On 1 April 1999, 481 primary care groups (PCGs) covering England assumed widespread responsibilities with delegated budgets totalling £19 billion.

- promoting health in their local areas
- commissioning many hospital and community health services
- developing primary healthcare

In their first few months, many PCGs have made progress towards key aims of ‘The New NHS’ White Paper...

- contributing local evidence to health planning
- gathering data to plan primary care investment
- co-ordinating services
- employing pharmacists to help GPs to make more efficient use of drugs
- setting up programmes of inter-practice audit and learning
- agreeing targets and making board decisions in public

...but most PCGs have limited staff and face barriers to success.

- time pressures on both the organisation and key individuals
- restricted funds to carry out key developments

- poor data, information technology and communications facilities
- mixed attitudes and lack of involvement of some GPs
- conflicts between local initiatives and central targets

PCGs/primary care trusts (PCTs) now need to engage more with their stakeholders and local communities, demonstrate public accountability and find ways to make best use of their limited resources...

- involving patients, carers and the public more meaningfully in decision-making

- collaborating to make efficient use of staff and support
- developing systems to ensure the probity and cost-effectiveness of their services
- agreeing measurable milestones against which to monitor PCG achievements

...but will need support from health authorities.

- to give them scope to pursue local as well as national priorities
- to release resources to reward practices that achieve clinical governance targets and make economical use of resources

Nearly one-half of PCG boards have already resolved to seek more independence by becoming PCTs and providing community health services...

- enabling further local integration and rationalisation of primary, community and social care
- increasing staffing flexibility

...and one in three PCGs is actively considering mergers to increase its administrative resources and commissioning influence.
1. PCGs in ‘The New NHS’

This is the second Audit Commission publication to track the development of primary care groups (PCGs). The first, PCGs: An Early View, was published shortly after PCGs were formed. The present briefing is based on a survey that was completed by a representative sample of one in eight PCG chief executives between July and September 1999, and on interviews with PCG board members and staff elsewhere. A full report is available on the Audit Commission website, or a photocopy by post (telephone 020 7396 1494).

This briefing will be of interest to PCG board members, to those in health authorities that support PCG development, and to a broader readership with an interest in the successful implementation of ‘The New NHS’ reforms.

It does not examine the important issues of regularity that could arise as PCGs and primary care trusts take on greater budgetary responsibilities and freedoms. Nor does it cover local health groups in Wales, which will be the subject of a later publication.

1. Primary care groups (PCGs) were formed on 1 April 1999 with delegated responsibilities in their first year for budgets totalling some £19 billion. They bring together all local general practices and community nurses under a board with social services, health authority and lay representation, to:
   - promote the health of the local population;
   - commission hospital and community-based health services; and
   - develop primary healthcare.

2. It is still early days to examine PCG achievement. The study found considerable variation. Nevertheless, most are making some progress towards the aims set out in ‘The New NHS’ White Paper to modernise the NHS and improve patient services [EXHIBIT 1].

Fair access to healthcare services

PCGs are becoming more optimistic about their ability to influence local healthcare planning … but face difficulties in assessing local needs.

3. PCGs contribute to co-ordinated planning of local services through their input to:
   - the health improvement programme (HImP) that is prepared by the health authority (HA) as a framework for local plans; and
   - HA-wide planning and co-ordinating groups, and other health-related programmes.

4. Most shadow PCGs had little involvement with the first HImPs. GP awareness was minimal. PCGs also lacked the capacity to implement HImP plans. The PCGs surveyed were evenly divided on the extent to which their evidence and priorities will influence future HImPs. An increasing number of national targets could squeeze out local priorities. But later survey respondents and the 60 per cent of PCGs that have formed HImP subcommittees were the most likely to be optimistic.

5. If they are to ensure that local healthcare needs are reflected in HImPs as well as national and HA priorities, PCGs will need to involve as many practices and stakeholders as possible in developing their contribution to the HImP. HAs should ensure that:
   - local public health and census data are available on PCG boundaries – one in three PCGs cannot obtain these at present;
   - PCGs have the requisite public health and analytic support to collect and process local views and data – many lack this at present; and
   - the HImP leaves scope for local initiative, clinicians’ views, user perspectives and analytical resources.

6. Improved equity of healthcare will also require PCG action to develop primary care and commissioned services.
EXHIBIT 1
How PCGs/PCTs contribute to ‘The New NHS’

<table>
<thead>
<tr>
<th>The six principles of ‘The New NHS’ white paper...</th>
<th>...are echoed in section 1 of this paper</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guarantee FAIR ACCESS to consistently high quality, prompt and accessible services right across the country</td>
<td>PCG input Health Improvement Programme Action plans Co-ordination between PCGs</td>
</tr>
<tr>
<td>Make the delivery of healthcare a matter of LOCAL RESPONSIBILITY</td>
<td>Commissioned care Investment plans Primary care development Practice based services</td>
</tr>
<tr>
<td>Get the NHS to work in PARTNERSHIP breaking down organisational barriers and forging stronger links with local authorities</td>
<td>Co-ordinated deployment of skills Involving other organisations and professions Joint working</td>
</tr>
<tr>
<td>Drive EFFICIENCY through a more rigorous approach to performance and by cutting bureaucracy</td>
<td>Helping practices to control prescribing costs Improving performance Incentives Cost-effective administration</td>
</tr>
<tr>
<td>Shift the focus on to QUALITY of care so that excellence is guaranteed and quality becomes the driving force for decision-making</td>
<td>Clinical Governance Developing skills</td>
</tr>
<tr>
<td>A PUBLIC SERVICE accountable to patients, open to the public and shaped by their views</td>
<td>Involving the public Public scrutiny Accountability framework</td>
</tr>
</tbody>
</table>

Source: Audit Commission
Local responsibility for healthcare delivery

Many PCGs are making progress in developing local healthcare, but most are constrained by resources and poor information.

7. Key roles of PCGs are to ensure that healthcare delivery is responsive to local needs and priorities, and to address areas of historically poor provision through primary care investment and services commissioned from NHS trusts.

8. Primary care investment: Most PCGs have made a good start in collecting information about their practices. Two out of five PCGs surveyed had agreed a methodology for prioritising bids for new investment by practices and most others were discussing one. But one in three could not finalise decisions because they did not yet know their total 1999/2000 budget for primary care investment.

9. Nationally, PCGs’ foremost priorities for primary care investment were information management and technology and expansion of prescribing support. Other priorities frequently mentioned were premises, nursing staff and staff development. Some PCGs would use Personal Medical Services (PMS) pilot schemes [BOX A] to create facilities shared by clusters of small practices.

10. Many neighbouring former GP-fundholding practices have developed very different in-house services. Although these are often liked by patients, there is little evidence to prove which are cost-effective. Many PCGs question the affordability of levelling-up services. Two out of five PCGs thought that it might be necessary to discontinue funding some practice based services this year. Securing board agreement has sometimes proved difficult. And only one-quarter of PCGs have yet decided how to broaden access to any existing practice based services.

11. Commissioned services: PCGs, with provider trusts, will need to find innovative ways to improve the scope and delivery of commissioned services within available funds, and must also monitor services to ensure that they meet requisite standards.

12. To do this, PCGs will need:
   - more timely and accurate data – its absence is a pervasive concern of many PCGs;
   - greater involvement of clinicians in reviewing and monitoring services – one in five PCGs had not yet involved clinicians in any service review meetings; and
   - collaboration with other PCGs and trusts to solve problems and manage financial risks.

BOX A

Personal Medical Services (PMS) schemes

Some PCGs see great potential in PMS schemes, which allow GPs to work outside standard terms of service and the appointment of specialist nurses to work with a number of practices. Such schemes can facilitate flexible working patterns, improve access to services, provide specialist skills and cover while single-handed GPs are on courses or leave. Salaried GPs may be employed in disadvantaged areas to which it is difficult to attract doctors. Nurse-led schemes may relieve doctors of practice administration.

Some potential PCTs intend that all practices become part of PMS schemes. This would help a PCT to discharge its clinical governance responsibilities. Others suggest that PCG-wide PMS schemes would help to avoid the ‘patchwork quilt’ of practices subject to differing conditions of service that existed with fundholding.
Partnership
Possibilities for greater partnership working are the most popular features of PCGs, but progress in some areas has been slowed by boundary differences between PCGs and local authorities.

13. PCGs were designed to ensure that care can be focused on the needs of patients without unnecessary hindrance from budgetary or organisational constraints:
- many PCGs are promoting reorganisation of community care and social services around practices or clusters of practices;
- some have agreed common evidence-based treatment protocols across practice and community nursing;
- others are developing cover arrangements to allow all nurses to attend courses and to maintain services when nurses are on leave; and
- one in five PCGs has developed a database of nursing skills by practice to ensure equity of cover and to help to identify development needs.

14. Some PCGs are partially funding carer support schemes. PCGs also provide a new focus for joint health promotion activity that supports local priorities and the HImP: for example, healthy living centres, coronary heart disease rehabilitation programmes, work with schools on drug misuse, teenage pregnancy and smoking. They are also well placed to ensure that the outcomes and cost-effectiveness of such schemes are kept under review. One in four PCGs surveyed is in discussion with a local authority about projects with pooled budgets. But, in some areas, new relationships with local authorities have got off to a slower start because potential partners do not share the same borders.

15. Collaborative working may itself improve the efficiency and quality of healthcare, but PCGs must also keep administrative costs to a minimum and encourage practices to be economical.

Efficiency
Most PCGs are lean organisations, but there is considerable variation in both PCG management costs and in help for practices to improve their efficiency.

16. Cost-effective administration: It is too early to assess the overall effect of PCGs on health service management costs. A full evaluation should consider the additional administrative burden on practices and clinicians as well as the costs of PCG staff and HA support.

17. The survey confirmed wide differences in PCG management budgets: from £119,000 to £1.28 million, or between £1.54 to £5.57 per resident. The majority of PCGs are likely to remain lean organisations that are reliant on stakeholders and others to formulate and deliver many of their plans. The difficulties that this causes, and ways in which some PCGs believe that they can be overcome are discussed later in this briefing (paragraph 36 onwards). However, it would be a false economy to deny PCGs sufficient skills and resources to manage delegated responsibilities effectively or to promote rational, cost-effective practice procedures.

18. The ‘average’ PCG spends over one-third of this budget on its chair, board and other clinicians’ remuneration and allowances. Small PCGs, in particular, have very limited funds for staffing once board costs have been met. The number of (whole-time equivalent) managers, staff and advisers to be employed by responding PCGs by March 2000 varied from 1 to 30, with an average of 4.4, of which 3 were in post at the time of the survey [EXHIBIT 2, overleaf]. Staffing largely reflects the populations of each PCG, but significant variation remains that can be justified only partially, if at all, by differences in responsibilities.

19. Helping practices to control costs: Prescribing costs represent only 15 per cent of total PCG expenditure, but their control is key for all PCGs. Most have nominated clinicians with specific responsibility for leading on prescribing issues and nine out of ten have a prescribing or drugs subcommittee.
There are major cost pressures on prescribing: from novel drugs, rising demand, and new emphases on disease prevention. Recent increases in the prices of some generic drugs are posing a major problem for PCGs. But there is still significant scope for cost savings: by substituting cheaper but equally effective drugs and by reducing inappropriate prescribing. Sustained GP effort will be required to make these changes. Substantial economies, in particular, may be difficult to achieve without additional support. Four-fifths of PCGs already have a dedicated pharmaceutical adviser. However, their availability to the PCG varied from just 4 to 70 hours per week [EXHIBIT 3].

In selecting changes to be prioritised, the PCG should take into account strength of evidence, workload implications and the probability that any savings would be long-term. Strategies must be co-ordinated between clinical governance and prescribing leads; cost pressures must not dominate the prescribing agenda. PCGs also need to agree how their pharmacists can best, at present, support PCG budgetary and clinical governance objectives. As well as providing practical support to practices in implementing change, most PCG pharmacists will be involved in budget-setting and monitoring prescribing spend, and will attend review meetings with practices. However, many will also run face-to-face medication review clinics. These are valuable for individual patients but, because they are so time-consuming, unlikely to make as much short-term impact on expenditure as review of medication records.

Hospital prescribing remains a major influence on drug expenditure in general practice. Some PCG prescribing leads have negotiated with local hospital consultants more cost-effective prescribing on discharge [BOX B]. Also, most area prescribing committees have reviewed their membership to ensure that each local PCG is represented.
Practice incentives: Nine out of ten PCGs will run a prescribing incentive scheme this year. Many will require practices to meet generic prescribing targets, audit repeat prescribing systems, adopt a formulary or clinical protocols, or participate in inter-practice audits to qualify for incentive payments, as well as making savings on indicative prescribing budgets. In the longer term, incentives may reflect a wider range of PCG objectives. Two in five PCGs may introduce practice incentive payments based on the attainment of clinical governance goals. Almost as many would consider schemes based on practice savings on indicative referral budgets or practice running costs. It is important that incentives reward practice that meets high standards of quality as well as economy.

Source: Audit Commission survey

23. **Pharmaceutical advice for PCGs**

The amount of pharmaceutical support available to PCGs varies considerably.

**EXHIBIT 3**

The amount of pharmaceutical support available to PCGs varies considerably.

**Hours per week of dedicated pharmaceutical support**

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**BOX B**

**Reducing expenditure consequences of hospital prescribing decisions for PCGs**

PCG prescribing leads in West Surrey have jointly negotiated with some local hospital consultants that the expensive once-a-day ‘modified release’ form of a certain heart drug will be prescribed to patients on discharge from hospital only if there are specific clinical reasons. If uniformly adopted, this policy could save up to £250,000 per year for PCGs across the HA. It has taken a co-ordinated approach by primary care clinicians to secure agreement on this policy.
Most PCGs have made an enthusiastic start on clinical governance, but have a long way to go.

PCGs are uniquely placed to break down professional isolation in primary care, develop and spread good practice, and span the interface with secondary care and social services.

Clinical governance: PCGs plan to spend an average of £20,000 on clinical governance this year, but there is considerable variation: between £5,000 and £200,000, (or between £150 and £9,450 per practice). Contrary to NHSE guidance, many PCGs expect to have to draw on their management budgets to fund some of this activity. Most PCGs have both nurse and GP clinical governance leads and, in three-quarters of PCGs surveyed, all or most practices also have their own clinical governance leads. Three out of four PCGs felt able to call upon day-to-day public health support for clinical governance; a similar proportion were supported by a medical audit advisory group. Other sources of support included education purchasing consortia, academic and industry-funded bodies. However, almost one in ten PCGs said that they had no regular support.

Clinical audit is a key element of clinical governance. It should cover nursing as well as medical issues, total packages of care, as well as treatment of specific conditions. Seven out of ten PCGs confirmed that this year’s plans included inter-practice audit of treatment and/or referral for one or more of the conditions prioritised in their HImP [EXHIBIT 4]; various heart conditions and diabetes were the most frequently mentioned. However, only one in three would develop standard protocols for any interventions carried out by both community and practice nurses. One in eight would prioritise audit of services received by a group of patients – for example, rehabilitation for the elderly. Less than one in four PCGs had yet agreed to share clinical audit data showing named practices. A small minority of GPs would not share data even if their practices could not be identified; this is unacceptable.

PCGs cannot tell GPs what to do; only advise, educate, and apply peer pressure. Clinical governance leads who were interviewed planned to offer additional resources to help practices to collect key data, conduct audits, and rectify organisational problems. But it is not clear how PCGs will afford this. At some point, too, PCGs will need to tackle the small number of ‘problem practices’ that remain despite this assistance. It has been difficult to prove unacceptable performance in the past. Although PCG lead clinicians are better placed to exert peer pressure, this is likely to remain one of their greatest challenges.

### EXHIBIT 4

**PCGs’ 1999/2000 clinical governance programmes**

Seventy per cent will audit HImP priorities and improve data quality.

Source: Audit Commission survey
28. **Education and development:** Nearly all PCGs surveyed plan to appoint education and training leads; seven out of ten had done so. Some are promoting mentorship or accreditation for both practice administration and clinical practice. PCGs need to audit the skills and training needs of primary care and PCG staff, and agree a development plan as a basis for creating individual training plans. As yet only a minority have made much progress [EXHIBIT 5]. Also, only one in four PCGs is separately represented on its local education purchasing consortium.

### A public service

**PCGs should do more to involve the public.**

29. **Accountability:** PCGs, as public bodies, must be able to demonstrate probity and accountability for their own corporate actions and those of their individual members.

30. Each PCG works to an accountability agreement and targets that are negotiated annually with their HAs. But, in many areas of PCG responsibility, its staff cannot deliver change without the willing participation of independent contractors. PCG management can only be held to account for the vigour, subtlety and inventiveness with which it goes about securing co-operation with its policies. For the PCG’s GPs and other stakeholders, involvement in compiling and agreeing primary care targets could influence change more than the completed accountability document.

31. Targets should be agreed as early as possible in the year. Only one-third of the PCGs surveyed in July/August 1999 had finalised 1999/2000 annual accountability agreements. Measurable targets were most likely in the areas of prescribing and clinical governance [EXHIBIT 6, overleaf]. However, one in five PCGs with agreements had no measurable targets.

32. As PCGs develop and PCTs are formed, targets are likely to focus less on processes and more on outputs. The mix should reflect the organisational maturity of the PCG. Agreements should include a realistic number of measurable targets that reflect key organisational developments and a balance of HImP priorities. These may be milestones within an ongoing development programme. But each PCG should retain some discretion over how its targets are delivered. Most HAs continue to support their PCGs with information, expertise, and developmental activity. Essential HA support should also be the subject of service level agreements – which are rare at present.
Open to public scrutiny: PCGs need to present a competent, professional face and demonstrate balanced, open consideration of all interests. Nine out of ten PCGs permit public attendance for part of each main board meeting, the majority monthly. But open board meetings, by themselves, are not necessarily the best way to inform and involve the public. Most attract only two or three observers. Some PCGs permit no public contribution. There need to be alternative, well-publicised ways for people to question board members and to put forward views.

Consulting and involving the public and voluntary bodies: To deliver their service development agenda, PCGs must enlist the support of patients, carers and the broader public. Although a majority of PCGs have co-opted a Community Health Council (CHC) representative to their boards, wider public involvement has been limited. For example, 70 per cent of PCGs consulted their CHC on their primary care investment plans and 42 per cent asked established patient groups. But usually comments were requested on plans already made; only 18 per cent of PCGs sought fresh suggestions from patient groups on how services could be improved.

EXHIBIT 6
PCG accountability targets

Most agreements included targets for prescribing and clinical governance. However, almost one in four had no specific (hard) targets.

Source: Audit Commission survey

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improved. Each PCG should have a strategy for communicating with stakeholders and the public. Consultation is neither cheap nor straightforward, but PCGs need to do more in future, perhaps in collaboration with individual practices or other authorities. The Audit Commission management paper, *Listen Up!: Effective Community Consultation*, suggests best practice.

### BOX C

**PCG board meetings – examples**

<table>
<thead>
<tr>
<th>PCG A</th>
<th>THE IDEAL?</th>
<th>PCG B</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Quarterly meetings held in the afternoon. No information available in local central library or from local newspapers.</td>
<td>• Dates and locations of public meetings displayed in practices, clinics, local libraries and advertised in local newspapers, with an indication of the main issues to be discussed and information on how to obtain copies of papers. At least some evening meetings. An accessible public venue of suitable size.</td>
<td>• Monthly public board meetings. Friendly atmosphere. Informal setting and conduct of meeting.</td>
</tr>
<tr>
<td>• No papers available for observers at the meeting or information on how to obtain them in advance.</td>
<td>• Copies of papers available at the meeting with brief explanation of common jargon and a form to request minutes.</td>
<td>• Copies of agenda and papers provided for observers.</td>
</tr>
<tr>
<td>• No nameplates or introduction of board members. PCG chief executive absent (on a course).</td>
<td>• Nameplates, stating affiliation if any.</td>
<td>• Board members had nameplates, but without job titles.</td>
</tr>
<tr>
<td>• HA suggested a financial fait accompli – no PCG budgetary freedom or discretion on timing.</td>
<td>• Each topic ‘sponsored’ or introduced by a nominated board member.</td>
<td>• Relaxed but well paced. Somewhat bland discussion. Few resolutions passed.</td>
</tr>
<tr>
<td>• Discussion dominated by three GPs. Little or no involvement of nurse, lay member, social services.</td>
<td>• Chair ensures well-paced but balanced discussions resulting in either firm decisions or a working group remit.</td>
<td>• Input mainly from GPs but everyone had ample opportunity to express an opinion.</td>
</tr>
<tr>
<td>• No date agreed for next meeting.</td>
<td>• Observers have opportunity for informal discussion with board members at the end of meetings and to express interest in topics.</td>
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<tr>
<td></td>
<td>• Rapid communication of board decisions to practices and other stakeholders.</td>
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*Source: Audit Commission*
2. Maximising benefits of PCG status

Many PCGs will wish to consolidate before moving on to consider merging with neighbouring PCGs, or applying for trust status.

35. Responses to the Commission’s survey identified five main barriers to the success of PCGs:
- time pressures;
- funding constraints;
- poor information technology and communication facilities;
- the attitudes of some general practices; and
- conflicts between local initiative and central prescription.

36. Overcoming time pressures: A majority of PCG chief executives commented that, due to the pace of PCG development, there had been insufficient time to develop board capacity, or to involve clinicians and other stakeholders.

37. Most PCGs have a very small administrative staff. Respondents believed that work levels for key individuals are unsustainable. There is a danger that paperwork will leave little time for PCG development. HAs must pace their own reorganisations to reflect changing responsibilities, and release commensurate shares of total permitted management costs.

38. There are even greater time constraints on clinicians’ involvement in PCG matters. Concern was expressed about ‘burn out’ of those most heavily involved due to lack of support. PCGs must ensure that they use the time of clinicians who serve on PCG committees effectively and that all board members have clear lead responsibilities.

39. PCGs can make a virtue of remaining compact organisations by devolving planning and development work. Drawing practices and other stakeholders into project groups and subcommittees could improve local ownership of problems and plans. It will often be better to develop practice manager roles, or pay an individual practice manager to gather information or complete a particular aspect of a plan, than to take on additional PCG staff.

40. Some PCG initiatives, too, could be developed in collaboration with other organisations or neighbouring PCGs. It may be better to share specialist expertise, or to buy it in from a community trust. PCGs should also try to involve other local bodies, such as further educational establishments, that have shared interests and objectives and may be willing to offer their expertise for little or no cost. One survey respondent commented, ‘when work is required, our first instinct is not to take on staff, but to identify partners with whom to work. The result is that much of the PCG agenda is being delivered by staff from the local community trust, voluntary organisations, college of further education, and others, because it is consistent with their own objectives’.

41. Living within funding constraints: The most commonly mentioned barrier to success was the inadequacy of PCG budgets to deliver the agenda; for example, funds for developing the practice information needed for clinical governance were insufficient. PCG development, some said, was inhibited by the overall financial deficit position of their HA. However, some PCGs are successfully limiting prescribing expenditure and hospital referrals [CASE STUDY, page 18].

42. Improving data, IT and communications: Poor data and inadequate communications facilities affect all areas of PCG development. Seven out of ten PCGs have set up subcommittees to develop information management and technology (IM&T). Some are represented on a wider HA IM&T strategy group. A number of PCGs have given priority to IM&T in their clinical governance development programmes, a few setting up demonstration sites. Over one-half of those surveyed named it as a top primary care development priority.
Winning over general practices:
A majority of PCGs perceive their GPs to be supportive. However, poor communication between practices and with the PCG can also affect GP attitudes and involvement. A number of PCG chief executives expressed concerns about the suspicion of GPs, their lack of involvement or vision, and the scale of cultural change required. Some saw ‘practice culture’, the independent contractor status of GPs and inflexibility in the deployment of support staff as significant hurdles.

Stakeholder support and involvement can be further increased by:
- consulting and involving all practices and their staff in working groups or informal discussion workshops;
- a grass roots approach to decision-making;
- setting up a patch-and-cluster model of practice organisation and support – PCGs with area subgroups were the most likely to report supportive practices;
- developing good communication through information and news-sheets;
- spending time developing PCG values, principles and methods of working;
- establishing a constructive, supportive ethos for practices; and
- developing a corporate approach to a wide range of services.

Professional forums, too, have a vital role in collecting and disseminating information and good practice. Seven out of ten PCGs have their own nurse forums; about half of the rest have joint nurse forums that cover the whole HA. Almost as many have PCG specific meetings for practice managers, and one-third of PCGs have set up forums for their own GPs. Attendance at forums needs to be encouraged by providing appropriate cover.

Reconciling local initiative and central prescription: PCGs perceive it to be vital that their policies and priorities are locally ‘owned’. HAs have wider preoccupations and must meet national targets. It is not surprising, therefore, that the second most pervasive theme in survey responses centred on PCGs’ perceptions of HA inertia, unwillingness to ‘let go’ and preoccupation with waiting lists. Although a majority of PCGs found their HA supportive, a substantial minority was more critical [EXHIBIT 7, overleaf]. Three out of ten considered their HA to be ‘dictatorial’. Surprisingly, PCGs whose chief officers regularly attended HA senior management team meetings were, on average, no better disposed towards their HAs than others! This may reflect the quality of their involvement in HA management.

Each HA must ensure that its own organisation changes in parallel with the progressive transfer of responsibilities to PCGs. But HAs will nevertheless need to retain a balanced perspective over the entire healthcare spectrum, with continued access to primary care expertise to inform strategy and PCG accountability arrangements.
EXHIBIT 7
How PCGs view their HA

Although a majority found their HA supportive, a minority were more critical.

Note: Percentages do not add up to 100 per cent as some survey respondents ascribed more than one characteristic to their HA.

Source: Audit Commission survey
3. Trust applications and mergers

48. Some PCGs will progress to become free-standing primary care trusts (PCTs). Subject to consultation, a first wave of 17 PCTs will be established in April 2000 and up to 44 more in October 2000. Most of these early PCTs will provide some community health services as well as commission services from other trusts.

49. Numbers of PCTs are likely to grow quickly. Most PCG boards have discussed the issue, and almost one-half of those surveyed had resolved to work actively to become a PCT within the next three years [EXHIBIT 8]. Only one in ten PCGs had definitely decided not to seek trust status in the foreseeable future.

50. PCT status brings added freedoms and opportunities to develop integrated services that are responsive to patient needs, but at the expense of greater risks and uncertainties. Decisions should not be driven solely by a desire to ‘escape from a HA’s clutches’ (the consideration most frequently quoted by surveyed PCGs), nor by dissatisfaction with current community trust services, local trust mergers or financial difficulties.

51. The most common, positive reason given for seeking trust status was the opportunity for further local service integration and greater flexibility in community care development. Some viewed a trust application as the natural consequence of having a strong community spirit, proactive GPs and a desire to develop community hospitals. Others saw benefits in direct funding. There could be better opportunities to develop primary care, with speedier implementation of plans, and fuller control over the local health economy. And preparing for PCT status could increase GP commitment.

52. The perceived disadvantages of trust status included loss of GP control and involvement, with a dilution of professional input to the board. Some saw threats to GPs’ independent contractor status, or believed that preparing for trust status could distract from the large primary care development agenda. There were concerns about the ability to prepare PCT applications within management cost allowances, and additional risk.

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**EXHIBIT 8**

PCG boards’ conclusions on trust status

Almost one-half of PCGs have resolved to work actively towards trust status.

<table>
<thead>
<tr>
<th>Percentage of responding PCGs</th>
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<tbody>
<tr>
<td><strong>50%</strong></td>
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<tr>
<td><strong>40%</strong></td>
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<td><strong>30%</strong></td>
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<td><strong>10%</strong></td>
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<td><strong>0%</strong></td>
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</tbody>
</table>

Source: Audit Commission survey
Almost one-half of respondents definitely wished to take over some community health services if they became a PCT, and most others might possibly do so. Of these prospective ‘level 4’ trusts, almost one-half envisaged a merger with a community health trust and one-quarter that the PCT would provide such services afresh. One-third might also take over services that are currently provided by a mental health or acute trust.

Prospective PCTs will need:
- a realistic view of the pros and cons of trust status, including potential benefits for patients and service efficiency;
- a strategy for communicating these considerations;
- systems or agency arrangements for managing premises, payroll, supplies, IT, accounting, budgets and risk;
- systems to ensure the probity and cost-effectiveness of such in-house services; and
- human resource plans, including provision for appropriate training and development.

Merger: One in eight surveyed PCGs will merge with neighbouring groups within the next few years, and over one-half thought it a possibility. One in three PCGs has already started discussions. Mergers could bring the budgetary stability, commissioning leverage and management capability that are considered necessary in order to become a PCT. Less than one in five PCGs had ruled out a future merger, despite worries that it could be divisive and distract from implementing primary care improvements. If the envisaged mergers occur, the average population of a PCG would rise from 107,000 to 157,000. And the proportion of PCGs with a population under 75,000 would fall from one-quarter to one in ten.

Transition to PCT status could also involve a merger with part or all of an existing NHS trust. Advantages could include:
- better integration of community and practice nurse workload, services, resources, skills, protocols, audit, etc;
- less disruption of existing services; and
- a ready-made management capacity for progression to PCT status (and an increase in permitted management costs).

But there could also be disadvantages:
- inherited financial difficulties or dissatisfaction with trust management;
- delays due to prolonged public debate;
- disparate cultures, conditions and uncertainty about the future;
- inheriting a possibly lacklustre trust management, simply because it is cheaper and quicker than starting afresh; and
- distraction from core PCT objectives if managing a directly employed workforce.

There is no national policy about whether, or when, PCGs should become trusts. However, it would be appropriate for HAs to influence the timing of these decisions in places where PCT applications could affect the viability of trusts that are currently providing community health services. Prospective PCTs should hold early discussions with all who might be affected. Although one prospective first wave PCT that was studied has been working closely with the local combined NHS trust, only two of the potential ‘level 4’ PCTs surveyed had held discussions with the current service-providers.
4. In conclusion

59. It is too early to judge PCG effectiveness. A few have made demonstrable progress. Others still appear to be struggling to establish themselves. The majority of NHS users remain barely aware of the existence of PCGs. It remains to be seen whether the present diversity of PCG/PCT structures and aspirations can continue indefinitely and, if so, whether this perpetuates inequity of patient care.

60. The Audit Commission and its appointed local auditors will continue to monitor the development of PCGs and PCTs with particular regard to probity, efficiency and the adequacy of their management arrangements, systems and controls.
CASE STUDY

N E Lincolnshire PCG covers a population of around 170,000 and is coterminous with a unitary local authority and a combined NHS trust. It has a history of locality commissioning and both primary and community care are organised in six primary healthcare teams (PHCTs). But it also has a high proportion of single-handed GPs, some based in less than ideal premises, and an ageing GP and nursing workforce. The area has an above-average number of hospital referrals and the PCG inherited a budget deficit on commissioned care and unacceptable waiting lists for some specialties.

The PCG has had some success in beginning to tackle budget and waiting list problems. It was 5 per cent below budget in September 1999.

Indicative referral levels supported by referral guidelines have been set for each of the PHCTs that cover clusters of practices and, by them, for individual practices. Focusing attention on the problem has had a noticeable impact.

A Primary Care Surgery Initiative, kick-started with waiting list monies as well as PCG funds, provides GPs with an alternative to a hospital referral. If doctors are in doubt, they can refer patients to another GP for an opinion instead of directly to a consultant. Some GPs have been accredited to undertake certain procedures locally on behalf of colleagues in other practices. The initiative fits with local GPs’ own views on how they wish PHCTs to develop. GP acceptance has been fostered by offering training to all those who wish to develop a specialism. A PCG survey showed that patients also liked the scheme. Overall, the initiative supported 650 first attendances and procedures in its first year, resulting in a substantial cost saving.

Referral data have been improved to give better information about waiting lists and potential trust activity. Trust data are now validated by practices against their own referral records and returned to the PCG.

The initiative has demonstrated that indicative referral levels are effective, provided that they are followed through with audit, help and practical alternatives. The scheme has also helped practices to get used to the idea of sharing specific skills (for example, a mental health nurse) within PHCTs. And it has shown that, unlike previous clinical audit, clinical governance can bring about direct changes to practice and provision of care.

The PCG has applied to become a first wave, level 4 PCT in April 2000.

PCT status will facilitate the development of flexible packages to attract doctors and nurses to more deprived parts of the area:

- salaried GPs with specific skills to work across practices to further improve waiting times for certain outpatient procedures and reduce hospital referrals;
- opportunities for GPs to continue work after retirement on a part time basis;
- authority to pay GPs to research certain topics part time on behalf of the PCG; and
- an integrated practice and community nursing team using common procedures, that can be deployed flexibly to provide continuity of care as nurses retire.

Trust status will facilitate rationalisation of premises. One PHCT with mainly single-handed GPs wishes to rationalise from 12 sites into 3 health centres so as to improve facilities, support staff and cover. GPs could use PCT-employed practice staff on an agency basis. This would improve employment practices, training opportunities and skill-mix. In time, if practices agree, other practice nurses could become PCT employees.

PCT status will provide increased scope to develop and fund Partnership Action Programmes. To date, the PCG has agreed that a PCT would pick up joint funding of three carer schemes next year. It is setting up a working group to consider other schemes that are currently jointly funded by the HA, and to investigate opportunities for attracting more joint funding and making better use of it.
Checklist

Has your PCG...

**Primary care development**

1. ...set up a database of skills available to each practice (including attached staff), current services, facilities and computerisation?

2. ...projected future skill shortages and planned how these will be addressed?

3. ...agreed how to assess the cost-effectiveness of practice-based services, and widen access to them?

4. ...developed cover arrangements for practice nurses, to facilitate continuing education and continuity of patient care?

**Commissioned services**

5. ...involved clinicians in service review meetings?

6. ...investigated ways to improve the accuracy and timeliness of monitoring data?

7. ...started to develop primary care alternatives to secondary care referral for appropriate conditions, supported by referral protocols, training and audit?

**Partnership**

8. ...reviewed the scope for reorganising both community and social care around clusters of practices?

9. ...agreed evidence-based protocols common to practice and community nursing, and a programme of joint audits?

10. ...agreed how partnership enterprises will be evaluated?

**Economy**

11. ...supported practices with pharmaceutical advice and practical help in implementing prescribing changes?

12. ...agreed priorities for PCG prescribing advisers and for prescribing changes?

13. ...devised incentive schemes to reward care that is both high quality and economic, as part of an integrated package of clinical governance, audit, education, information and support?

**Quality**

14. ...ensured that all practices have their own clinical governance/quality leads?

15. ...negotiated sharing of clinical audit findings and data on a named practice basis?

16. ...agreed minimum acceptable standards for practice administration, facilities and key clinical areas and the approach to be taken with any ‘problem practices’?

17. ...assessed the skills and training needs of PCG, community nursing, and practice staff, and drawn up skills development and training plans?
Has your PCG...

**Accountability and public involvement**

18. ...agreed measurable targets/milestones for PCG/clinical developments (including some that can be included in the PCG’s accountability agreement with the health authority)?

19. ...developed a communications strategy?

20. ...planned how best to gather the views of stakeholders, service users and the local community on health needs and service options?

21. ...involved service users and local people in working groups?

**PCG management**

22. ...established shared PCG principles and values, a patch and cluster model of practice organisation, supported by good communication through news sheets, forums and meetings?

23. ...ensured that board members have clear lead responsibilities?

24. ...considered how to develop practice manager roles?

25. ...attempted to involve service users, and also other local bodies that may be willing to offer the PCG their resources and experience?

**Future development**

26. ...formed a clear view of the advantages and disadvantages of trust status in the local situation, including potential benefits for patients and service efficiency?

27. ...agreed how best to discuss options for the PCG’s future with stakeholders (including the public and any service providers) and with other PCGs that could be affected?

28. ...ensured that strategies, structures, protocols and procedures, and commissioning decisions are developed in parallel with those of neighbouring PCGs, where appropriate?

29. ...(potential PCTs) assessed the relative value for money of buying in services or providing them in-house?

30. ...(shadow PCTs) set up systems, or agency arrangements, to manage premises, payroll, supplies, IT, accounting, budgets and risk, and clinical governance support?