer and larger PCGs, particularly if each group has a similar range of devolved responsibilities. In these circumstances, however, they will need to retain a strategic perspective and avoid getting too close to operational issues.

- PCGs that contain a large number of smaller GP practices may find it more difficult to build relationships. In over one-quarter of PCGs, one-third or more practices have only one full-time partner.

- Having to work with more than one local authority will also make for complexity for a minority of PCGs. HAs report that 14 per cent of PCGs span more than one social services department, and 24 per cent span more than one district or unitary authority.
2. PCG responsibilities, governance and management

9. Some of the most important early tasks undertaken by PCGs in consultation with their HAs have been:
   • to set up governance arrangements;
   • to agree delegation of commissioning responsibilities and hence the level of entry into the scheme;
   • to appoint chief executives and decide the staff needed to develop the organisation and carry out delegated roles; and
   • to consider financial pressures (including those on the prescribing budget) and set up procedures to monitor and influence practice expenditure.

This section describes how these tasks are being approached.

PCG governance and management arrangements

10. PCG boards vary in size between 9 and 16 voting members. Nearly all (86 per cent) have 12 or 13 members, however, in line with NHS Executive guidance, and have elected a GP as chair (97 per cent).\(^2\) One-third of PCGs have already co-opted further non-voting members – such as pharmacists, dentists or trust administrators and clinicians – to the main board to improve representation and the range of expertise available. Some others have co-opted members to specialist subcommittees. Overall, GP and practice nurse board members are not representative of all general practice. Former fundholding practices, training practices, and those serving more affluent areas, are all more likely (in relation to the prevalence of these types of practice) to contribute a member to a PCG board than others (Exhibit 4).

11. There has been more variation around the appointment of a chief executive (or general manager) and supporting staff:
   • in the timing of the appointment: 25 per cent of PCGs had not appointed a chief executive when the Commission's survey took place (typically one to two months before the PCG went 'live'); 60 per cent had not at that time agreed any other managerial or advisory posts. Such local differences in timing are inevitable given the tight timetable, but PCGs that made early appointments should be able to develop more rapidly than the others.
   • in background of chief executives: the majority are former HA employees (Exhibit 5), while a minority are from primary care or community trusts;
   • in salary: the minima of advertised salary ranges\(^3\) spanned, and occasionally fell outside, the range suggested by the NHS Executive (£34,000 to £50,000 for an average-sized, level two PCG; £26,000 to £40,000 for those with lesser responsibilities); and
   • in contractual terms: 23 per cent of chief executive contracts are for terms of up to two years. This may prove a sensible approach, since the immediate task is to develop the organisations from a standing start. In the longer-term, different skills may be needed, particularly in PCGs that move quickly towards primary care trust status.

\(^2\) The PCG chair is also the 'responsible officer', accountable to the HA chief executive.

\(^3\) Audit Commission review of job advertisements appearing in the Health Service Journal.
Exhibit 4

**General practices with a member on a PCG board**

Former fundholding practices, training practices, and those serving more affluent areas, are all more likely (in relation to the prevalence of these types of practice) to contribute a member to a PCG board than others.

Note: These differences persist when the different sizes of practices in these categories are taken into consideration.

*Source: Audit Commission survey of HAs*

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Exhibit 5

**Previous employment of PCG chief executives appointed by February 1999**

The majority of PCG chief executives were former employees of an HA.

*Source: Audit Commission survey of HAs*
12. The costs of the board and chief executive comprise a relatively fixed overhead regardless of the size of the PCG. However the total central contribution to supporting PCG running costs is proportional to population size (Ref 2), leaving small PCGs with less scope than large ones to employ support staff (Exhibit 6). In practice, HAs have considerable flexibility in setting PCG management budgets (provided that these can be accommodated within their own overall management costs) and in deciding the levels of shared administrative support that they fund from their own budgets. At the time of the Commission’s survey, many HAs had not reached final agreement with their PCGs on delegated responsibilities, staff requirements or resulting management cost budgets. Figures reported ranged from £1.09 to £5.43 per patient with an average of £2.80. The survey did indeed suggest, however, that 70 per cent of the small PCGs (80,000 patients or fewer) will have less than one-half of their provisional management allowance available for support staff and other running costs after paying board members and the chief executive.

13. Two possible approaches mooted for small PCGs were to make the chief executive post a joint appointment with another PCG or organisation, or to make it a part-time appointment. Very few PCGs have taken either of these routes, however, (6 per cent and 3 per cent respectively). Interviews suggested that board members considered it important for establishing the identity and ethos of the PCG that each group should initially have its 'own' chief officer. Early indications are, however, that somewhat more PCGs are considering sharing supporting staff. Also, in some areas, chief officers of neighbouring PCGs are sharing the lead on certain common issues, and then adapting draft documents to meet their own local circumstances.

Exhibit 6
PCG board and chief executive costs compared to total management costs
Small PCGs have less scope than large ones to employ support staff.

Source: Audit Commission survey of HAs
The commissioning role

14. The commissioning of hospital and community health services (HCHS) typically forms over 80 per cent of the expenditure that HAs can delegate to PCGs. The extent to which these responsibilities for commissioning and setting up long-term service agreements are delegated to PCGs therefore determines their operational ‘level’ and will significantly affect their staffing requirements.

15. Decisions about which areas of commissioning to delegate to PCGs were still being finalised at the time of the Commission’s survey. Responses suggested that, overall, responsibility for around three-quarters of the total HCHS budget would rest with PCGs. Where commissioning arrangements had been finalised, PCGs were most likely to be responsible for community health services such as district nursing (Exhibit 7); about two-thirds would be wholly responsible for this aspect of care (although some community hospitals were excluded) and a further one-quarter partially responsible. A majority would be completely responsible for commissioning maternity services. Almost 40 per cent would be completely responsible for commissioning planned acute and general healthcare, with an equal percentage partially responsible. In contrast, 11 per cent would have full commissioning responsibility for learning difficulties, and 20 per cent for mental health services.

Exhibit 7
Commissioning responsibilities delegated to PCGs

In 1999/2000, PCGs are most likely to be responsible for commissioning community health services such as district nursing.

Note: Excludes certain specialised services, and the 30 per cent to 40 per cent of HAs that had not finalised these decisions at the time of the survey.

Source: Audit Commission survey of HAs (February 1999)

4 National guidance specifies that to be recognised as level two (with consequent implications for the level of payments to board members) a PCG must take on devolved responsibility for at least 40 per cent of its total unified budget in 1999/2000 and 60 per cent in subsequent years.
16. The expertise required by PCGs for successful commissioning is likely to be more akin to that developed by multifunds, and some GP locality commissioning groups, than that of GP fundholders. Most of the latter 'purchased' a far more limited range of services than will PCGs, and on a less significant scale in terms of overall implications for provider trusts. Thus, the extent to which member practices have any previous experience of working together in these ways is likely to be a key difference between PCGs. Almost two-thirds of PCGs contain some practices that belonged to either a multifund, a total purchasing project, a commissioning group pilot, or a locality commissioning group. However, in only one in five PCGs have all practices previously worked together in these ways (and not all of these may have been active members of a group). The remaining third of PCGs, which have no such background in joint commissioning, are more likely than the others to have entered as level one (advisory) PCGs. This differential is likely to persist: 81 per cent of those that aspire to trust status in the year 2000 have previous experience, compared to 56 per cent of those that are expected to remain at levels one and two.

17. Staff with relevant experience of large-scale commissioning are a scarce resource that would be very thinly spread if it were to be divided between all PCGs. Fears have also been expressed about the time commitment involved for trusts if each PCG were to negotiate contracts separately and impose differing quality requirements, and also about possible inequity of care provision for patients in neighbouring PCGs.

18. To overcome these problems, some HAs (50 per cent of those that had reached a decision) have linked each PCG to a particular NHS trust and that PCG is developing service specifications with that trust for all the PCGs. Alternatively, in 23 per cent of HAs each PCG is leading on a particular specialty on behalf of the others. PCGs' commissioning flexibility over delegated budgets is, in any event, likely to be limited by service developments previously agreed by the HA. Also many HAs say that their own staff will, at present, retain a major role in the day-to-day management of commissioning responsibilities delegated to PCGs, both in terms of financial aspects (77 per cent of those that answered) and negotiation of service standards (73 per cent). HAs will find it organisationally easier to provide this support if all of their PCGs are starting at the same level. This was so in five out of six HAs that had reached decisions at the time of the survey.

### The prescribing budget

19. Prescribing is the element of delegated budgets over which PCGs can exercise the greatest short-term influence, but also that most likely to present the greatest in-year cost pressures. Expenditure on drugs prescribed in primary care is rising faster (at 8 per cent a year) than general inflation in health. These extra costs will have to be met out of uncommitted growth money. Economies made by switching to cheaper drugs or cutting out unnecessary prescriptions have not matched the cost of expensive new drugs, rising patient demand and more preventive prescribing. Had PCGs been in existence in 1997/98 (with prescribing budgets equal to the sum of those in constituent practices), most would have overspent (Exhibit 8).

20. Further, there is a good case for increasing expenditure on certain types of drugs. For example, evidence suggests that many practices should prescribe costly statins/lipid-lowering drugs more widely so as to reduce the prevalence of heart disease (and also of impairment and treatment complications) (Ref.3). Conversely, there is concern that other types of drugs, such as antibiotics, are on some occasions prescribed without clinical justification. Keeping prescribing budgets within check, without sacrificing the quality of patient care, is therefore likely to be of particular significance to PCGs.
21. A great deal of detailed data is potentially available to PCGs on prescribing rates. And nearly all HAs employ prescribing advisers, pharmacists and some doctors to help, for example:

- to set equitable prescribing budgets,
- to ensure a co-ordinated approach to prescribing in primary and secondary care,
- to facilitate new prescribing initiatives, and
- to visit practices to advise on cost-effective prescribing.

Promotion of cost-effective prescribing, however, also requires a sustained input of time from practices to keep formularies up-to-date on practice computers, review repeat prescriptions and monitor patients’ changing needs. Responsibility for much of the practical support that has been provided to general practices or facilitated by HAs will now pass to PCGs. There has been concern that, in some areas of the country, staff with the requisite skills will be thinly spread.

Exhibit 8
Imputed over/under-spending by PCG, on practice prescribing

Had PCGs been in existence during 1997/98 (with prescribing budgets equal to the sum of those set for constituent practices), most would have overspent.

Prescribing data at general practice used in this chart were collected for running 12-month periods ending December 1997, March 1998, June 1998 or September 1998 (depending on HA). They have been aggregated into PCGs, converted to a ‘cash’ basis comparable with budgets using a factor supplied by the Prescription Pricing Authority and then by an expenditure growth factor calculated for each HA to obtain approximate 1997/98 expenditure. Most expenditure incurred by deputising services is excluded. Data for areas where significant proportions of total HA prescribing allocations were not included in the recorded practice budgets have also been excluded. The results suffice to give a general indication of what the levels of overspend might have been.
22. A number of HAs have formed a pool of pharmacists who have been accredited to give certain types of prescribing advice and practical assistance to GPs to improve their prescribing. Some individual fundholders have successfully employed non-dispensing practice pharmacists with a broader remit, including medication review, overhaul of repeat prescribing systems, provision of drug advice to patients and GPs, and audit. PCGs will wish to draw on this accumulated local expertise and devise ways of spreading it more widely without diluting the value to individual practices. It is important that PCG members agree prioritised objectives for pharmaceutical support, so that a substantial proportion of available pharmacist skills are used to promote cost-effective prescribing, and for the benefit of all patients, rather than in time-consuming review clinics.
3. Meeting the challenges

23. The task facing PCGs is a radically new one. They will have to bring together a wide range of interests (board members and external stakeholders) and work with them by negotiation, not by command management. At the same time, they will have to link in to the existing structures of NHS trusts, HAs and regional offices. How effective they are will depend a great deal on intangibles, such as the quality of leadership, and the readiness of all the parties to collaborate and communicate. There are, however, a number of actions that are more likely to predispose a PCG to success. They can be illustrated by selective examples of how such challenges are being tackled around the country (Box B, overleaf). More detailed guidance on many of these issues has already been issued by the NHS Executive.

24. Those 170 PCGs\(^6\) that have expressed an interest in applying for early trust (PCT) status face additional tasks. Some already recognise that they will need to merge with other PCGs if they are to become big enough organisations to run community health services. To prepare for trust status they will need additional management capacity. It is therefore important that they ensure that their strategies, structures, protocols, procedures and approaches to commissioning decisions are developed in consultation with those neighbouring PCGs. It may be possible to appoint certain administrative staff jointly, or to draw on the skills of community trust managers. In some cases, it could be appropriate to use managers flexibly between community health trusts, HA and PCGs. Once established, PCTs will require a different range of management skills to PCGs. Employment contracts should be framed to permit this flexibility. Potential PCTs should also be starting to plan the public consultation that will be necessary if their formation will imply a change in the pattern of service provision. They will need to justify the change by showing how it would result in improved patient care.

\(^6\) Information provided by NHS Executive, May 1999.
Audit Commission

Box B

Tackling the challenges

Each PCG in the HA has an executive group, comprising the chair, clinical governance lead, executive nurse and manager, which meets between main board meetings. Other nurses on the board have project roles. Many areas have committees attended by all PCG chairs and chief officers and key HA staff. These may have executive powers to agree a corporate approach to issues of common concern, for example, staff recruitment or a local NHS trust's estates plan.

An accountability agreement between the PCG and its HA includes, under each of the six dimensions suggested by NHS (Health improvement, fair access, effective delivery, efficiency, prevent/over experience, health outcomes), specific actions, target dates, their impact and a lead person.

GP commissioning groups in the area promote increased involvement of local people and voluntary organisations in planning and improving care delivery, through self-help groups, local groups and project groups. Resources were provided for facilitators, interpreters and childcare for participants. Achievements included better patient information about their medicines, care plans and out of hours telephone help.

A community NHS trust has seconded a nurse manager to a PCG to manage an integrated nursing team across the PCG.

Level surveys, epidemiological data, practice-held information and focus groups of key residents are all powerful sources, especially in combination.

In addition to monthly reports of expenditure and number of persons treated, advanced fundholders also produced:

- projections to the end of the year;
- changes to waiting lists; and
- commitments for forecasting.

PCGs need to:

- set up effective board, executive, and subcommittee structures with wide representation, documented responsibilities and powers, and clear roles for each member;
- act within strategic frameworks agreed in discussion with other local PCGs and NHS trusts; and
- present, at board meetings and through their other communications, a public profile which is efficient, open and accountable.

- agree with their HA a manageable number of specific, measurable, action-related targets relating to:
  - national and local priorities for all core PCG functions,
  - development of PCG management structures and procedures, and
  - support from their HA; and
- reflect these targets in agreements with member practices.

- draft a strategy for communicating and consulting with all members, stakeholders, relevant local groups, patients and the broader public and neighbouring PCGs; and
- hold initial meetings with all of these constituencies to explore their views on service development and delivery.

- develop partnerships with other organisations, between practices and with other PCGs; and
- identify novel services or arrangements existing in particular practices or localities systematically, and consider ways to improve equity of access to those which produce clear benefits for patients.

- develop procedures for identifying the health needs of the local population, prioritising bids for resources and agreeing plans with member practices;
- ensure that the skills and resources needed for assessing needs are available; and
- establish channels for ensuring that the most pressing needs and developments feed through into HA health improvement programmes.

- agree realistic and fair budgets with member practices;
- specify service level agreements for regular provision of expenditure data by HAs or agencies;
- set up internal procedures for monitoring expenditure against budgets and reporting areas of concern to the board; and
- devise mechanisms to influence practice behaviour if an overspend is forecast.
### PCGs need to:

<table>
<thead>
<tr>
<th>Risk management</th>
<th>Incentives</th>
<th>Access to adequate skills, support and advice</th>
<th>Systematic analysis of training and staff development needs</th>
<th>Clinical governance strategy</th>
<th>Investment plans for primary care development and for support functions (such as Information Technology)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• set up a rolling programme of systematic evaluation of potential financial, clinical, operational and litigation risks;</td>
<td>• put in place a system of practice incentives that reward improvements in patient care and are linked to clinical governance priorities, rather than just to the economical use of drugs.</td>
<td>• be allocated a share of the overall HA management cost budget that is commensurate with the PCG's responsibilities and development needs;</td>
<td>• assess systematically, with the HA, the training and development needs of board members, staff and clinicians; and</td>
<td>• have appointed one or more clinical governance leads and identified contacts in each practice;</td>
<td>• collate sound information on current provision of services and facilities and their usage in each general practice;</td>
</tr>
<tr>
<td>• identify actions to reduce these risks; and</td>
<td>• recruit adequate staff to carry out delegated functions, or negotiate access to the required skills from the HA or trusts; and</td>
<td>• start to put in place a human resource policy designed to identify the skills required and ensure continuity of provision.</td>
<td>• start to put in place a systematic impartial method for identifying and evaluating bids for new investment against evidence and local priorities, and for ensuring that developments are co-ordinated with those in neighbouring PCGs; and</td>
<td>• agree, in consultation with neighbouring PCGs, a clinical governance strategy including its approach to problem performers; and</td>
<td>• set up a systematic impartial method for identifying and evaluating bids for new investment against evidence and local priorities, and for ensuring that developments are co-ordinated with those in neighbouring PCGs; and</td>
</tr>
<tr>
<td>• establish arrangements for sharing the risk of high cost procedures with the HA, other PCGs or provider trusts.</td>
<td>• be supported with constructive advice, information and specialist services from its HA.</td>
<td>• have outlined, for this year, a programme of work which reflects local health improvement programme priorities, is manageable, well integrated with continuing professional development and education, and is likely to produce early improvements in care or record-keeping.</td>
<td>• have outlined, for this year, a programme of work which reflects local health improvement programme priorities, is manageable, well integrated with continuing professional development and education, and is likely to produce early improvements in care or record-keeping.</td>
<td>• start to incorporate their HA's information management and technology local implementation strategy into their PCG's own information action plan.</td>
<td>• start to incorporate their HA's information management and technology local implementation strategy into their PCG's own information action plan.</td>
</tr>
</tbody>
</table>

**A PCG's organisational development subgroup had carried out assessments of risk in areas including finance, litigation, health and safety, supervision, hazardous substances and complaints procedures.**

**One PCG has set up two incentive schemes to run side by side:**
- prescription of prescribing savings, and
- payments based on quality criteria such as date ordered, notes, and audited register, evidence of altered behaviour as a result of audit, and adoption of clinical guidelines for certain referrals. This has been funded by exploiting practice prescribing budgets.

**A HA public health director has derived a PCG support framework to include for each PCG:**
- a prescribing adviser;
- a named health promotion advisor, and
- a generic team to give advice on health needs assessment, clinical governance and analysis of small area data.

**A NICE regional office set out a matrix showing what education and skills training PCGs need for strategic and service development, team development, clinical governance, finance, and information management. It distinguishes:**
- knowledge and awareness that can be provided by the HA or through local forums for PCG lead staff; and
- more specialist skills and competencies, where involvement of educational institutions in training is a 'prime contractor' field is desirable.

**One PCG had made early progress in clinical governance by:**
- setting up strategic and working level umbrella groups;
- establishing systematic assessment of current issues, complaints/adverse events, good practice/evidence based medicine, clinical risk management, data and appraisal in general practices and community health teams;
- meetings with practice leads to explain the clinical governance action plan;
- engaging a local market to liaison with leads and help with data collection and analysis; and
- securing agreement that shared and joint data should not be managed, is at to increase their influence on clinical practice.

**Despite inheriting a poor IT infrastructure, a PCG had:**
- established referral data for several months, which led to near improvement in data accuracy, and
- mapped IT software and hardware and used across its GP practices.
4. Conclusion

25. Getting PCGs started on 1 April 1999 involved HAs and shadow PCGs in a great deal of organisational work. A huge agenda lies ahead: not just in the range of topics to be addressed, but in the need for professionals and managers to work together in new ways. PCGs differ widely in their size, their previous experience, and in the local circumstances to which they have to adapt. This paper has provided a snapshot of these organisations as they move from setting up structures and processes, and begin to exert influence on the provision of care for local people. Many questions are as yet unanswered about problem-solving and best practice; but there is also ample potential for them to bring about change for the better (Box C).

Box C

The Audit Commission’s role in helping PCGs fulfil their potential

The Commission plans a further sample survey of PCGs’ management arrangements and follow-up work later this summer to complement the evaluation of the PCG initiative commissioned from the National Primary Care Research and Development Centre and the King’s Fund by the NHS Executive. A second publication and associated events will follow early next year.

The Commission will also undertake ongoing research into Local Health Groups (LHGs) in Wales. A paper recognising their distinct approach to the agenda addressed by PCGs, but drawing parallels with lessons from developments in England where relevant, will follow at an appropriate time.

The Commission’s local auditors will also be examining the adequacy of PCGs’ financial controls and, more broadly, ensuring that good practice is shared and pitfalls avoided. In some cases they are setting up PCG board workshops to cover probity and governance issues.
References


This paper provides a snapshot of primary care groups (PCGs) just before they started work, highlighting some of the key differences between them – such as size, local characteristics, members' experience, and the groups' initial responsibilities. This comparative approach will help those involved to understand where they stand in relation to other groups. The paper also highlights key actions for both health authorities (HAs) and PCGs to provide a secure organisational foundation for future progress on PCGs' core health-related functions.

Most of the information comes from a survey of HAs carried out in February and March 1999, to which 91 of the 100 English HAs responded. A small number of HAs and PCGs were visited around this time to discuss issues in more depth.

The paper is particularly aimed at those who are directly involved with PCGs: managers and professionals in primary care, HAs, social services and NHS trusts.

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