

# the **PCG** agenda

early progress of primary care  
groups in 'The New NHS'



AUDIT  
COMMISSION

Promoting the best use of public money

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## Preface

Primary care groups (PCGs) came into existence on 1 April 1999 with delegated responsibilities for budgets totalling some £19 billion this year. They bring together all local general practices and community nurses, 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.

This is the second Audit Commission publication tracking primary care group (PCG) development. The first paper, PCGs – *an early view*, was published shortly after PCGs were formed. This present report is based on a survey completed by a representative sample of one in eight (57) PCG chief executives between July and September 1999 and on interviews with PCG board members and staff elsewhere. It will be of interest to members of PCG/PCT boards, to those in HAs responsible for supporting PCG development, and to a broader readership with an interest in the successful implementation of 'The New NHS' reforms. A shorter briefing is also available.

It is early days to examine PCG progress. In their first few months, most PCGs appear to have made some progress in starting to tackle their part of the substantial agenda of change and development needed to implement the principles of 'The New NHS' white paper. However, there are many outstanding issues:

- *Time pressures* on both the organisation and key individuals: PCGs have an average of only four staff and most will continue to have a very small administrative staff. To manage the large agenda they will need to devolve some planning and decisions to practices. And they should co-operate with other PCGs and trusts, both to be effective purchasers and to make efficient use of administrative resources and the support available from health authorities.
- *Tight budgets*: Lack of funds is said to be inhibiting PCGs' primary care development plans. Resources are insufficient for levelling up current practice based services. And, because of recent unpredicted increases in the cost of prescribed medicines, few PCGs will be able to afford to make incentive payments this year to those GPs that meet clinical governance targets and make economical use of resources.
- *Poor information management and technology and inadequate communication facilities*: Deficiencies are causing problems in planning services, monitoring contracts and managing budgets as well as in providing patient care.
- *Lack of involvement and unhelpful attitudes of some GPs*: Refusal by practices to share even anonymous clinical audit data, although rare, is unacceptable. PCGs should aim for 'ownership' for their plans by GPs and nurses by devolving planning to clusters of practices wherever possible.
- *Conflicts between local initiative and central targets*: Health authorities should give PCGs scope to pursue local as well as national priorities, but ensure that they agree measurable targets and milestones.

A majority of PCG boards have already agreed to work actively towards primary care trust (PCT) status. In many cases, prior mergers with other PCGs were thought likely. A first wave of up to 17 free-standing PCTs will be formed in April 2000 and more in October 2000. Most PCTs will provide some community health services as well as commissioning services from other trusts. But few prospective PCTs had yet discussed this with the community health trusts that would be affected. And only a minority had a clear vision of specific benefits that PCT status would bring for patients.

Public awareness of PCGs is low. More needs to be done to increase public consultation and involvement in PCG decision making.

**An ongoing programme of work tracking the development of PCGs/PCTs and LHGs is being carried out by Ian Jones and Tonia Ghista from the Audit Commission's Public Services Research Directorate under the direction of Ian Seccombe. Clare Hazard and Samantha Jackson have provided analytical support. The study team is particularly grateful to the PCG chief executives who completed questionnaires, all those interviewed and all who have commented on draft questionnaires or reports, acknowledged in Appendix 1.**

## Introduction

1. In December 1997, the White Paper, *The New NHS* (Ref. 1) set out a vision for modernising the NHS in England to improve services for patients, founded on six key principles:<sup>1</sup>

- a national service providing fair access to services
- local responsibility for the delivery of healthcare
- partnership working
- efficiency
- a focus on quality of care
- a public service, accountable to patients and the public.

2. One of the key mechanisms for achieving this vision was the formation of primary care groups (PCGs) [BOX A]. These bring together all local general medical practitioners (GPs) and community nurses, under a board which also has social services, health authority (HA) and lay representation, to:

- promote the health of the local population in partnership with other agencies and contribute to a local health improvement programme (HIMP) forming the blueprint for action and investment in each area;
- commission stable hospital and community-based health services to meet patient needs equitably within the framework of the HIMP; and
- develop the quality of primary healthcare received by patients through investment, joint working, sharing skills and good practice, professional development, audit and other aspects of clinical governance.

3. In June 1999, the Audit Commission published the first of a planned series of publications on PCGs (Ref. 3). That first paper was based largely on a survey completed by HAs as PCGs prepared to 'go live', supplemented by interviews in a cross-section of authorities. It concluded that most PCGs would be small organisations with very limited budgets for management. Key challenges were identified, and examples given of how some PCGs were tackling each of them.

4. Since that first publication, many PCGs have made good progress in setting up their organisations, recruiting key staff and starting to tackle an enormous agenda of change and development. But all have many outstanding issues to address. A further report is therefore timely.

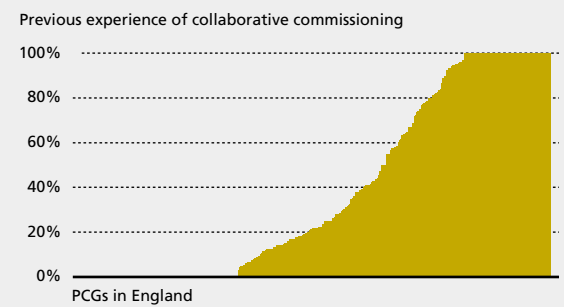
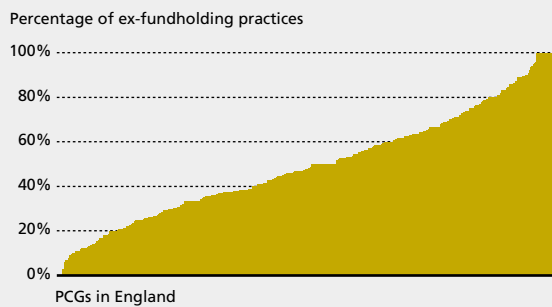
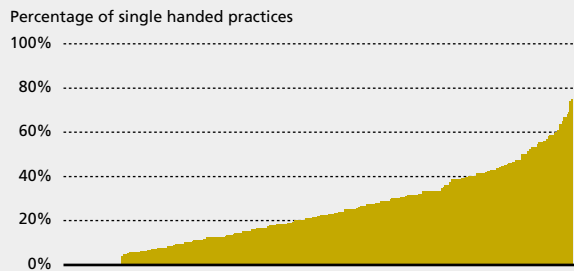
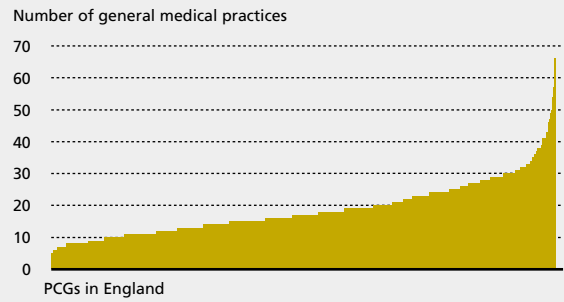
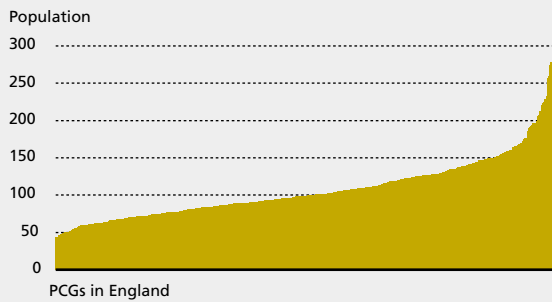
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<sup>1</sup> The NHS performance assessment framework (Ref. 2) subsequently presented indicators under six similar, but not quite corresponding headings: i. health improvement, ii. fair access, iii. effective delivery of healthcare, iv. efficiency, v. patient/carer experience, and iv. health outcomes of NHS care.

BOX A

PCG characteristics

- The 481 PCGs were launched on 1 April 1999 as subcommittees of HAs. At the same time, GP fundholding and a variety of other GP commissioning mechanisms were effectively abolished.
- PCGs could start either as 'level 1' bodies, which are mainly advisory, or as 'level 2', with substantial delegated responsibilities. Eighty three per cent of PCGs started at 'level 2'. Budgets totalling some £19 billion have been delegated to PCGs this year.
- PCGs differ greatly, most obviously in size, practice composition and previous experience of commissioning and collaboration.
- It is expected that some PCGs, probably a majority, will become free-standing 'level 3 or 4' PCTs. A first wave of up to 17 PCTs will be established in April 2000 and, subject to the outcome of consultation, up to 44 more in October 2000. Most of these will be 'level 4' PCTs, which means that they will provide some community health services as well as commissioning services from other trusts.



Source: Department of Health and Audit Commission survey (Spring 1999)

## About this report

5. In July 1999, the Commission conducted a sample survey of PCG chief executives, focusing on organisational development, early progress on key objectives, the resources available to them for this work and future plans (Appendix 3). The present report is based on data and comments from the 57 PCGs that responded to this survey, and from interviews with board members and staff of a number of other PCGs.
- Section 1 reviews the extent to which PCGs, working with their HAs and other partner organisations, are starting to progress the six key principles of the New NHS white paper<sup>2</sup> [EXHIBIT 1, overleaf].
  - Section 2 draws together concerns commonly raised by survey respondents and suggestions by other chief executives about how to tackle some of these problems. It then examines these PCGs' future intentions and, for those wishing to become PCTs, makes recommendations for a successful transition.
6. It is not the purpose of this report to examine the important issues of regularity that could arise as PCGs and PCTs take on greater budgetary responsibilities and freedoms.
7. This report will be of interest to PCG/PCT board members, to those in HAs responsible for supporting PCG development, and to a broader readership with an interest in the successful implementation of 'The New NHS' reforms.
8. It does not describe the situation in Wales, where the Commission conducted a separate survey of the 22 local health groups (LHGs) in December 1999. A publication on LHG development, contrasting the situations in Wales and England, is planned for June 2000. However, although LHGs differ from PCGs in several important respects, many of the issues they face are similar to those discussed in this report, so readers in Wales may also find it relevant.
9. Clearly it is still early days to examine PCG progress. And, as noted in the Commission's earlier publication, the pace of PCGs' initial development may be affected by a wide range of historical and structural factors. Nevertheless there are the beginnings of some welcome improvements to health-related services. But the wide variety of responses to the survey is also instructive.

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<sup>1</sup> In practice, any single PCG initiative may address more than one of those key principles.

EXHIBIT 1

Report Structure

The six principles of  
'The New NHS' white paper...

...are echoed in the flow of section 1 of this paper



# 1. PCG progress in bringing about 'The New NHS'

## i. Fair access

*... to consistently high quality, prompt and accessible services right across the country.*

10. Setting the strategic direction of healthcare remains the responsibility of HAs, working under the broad guidance of the NHS Executive. They have lead responsibility for drafting the Health Improvement Programme (HImP). This interprets national priorities in the context of local needs and priorities, providing the framework for local plans and action [EXHIBIT 2]. However PCGs also have a major role in promoting fair and equitable access to appropriate healthcare by contributing to the co-ordinated planning of local services. They do this through their input to:

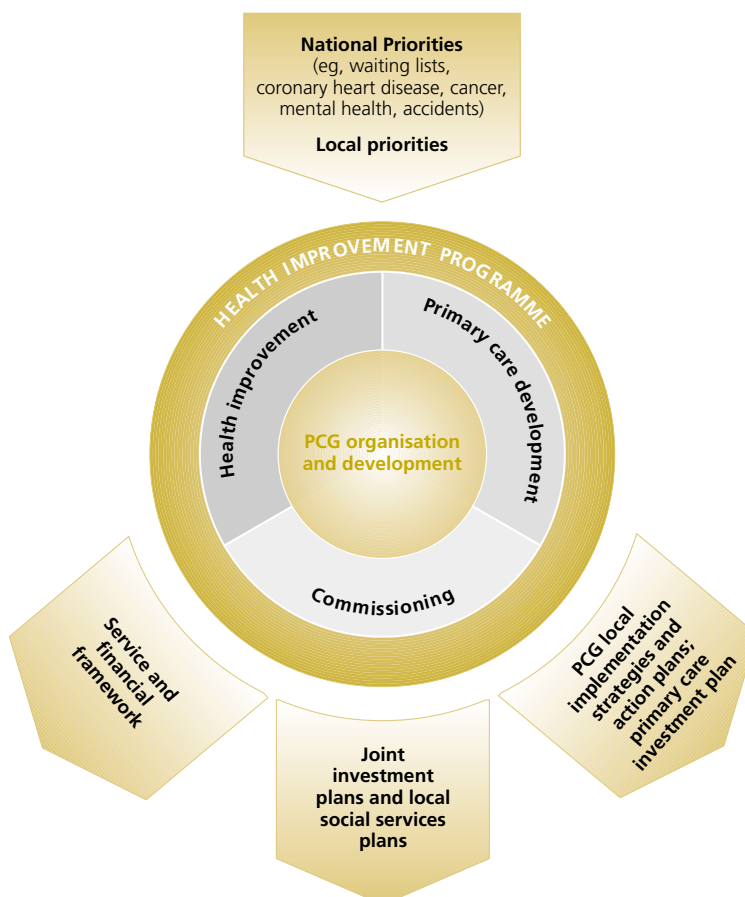
- the HImP, and the service strategies and action plans that flow from it; and
- HA-wide planning and co-ordinating groups, and other health related programmes such as health action zones (HAZs).

Issues of equitable access to primary care and commissioned services on a more local level are considered under the heading 'local responsibility'.

EXHIBIT 2

### The health improvement programme

HImP provides a framework for local action that interprets national priorities in the context of local needs and priorities.



Source: Audit Commission

## Co-ordinated local planning through the HImP

11. PCGs should be uniquely placed to ensure that evidence of local needs and the views of clinicians and their patients are reflected in healthcare planning in addition to national and HA priorities. To do this, PCGs need appropriate data, user perspectives and analytical resources [BOX B]. Equally important, participation in the planning process itself should generate commitment to deliver change.

### BOX B

#### PCG input to the HImP

- patient/public views should actively be sought and taken into consideration, using established consultation channels where appropriate,
- wherever possible the PCG should make use of other local organisations to gather evidence,
- there should be sufficient PCG resource to collate and weigh evidence,
- comprehensive public health data (on PCG boundaries) should be available, and support from the HA,
- PCGs, practices and nurses should be consulted and involved in strategy working groups for each HImP topic and not given the impression that it is all a fait-accompli,
- there should be a balance between national targets that are relevant to the area, HA and PCG priorities,
- plans and proposals should be prioritised in a way that appears realistic in terms of cost and resources,
- co-ordination may be needed with HAZ and other initiatives,
- PCG clinicians and managers should be involved in working groups to turn HImP results into locality plans (related or incorporated) containing specific actions for PCGs.

HImP priorities should feed through into investment, clinical governance, public and professional education, accountability targets, supporting local government initiatives etc.

12. PCG input to the HImP should be based on analysis of public health and census data, plus additional local information and views on health needs and services. However, one in three PCGs surveyed said that the only readily available planning data are based on boundaries that differ from those of the PCG. Many also lack the resources and skills needed to collect and analyse additional data and user views at present. One PCG chief executive, for example, commented that local exploration of needs and development of priorities, and thus the PCG's ability to contribute to the HImP, would be compromised by lack of management resource and public health support for some years.

13. PCGs should feel that they have been actively consulted during the planning process and are committed to implementing HImP priorities. Individual GPs, nurses and patients, as well as PCG board members and officials, must be able to express a view if they wish. This is particularly true of clinicians working in more deprived areas, who, as noted in the first Audit Commission report on PCGs, are under represented on boards. This consultation did not always take place with the first HImPs; most shadow PCGs and clinicians had little involvement, largely because of the tight timetable. In some places only the shadow PCG chair was consulted. Awareness among other GPs was minimal.

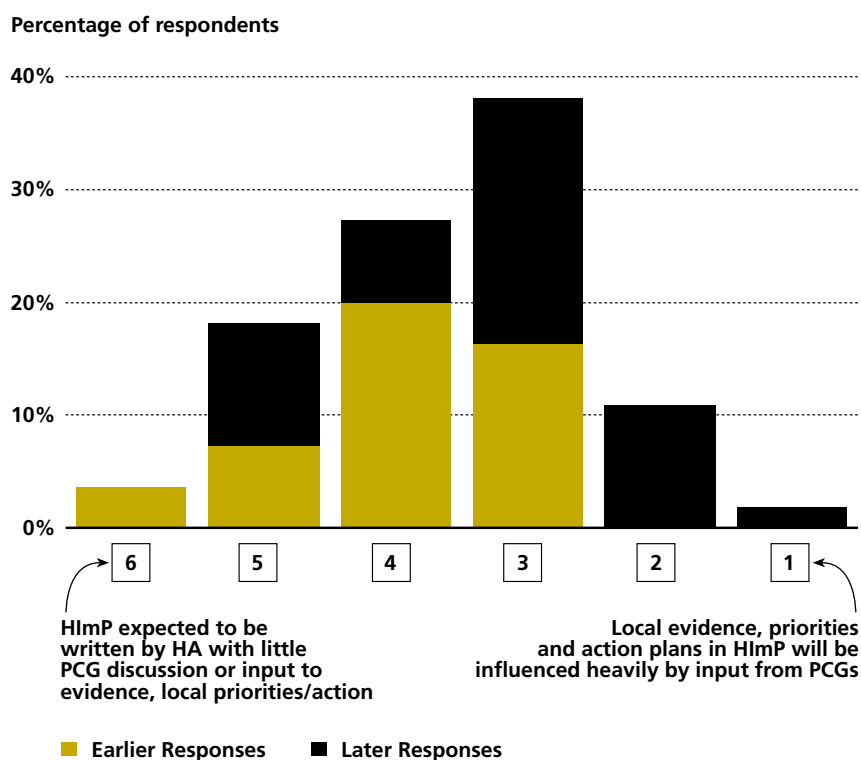
14. Future HImPs will be fuller documents with a three-year planning horizon. However, some PCGs expressed the feeling that the process is still very top down and that, in general, local initiatives are discouraged. There is also a wider perception that a requirement for HImPs to include an increasing number of national targets could squeeze out work to address local priorities. One chief executive commented that, in the absence of additional funding, the HImP needs to be cost balanced. Patient expectations should not be raised until it is clear that plans are affordable. A King's Fund report has also expressed concern about the capacity of PCGs to implement HImP plans (Ref.4).

15. Although PCGs were divided on the extent to which their evidence and priorities would influence HImPs, many, especially later survey respondents, were hopeful there would be greater PCG involvement this year [EXHIBIT 3]. Sixty per cent of PCGs have formed HImP subcommittees that enable deeper consideration and a wider input of views. These PCGs were also more likely to have expressed satisfaction with their input to the HImP process.

EXHIBIT 3

**Chief executives' perceptions of PCGs' impact on formulation of HImPs**

Later respondents were the more positive about their ability to influence HImPs.



Source: Audit Commission survey (July to September 1999)

## Co-ordination between PCGs

16. There can be tensions between developing services to meet the distinct needs of a PCG’s local population and avoiding the ‘postcode treatment’ that could result if neighbouring PCGs adopt differing policies. Guidelines from bodies such as the National Institute for Clinical Excellence (NICE) should help to ensure that some key areas of healthcare develop along similar evidence-based paths right across the country. But they will necessarily be selective and may not always be sufficiently timely to inform immediate precedent-making local decisions. Co-ordinated planning is particularly important across cities served by a number of PCGs whose GPs refer patients to the same secondary care providers.

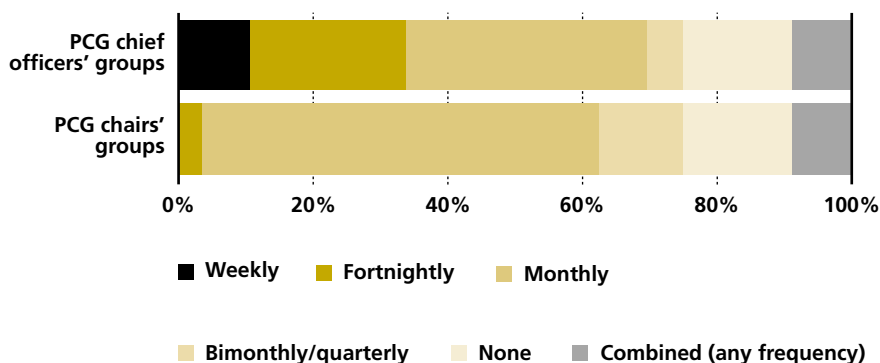
17. Many decisions will need to be taken jointly by several PCGs, where necessary in consultation with other members of the local health community. Examples include agreement of annual planning statements incorporating service and financial frameworks (SaFFs), budgetary and risk management strategies, and development of information management and technology. Most HAs have therefore set up a range of committees that include all PCGs in their area. At the most general level, chief officers and chairs of most PCGs surveyed meet with other PCGs regularly [EXHIBIT 4]. Other overarching committees cover such topics as commissioning and NHS trust liaison, resource allocation, finance and the SaFF, clinical governance, drafting the HImP, and prescribing<sup>1</sup>. Two out of five PCGs reported that some of these committees take joint decisions that are binding on PCGs without ratification by individual boards. Such committees should therefore have documented powers and responsibilities agreed by each PCG.

<sup>1</sup> These are examples of committees that exist in at least one in ten HA areas.

EXHIBIT 4

### Co-ordinating meetings between PCG chairs or chief executives and HAs

The majority of PCG chief executives met with those of neighbouring PCGs and HA managers either once or twice a month; chairs in general met monthly.



Source: Audit Commission survey (July to September 1999)

18. Understandably, in this first year, most co-ordination has occurred within existing HA areas. There have been limited exceptions in those few HAZs that span these sometimes artificial boundaries. Increasingly PCGs will need to consult with their neighbours in different HAs, with which they may have more in common than with some PCGs in their own HA.

### More equitable service delivery

19. Improved equity of access to healthcare will also depend on a host of operational plans by PCGs to:

- develop primary care services to address pockets of historically poor provision, broaden access to services and ensure common standards; and
- ensure consistent standards for commissioned services.

These are the subject of the next section of this report.

#### RECOMMENDATIONS (1i)

##### PCGs should:

- involve as many practices and stakeholders as possible in developing the PCG's contribution to the HImP and to the action plans flowing from it, so as to improve local ownership
- develop policies in parallel with neighbouring PCGs, unless in any particular instance there are sound reasons to do otherwise, and begin to develop dialogue with neighbouring/similar PCGs in other HA areas.

##### HAs should ensure that:

- PCGs have sufficient public health and analytic support to make a meaningful contribution to the HImP
- planning data are available on PCG boundaries
- the HImP leaves scope for local initiative by PCGs
- sensible milestones are established for achievement of HImP priorities
- committees representing all PCGs have clear, agreed responsibilities and authority, and that there is no duplication of activity.

##### The NHS Executive may wish to ensure that:

- the number of national 'must-dos' is commensurate with available resources and leaves scope for HAs and PCGs to address local priorities.

## ii. Local responsibility

*... for the delivery of healthcare.*

20. PCGs are required to ensure that healthcare provision is responsive to local needs and priorities. Key areas where PCG decisions are needed include:

- prioritising investment in primary care to reflect patient need and identified local deficits in skills and facilities, and, where appropriate, broadening access to practice-based services; and
- commissioning secondary and community services that complement primary care.

### Primary care investment

#### **Gathering baseline information and prioritising bids**

21. In order to plan primary care investment, PCGs need:

- comprehensive information on the staff, skills, services and facilities currently available in practices;
- evidence about unmet needs and what patients, carers and the wider public think about existing services, how easy it is to use them, and how they could be improved;<sup>1</sup>
- to know what funds will be available for primary care investment, and when;
- an agreed methodology for drawing up and prioritising funding bids, taking account of any available evidence on service effectiveness; and
- a mechanism for broadening access to existing services in ways that do not dilute their effectiveness.

22. Most PCGs have made a start in gathering basic data on practices. However, in August 1999, over a third did not yet know what services were currently available in their practices and how they were funded, while only one in five had yet compiled a database of all the nursing skills available to their practices. Some delay is due to the reluctance of a few GPs to supply information that they consider confidential to their PCG.

23. One-half of the PCGs surveyed had finished collating bids from practices for new investment. Many HAs have collected such bids for some years, but there have often been major gaps in the data. Two out of five PCGs had agreed a methodology for prioritising bids by the time of the survey, and most of the others were discussing one. For example, some have devised a points system based on accordance with HImP priorities, practice facilities and levels of investment in previous years. A full assessment should consider the needs of all practices, not just of those requesting additional funding; but only a minority of PCGs had also requested nil returns. Clearly, it is difficult to plan investment until budgets are confirmed. One in three PCGs surveyed had not been given even a provisional indication of their total budget for primary care investment in 1999/00. And only 30 per cent had firmly agreed specific projects for the current financial year.

24. Nationally, PCGs' foremost priority for primary care investment was information management and technology: over half ranked this as either their first or second priority. Close behind was the expansion of prescribing support to practices, ranked first or second by two in five PCGs. Other highly ranked priorities were nursing staff and premises. Some PCGs, for example, planned to use personal medical services (PMS) pilot schemes [BOX C] to rectify historic deficiencies and create facilities that could be shared by clusters of small practices. Many survey respondents also mentioned the need for investment in staff training and development.

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<sup>1</sup> Public involvement is explored further in Section 1(vi) of this report.

**BOX C****Improving access to services through personal medical services (PMS) pilot schemes**

Some PCGs, with their HAs, are expanding the use of PMS pilots (formerly known as Primary Care Act pilots). There are currently 201 of these schemes, with varying aims and sizes. A further 77 will commence on 1 April 2000. The Audit Commission has not evaluated them, but their potential for PCGs and PCTs deserves mention.

For example, they allow the appointment of salaried primary care doctors, of GPs working outside the standard terms and conditions of service and of other directly employed staff such as specialist nurses, who may work with a number of practices. Salaried GPs may work in disadvantaged areas to which it is difficult to attract doctors. They can facilitate flexible working patterns, improve access to services, provide relief cover while single-handed GPs are on courses or leave, or provide specialist skills. PMS pilots led by nurses may relieve doctors of some of the burdens of practice administration, allowing them to concentrate on patient care.

One survey respondent noted a PMS funded walk-in centre for homeless people, while another has appointed salaried GPs to facilitate a partial shift of chronic disease management from secondary to primary care.

Some potential PCTs (for example, The Nelson PCG) envisage that all of their practices will join PMS schemes. This would help the 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.

***Practice-based services***

**25.** Many neighbouring former fundholding practices have developed very different in-house services, using a variety of providers. For example, some have contracted with non-NHS providers as an alternative to outpatient referrals. Although many current in-house services are liked by patients, there is widespread agreement that not all are cost-effective. However, there is little evidence-based research to prove which. The affordability of levelling-up services, as envisaged in NHS Executive guidance, has been questioned. One in three PCGs surveyed by the Audit Commission thought that it might be necessary to discontinue funding some practice-based services during the current year without the willing agreement of the practices concerned. Sixteen per cent said that this would definitely be necessary this year in order to balance the books. Two out of five PCGs surveyed claimed to have a working methodology for assessing the continued funding of practice-based services [CASE STUDY 1]; but although most others said that they had started to discuss how such decisions would be made, securing board agreement has sometimes proved difficult.

**26.** Only a quarter of PCGs had yet agreed how to broaden access to existing practice-based services. Some practices fear dilution of services if in-house teams are required to tour other local practices, or would resist an enforced change of service provider. However, a few PCGs have begun to develop imaginative proposals for developing new services and facilities shared by clusters of neighbouring practices or by primary healthcare teams.

**CASE STUDY 1****Evaluation of GP physiotherapy referrals to non-NHS providers**

Restormel PCG commissioned an evaluation of whether to continue funding physiotherapy referrals to a non-NHS provider by former fundholding practices. The study found that usage of physiotherapy services by these practices was higher than of those referring to the local hospital. However, waiting times for non-NHS services were significantly shorter and the price was half that quoted by the local NHS trust, although the latter's case-mix was more extensive. A comparative analysis of outcomes was outside the study remit. A more detailed evaluation would be required to fully evaluate the cost-effectiveness of the current service framework.

The PCG board concluded that continued use of non-NHS physiotherapy represented good value for money provided that the referrals produce worthwhile benefit to patients. The study had also shown that it would not be practical to discontinue these contracts as the service offered by the local NHS trust was operating at full capacity.

**Commissioned services**

27. PCGs are already responsible for managing £14 billion of commissioned services. National service frameworks and HImPs should help to promote common basic standards for secondary and other care. Nevertheless, with provider trusts, PCGs will have a growing role in identifying imaginative ways in which the scope and delivery of commissioned services can be improved within available funds. PCGs will also monitor these services to ensure that they meet requisite standards. To fulfil these new responsibilities, they will need:

- access to the requisite skills and support;
- innovative approaches;
- timely and accurate data;
- the involvement of clinicians and other stakeholders; and
- a collaborative approach with neighbouring PCGs, the HA and provider trusts to solving problems and to managing financial risks.

**Skills and support**

28. As noted above, more than one in three PCGs contain no general practices with previous experience of collaborative commissioning. The commissioning experience of former fundholding practices, even if their fund managers are still available, is of less direct relevance. Collaborative and stable commissioning requires different skills from the past emphasis on cost and volume, although it is important that quality standards negotiated by the more progressive fundholding practices should not be lost. Further, the scale and nature of PCG budgetary responsibility for commissioned services do not always reflect ability to take on this role. Rather, in some areas, they appear to have been dictated by the percentages of budgets to be delegated for recognition, under national guidance, as a level 2 PCG. Nevertheless, many PCGs are starting to get to grips with these responsibilities.

### ***Innovative approaches***

29. A number of PCGs expressed frustration over their perceived continuing lack of real freedom to move funds between the elements of the unified budget, particularly if there is little uncommitted growth money. This is likely to be dissipated as responsibilities for more of the unified budget are devolved to PCGs and decisions are constrained less by the financial consequences of decisions taken in past years. However, if PCGs are to make real savings in the costs of commissioned care without compromising standards, they will need to find innovative ways to meet waiting list targets, for example, through development of primary care alternatives [CASE STUDY 2].

#### **CASE STUDY 2**

##### **Reducing overspend by developing primary care**

N.E.Lincolnshire PCG serves an area with an above average number of hospital referrals and a substantial historic overspend on acute hospital care services. The local NHS trust also had waiting lists for some acute specialties that were unacceptable to local patients and GPs. However, the PCG has had some considerable success in beginning to tackle these problems, and was more than 5 per cent below budget in September 1999:

- Indicative referral levels have been set for each of the primary healthcare teams (PHCTs) that cover clusters of practices and, by them, for individual practices. It has been stressed that these are not 'targets'. Nevertheless, by focusing attention on the problem they have had a noticeable impact. For example, one PHCT has reduced dermatology referrals by 200.
- The indicative levels are supported by referral guidelines agreed between the PCG clinical governance committee and local consultants.
- A primary care surgery initiative, kick-started with waiting list monies as well as PCG funds, provides GPs with an alternative to 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 that wish to develop a specialism. Some consultants were less receptive initially, but are now very supportive. A PCG survey showed that patients too 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 activity before it happens. NHS trust data are now disaggregated by the PCG and sent to PHCTs on disk. Practices then validate them against their own referral records and PHCTs return the disk 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 (eg, 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 the provision of care.

**Commissioning data**

**30.** One of the most pervasive PCG concerns has been the absence of accurate and timely data on commissioned services. In many instances PCGs are still reliant on HAs for commissioning data. One PCG chair compared it to ‘flying blind in a fog’. Some PCGs now gather data directly from local NHS trusts, rather than relying on national clearing systems, and validate them against information held by general practices. But the problem is compounded where PCG budgets have been set on the basis of a very approximate allocation of past contracts and out-of-area treatments.

**Involving clinicians in commissioning**

**31.** ‘The New NHS’ White Paper envisaged increased involvement of clinicians from both PCGs and NHS trusts in reviewing and monitoring services. By the time the survey was completed (mid July to mid September 1999), two out of every five PCGs had held meetings to review services with all of their main provider trusts and a similar number with at least some of their main providers. Yet, of these, only one in five had involved clinicians from both primary and secondary care in all these meetings. A similar number had not yet involved clinicians at all. In order to make cost-effective use of doctors’ time it may be appropriate to discuss, for example, the detail of service volumes and clinical or service quality issues at separate times. But many PCGs will need to find a way to increase GP involvement, and GP commitment to devising solutions to problems such as unnecessarily long inpatient episodes or waits.

**A collaborative approach**

**32.** Since PCGs started work in April 1999, commissioning arrangements have been refined and there has been a welcome increase in the extent of collaborative commissioning between neighbouring PCGs. Such collaboration can reduce the substantial time burden on clinicians, thus enabling them to participate, as well as improving service consistency. The Commission’s summer survey found that:

- two out of every three PCGs had formed a commissioning subcommittee;
- one in four was represented on a commissioning group spanning several PCGs;
- 55 per cent of respondents were taking the lead with certain provider trusts on behalf of other PCGs; and
- 43 per cent<sup>1</sup> were leading the commissioning or monitoring of certain specialties.

Worryingly, however, a few PCGs still did not know at the time of the survey whether they would be leading commissioning on behalf of other PCGs during the current year.

**33.** There are many other areas where greater collaboration could improve the delivery of greater healthcare. These are discussed next.

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<sup>1</sup> Some PCGs were leading both with specified providers and on certain specialties.

### RECOMMENDATIONS (1ii)

#### PCGs should:

- compile a database of skills available to each practice, services currently provided, practice facilities and computerisation
- project future skill shortages and plan how these could be addressed
- agree a methodology for assessing practice bids against data on current and future provision and needs
- evaluate current practice-based services and agree how those that are cost-effective can be accessed by patients of other local practices
- develop the skills needed for effective commissioning in collaboration with neighbouring PCGs
- collect key monitoring data directly from main providers, for validation by referring practices
- provide primary care alternatives to secondary care referral for appropriate conditions, supporting their use through referral protocols, training, audit and indicative levels
- find ways to involve clinicians in commissioning cost-effectively.

#### HAs should ensure that:

- PCGs are supported in evaluating the cost-effectiveness of practice-based services
- PCGs pursue a co-ordinated approach to commissioning in accordance with the annual planning statement/SaFF
- PCGs are provided with adequate support and advice on commissioning
- the data that PCGs need to monitor waiting times, referrals and expenditure are accurate and timely
- PCGs are supported in developing alternatives to hospital referral, and advised on how such services could be funded.

#### The NHS Executive may wish to:

- prioritise the roll-out of NHSnet connections to GPs and PCG offices so as to facilitate timely collection and validation of monitoring data for commissioned services
- ensure that PCGs have the flexibility to develop appropriate primary care alternatives to hospital referral, using waiting list monies and other funding.

### iii. Partnership

#### *... breaking down organisational barriers and forging stronger links with local authorities*

34. PCGs are designed to enable care to be focused around patient needs without unnecessary hindrance from budgetary or organisational constraints:

- PCGs themselves essentially function as informal partnerships between general practices, and with the other organisations most involved in delivering healthcare to their local population. Their multidisciplinary boards embrace both health and social services.
- Wider partnerships with local authorities and NHS trusts are being explored.

Recent surveys by the National Association of Primary Care showed that new possibilities for partnership working were seen by both PCGs and by general practices as the best aspect of the NHS reforms.

35. It will take time to realise the full potential benefits for improving patient care. However, some developments are already taking place, for example:

- co-ordinated deployment of practice, community nursing and social services skills and staff;
- involving and working with other bodies and professions;
- developing PCG representation on local projects bearing on the health of the local community, joint working with other agencies, and, in a few cases, shared budgets.

#### **Co-ordinated deployment of nursing skills, and social services staff**

36. Often in the past, the separate employment of nursing staff by individual practices, community trusts and voluntary agencies has led to:

- inefficiencies where the same patient is concurrently under the care of both practice and community nurses (Ref.5);
- disjointed care carried out to different standards and protocols;
- confusion for patients; and
- restricted opportunity for staff development.

Also, differences between the geographical organisation of community health and social services have sometimes made it difficult to develop the working level relationships needed for efficient, integrated patient care.

37. PCGs are beginning to tackle these issues:

- by reviewing the scope for reorganisation of community care and social services around practices or clusters of practices;
- by agreeing common evidence-based treatment protocols across practice and community nursing which are subject to periodic audit; for example one PCG surveyed has developed a leg ulcer clinic which uses evidence-based protocols;
- by developing cover arrangements to allow all nurses to attend courses and to maintain patient services when nurses are on leave;
- by compiling databases of nursing staff and skills available to practices, to ensure equity of cover, identify development needs, and record specialised skills that could be called upon by others; and
- through appointment of link workers and staff secondments.

38. Although three-quarters of survey respondents had information about the staffing (employed and attached) of all or most of their practices, only one in five had a skills database; one in four had not yet started to gather this information.

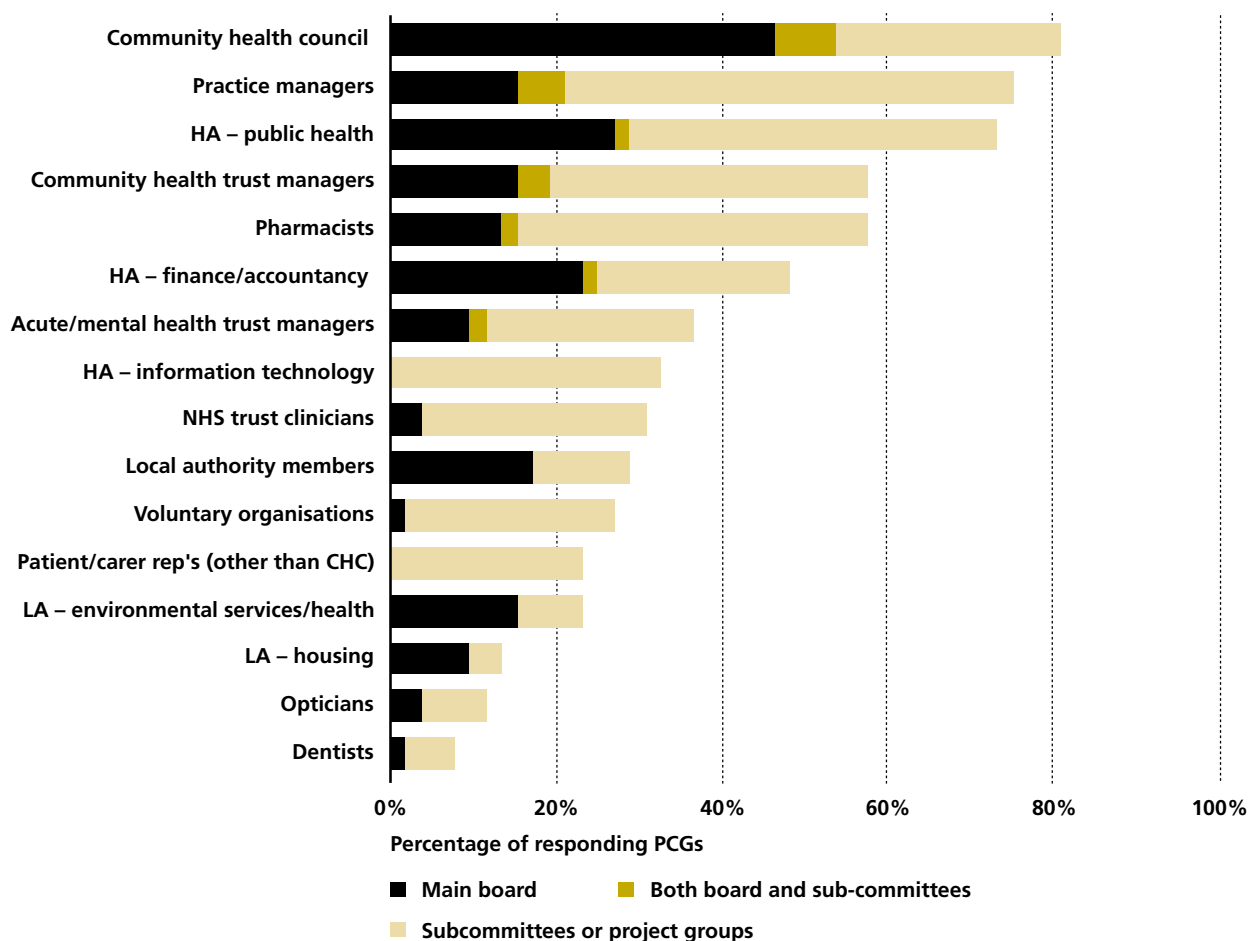
### Involving other bodies and professions

39. PCG can co-opt representatives of other bodies and professions and service users to boards, subcommittees and working groups. In this way, they can bring a wider range of experience to bear on decisions and broaden local ownership of plans. A majority of PCGs have co-opted CHC representatives to their main boards and over one-half of the remainder involve the CHC on subcommittees or project groups. Three-quarters have co-opted one or more practice managers to subcommittees or, less commonly, to the main board. A majority of PCGs involve public health managers from their local community health trusts and pharmacists. And almost one in four have co-opted a member of the health authority finance department to the board. [EXHIBIT 5]. However many PCGs may find it advantageous to develop more involvement in working groups of, for example, service users and local people with appropriate expertise.

EXHIBIT 5

#### Co-options to PCG boards, subcommittees and project groups

Through co-options, PCGs can bring a wider range of experience to bear on decisions and broaden local ownership of plans.



Source: Audit Commission survey (July-September 1999)

## Joint projects and health promotion initiatives focused on patient needs

40. PCGs need to develop relationships with a wide range of local authority departments (for example, housing, environmental health, environmental services, education, planning), community organisations and local bodies whose work has a bearing on health or access to healthcare. Regular meetings have taken place for some time in HAZs<sup>1</sup> but got off to a slow start in many other areas. This delay may reflect the potential complexity of these relationships. Many PCGs do not have the same boundaries as local authorities. One in four PCGs spans several district/unitary authorities; and conversely, one in three district/unitary authorities has to deal with several PCGs. In the most extreme case, the City of Birmingham has 12 PCGs within its area. Further complications can arise if it becomes necessary for a PCG to liaise with a local authority about individual patients treated by GPs within its area, but living in a neighbouring district.

41. In some instances, joint projects or informal partnerships focused on particular cross-cutting issues may be developed. For example, PCGs provide a new focus and a channel for funding joint health promotion activity that is consistent with local priorities and the HImP. A number of PCGs surveyed were involved in projects such as healthy living centres, coronary heart disease rehabilitation programmes, work with schools on drug misuse, teenage pregnancy and smoking [BOX D]. PCGs will need to ensure that, in due course, the outcomes and cost-effectiveness of these schemes are reviewed.

42. Sometimes it may be advantageous to enter into more formal partnership arrangements [BOX E, overleaf]. PCGs may also wish to take over partial funding of partnership projects, such as carer support schemes. Restormel PCG, for example, is part funding, with the local college of further education, a team of health visitors carrying out a healthy living community development project. PCGs may transfer budgets to other agencies to carry out specific aspects of their responsibilities, such as learning disabilities. Or they may operate pooled project budgets with an NHS trust, local authority or other local body. Three survey respondents were already doing this, and one in four were in discussion about pooled budgets, most commonly with a local authority.

43. Greater collaboration could, in some circumstances, improve the efficiency as well as the quality of integrated healthcare. But, as the next section describes, PCGs have far more immediate roles in improving the cost-effectiveness of the NHS.

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<sup>1</sup> Some PCGs within HAZs said that there was need for clarification of how their HImP responsibilities relate to what can be a very complicated planning process linking with HAZ and other joint funding.

## BOX D

**PCG HEALTH PROMOTION ACTIVITIES**

PCGs are becoming key players in a wide range of health promotion initiatives.

**Coronary heart disease (CHD) & stroke:**

The initiatives most commonly reported by surveyed PCGs reflect the national priorities of CHD and stroke including:

- involvement with healthy living centres, appointment of a healthy lifestyles officer and a healthy schools initiative, a healthy village project centred on a beacon practice, and partnership working on healthy living programmes and networks
- 'exercise on prescription', 'start to exercise' or 'exercise for nursing home patients' schemes
- a CHD rehabilitation programme and CHD work with patients
- schemes aimed at clinicians, for example promoting systematic identification and intervention of those at risk of CHD, management of high blood pressure, aspirin prophylaxis, use of ischaemic heart disease registers, or annual review and assessment
- schemes to increase public awareness and speed of first response to heart attacks, such as the planned provision of resuscitation training to members of the public through the Heart Start campaign.

**Diabetes:**

- work with diabetic patients from ethnic minorities
- accredited mini-clinics in general practices with referral of more complicated cases to consultant-led community clinics

- ensuring that all practices utilise diabetic registers.

**Substance abuse/smoking:**

- smoking cessation programme / smoking in pregnancy
- an evaluation of shared care for drug abusers
- tackling drug misuse in schools
- working with schools on a substance abuse living programme.

**Vulnerable patients:**

- combating post-natal depression
- a project on depression in nursing homes
- flu vaccine promotion.

**Sexual health:**

- work with schools on sexual health
- sexual health advertising
- reduction of teenage pregnancies.

**Sports medicine****Accident prevention:**

- falls prevention project
- a project focusing on hip fractures in nursing homes.

**Domestic violence****Improved access to care:**

- transport to improve access to health services.

Source: Audit Commission survey (July to September 1999)

**BOX E****Effective joint working**

The following principles (Ref.6) apply equally to joint ventures between PCGs and other organisations and to PCGs as effective partnerships in their own right.

Partnerships may be developed to:

- deliver co-ordinated packages of services to individuals
- tackle complex problems that cross traditional organisational boundaries
- minimise perverse incentives resulting from organisational fragmentation
- gain access to new resources
- meet a statutory/mandatory requirement.

But although quality and cost-effectiveness of services can be significantly improved when organisations work well together, it does not necessarily follow that a partnership is the answer to any problem; partnership working can be costly and potential gains are often difficult to realise in practice. Alternatives such as consultative arrangements, networks of personal or professional relationships, or contractual relationships should be considered first.

Key principles are that:

- prospective partners should have a clear, shared, realistic vision of potential benefits
- the anticipated marginal benefits of partnership working should outweigh the likely costs
- partnership objectives should be consistent with those of each partner organisation
- prospective partners should have clear roles and resource expectations and be willing to devote the necessary time and effort
- a focus on outcomes should be maintained
- there should be emphasis on building trust and familiarity with partner organisations (including understanding of their ethic and 'language')
- the partnership should have a properly structured executive committee and board whose members have sufficient authority to commit their organisations to a course of action.

**RECOMMENDATIONS (1iii)**

**PCGs should:**

- encourage reorganisation of community care around clusters of practices
- agree evidence-based protocols for nursing interventions, common to practice and community nursing, and audit them periodically
- promote cover arrangements for practice nurses to facilitate their continuing education and continuity of patient care when they are on leave
- involve service users and local people with appropriate expertise in working groups
- liaise with LA departments and local bodies whose work bears on health or access to healthcare
- ensure that any partnership enterprises with other bodies meet the principles of effective joint working and that their cost-effectiveness is evaluated.

## iv. Efficiency

*... through a more rigorous approach to performance and by cutting bureaucracy*

44. PCGs must keep their own running costs to a minimum. But they will need sufficient administrative resources to negotiate and monitor improvements to the overall efficiency of local healthcare services, through effective commissioning and by developing systems for timely budget allocation and expenditure monitoring. As PCGs do not directly employ the general practitioners that incur most of this expenditure on patients' behalf, many efficiency improvements will be dependent on:

- helping their practices to control expenditure, especially in areas such as prescribing; and
- giving all clinicians an incentive to promote cost-effective use of available resources.

### Cost-effective administration

45. As yet it is far too early to assess the overall effect that the creation of PCGs will have on health service management costs. A full evaluation would need to consider any additional administrative burden on clinicians and practice support staff as well as the costs of directly employed PCG staff and offsetting savings.

46. The Commission's earlier paper on PCGs noted wide differences in the per capita management budgets available to PCGs. Those figures, gathered while PCGs were forming, were provisional. However, over one-quarter of the PCGs that responded to the Audit Commission survey by early August had by then still not been notified of firm management budgets.<sup>I</sup> But this latest survey did confirm the significant variation. PCG management budgets ranged from £119,000 to £1.28 million, or between £1.54 and £5.57 per resident, the average being £2.96.

47. The 'average' PCG spends over a third (£99,000) of this management budget on chair, board and other clinicians' remuneration and allowances, and rather less than one-half (£120,000) on staff salaries, including that of its chief executive [EXHIBIT 6, overleaf]. But staff budgets reported by PCGs ranged from £39,000 to £836,000. Small PCGs in particular have very limited funds for staff once board costs are met.

48. Most PCGs were initially set up with very few employees and minimal accommodation, reflecting continuing uncertainties as to delegated functions, responsibilities and pace of development. The majority are likely to remain lean organisations reliant on stakeholders and others to formulate and deliver many of their plans. The number of whole time equivalent (w.t.e) managers, staff and advisers expected to be employed by responding PCGs by the end of 1999/00 varied from 1 to 30 with an average<sup>II</sup> of 4.4. On average, 3 were in post at the time of the survey, the maximum being 24 [EXHIBIT 7, overleaf].

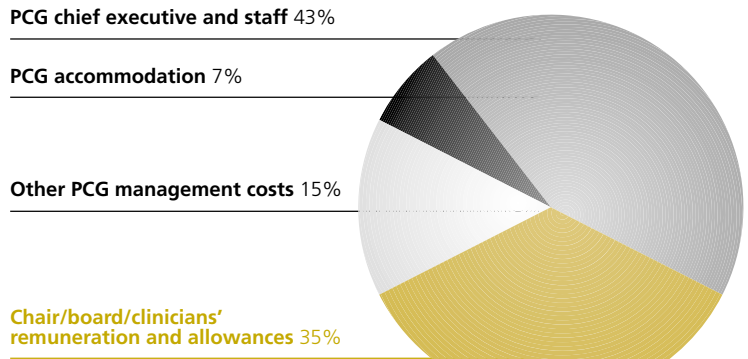
I Including all survey returns (between mid July and September 1999), 15 per cent of responding PCG chief executives did not have firm management budgets for the current year.

II Median.

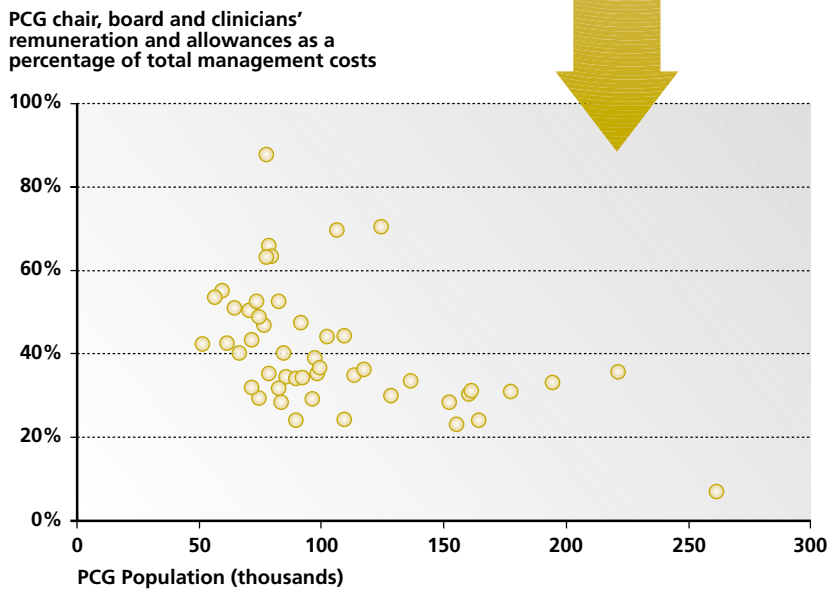
EXHIBIT 6

**PCG management budgets**

The *average* PCG spends over a third of its management costs on board and clinician remuneration and allowances and 40 to 50 per cent on staff...



...but board costs take up a far higher percentage for smaller PCGs.



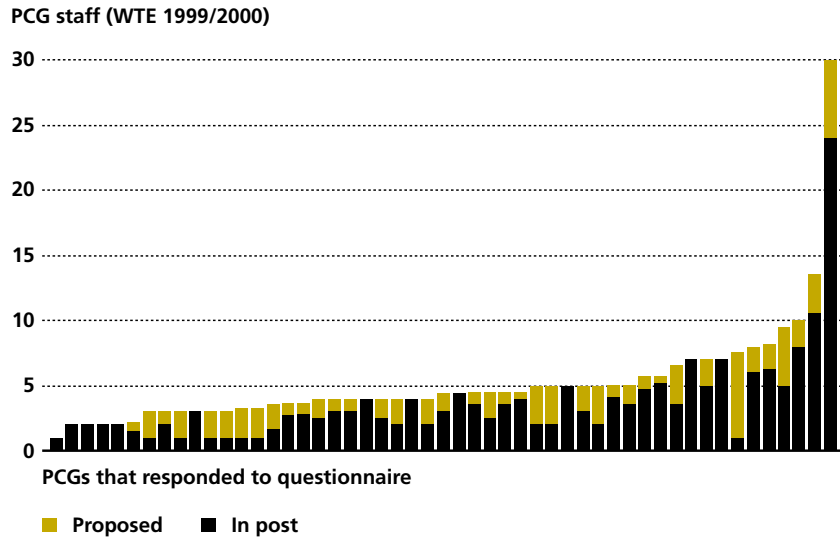
Source: Audit Commission survey (July to September 1999)

49. To a great extent, proposed staffing reflects the available management budget. This in turn depends largely on the population covered by the PCG. However, there is still a twofold variation in the staff numbers proposed by average sized PCGs. This variation seems to be justified only partially, if at all, by differences in PCG responsibilities [EXHIBIT 8]. Nor is it explained by differences in support available from HAs, NHS trusts or other sources. Salaries offered by different PCGs for similar posts also vary considerably (Appendix 3).

EXHIBIT 7

**PCG staffing – proposed and in post**

There is marked variation. On average PCGs planned to employ 4.4 whole time equivalent staff by the end of the year, of which 3 were in post by autumn 1999.

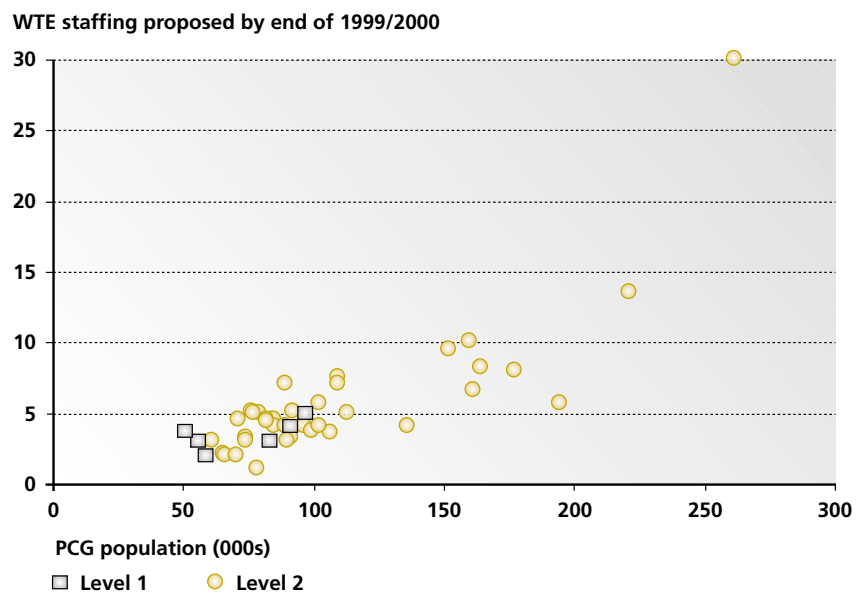


Source: Audit Commission survey (July to September 1999)

EXHIBIT 8

**PCGs' proposed staffing by size and 'level'**

Although staff numbers increase with PCG size, there is wide variation which seems to be only partially justified by apparent differences in their responsibilities.



Note: Excludes additional support funded centrally by HAs or community trusts.

Source: Audit Commission survey (July to September 1999)

50. There is inevitable tension between the desire to ensure that PCGs remain lean, sharply focused organisations with no unnecessary bureaucracy and providing sufficient skills and resources to tackle the significant development agenda that they face. It would be a false economy if they were denied the ability to manage their delegated responsibilities effectively and to promote rational, cost-effective procedures and decision-making in their practices. But some chief executives see advantages at present in retaining a compact central PCG administration and developing greater collaboration (paragraph 103).

### Helping practices to control prescribing costs

51. The control of prescribing costs is a key issue for all PCGs. Although they account for only about 15 per cent of their integrated budgets, for many prescribing will represent a much higher percentage of current delegated budgetary responsibilities. Also, unlike most other parts of the budget, prescribing costs are not constrained by agreements made months or years in advance but can be influenced throughout the year. However, there are major cost pressures and prescribing expenditure has for some years been increasing faster than other elements of PCG integrated budgets. These pressures have arisen from increased use of established drugs<sup>I</sup> as well as from new drugs (some for previously untreatable conditions). Some reflect price changes. In particular, since mid-1999, certain generic drugs have been in short supply due to the enforced closure of a large production plant. These shortages triggered price increases that have resulted in major budgetary problems for PCGs. Their effects may be partially offset by reductions in the price of many branded drugs negotiated as part of the Pharmaceutical Price Regulation Scheme settlement between industry and the government. But the budgetary situation is uncertain as prescription endorsements, necessitated by the supply shortages, have delayed processing by the Prescription Pricing Authority and receipt of the information that PCGs need to monitor drug expenditure.

52. Despite these recent price uncertainties, there is still significant scope for cost savings in most PCGs from substituting cheaper but, for most patients, equally effective drugs, and from reduced use of drugs such as antibiotics in circumstances where it is clinically inappropriate to prescribe (Ref.7). But there are also conditions for which additional prescribing, particularly of prophylactic drugs, is to be encouraged on quality grounds, with a consequent increase in expenditure. In all areas of prescribing, there is typically as much variation between individual practices within a single PCG as between PCGs across the country [EXHIBIT 9].

53. Most PCGs have appointed one or more clinicians with specific responsibilities for leading on prescribing issues and nine out of ten have established a PCG prescribing or drugs subcommittee. Strategies that could affect the quality of prescribing for individual patients must be carefully co-ordinated between clinical governance and prescribing leads<sup>II</sup> as cost pressures alone must not drive the prescribing agenda. The PCG board should also agree what types of prescribing change are to be targeted, taking into account the strength of supporting evidence, likely acceptance, workload and probability of long-term savings. They will need to co-ordinate some policies with neighbouring PCGs, to ensure that equity is not compromised through 'postcode prescribing'.

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I This may reflect new evidence on the effectiveness of prophylactic drugs (eg statins for patients who have suffered heart attacks), more complex conditions treated in the community, patient expectations as well as changes in morbidity or diagnosis (eg respiratory conditions).

II Examples include:

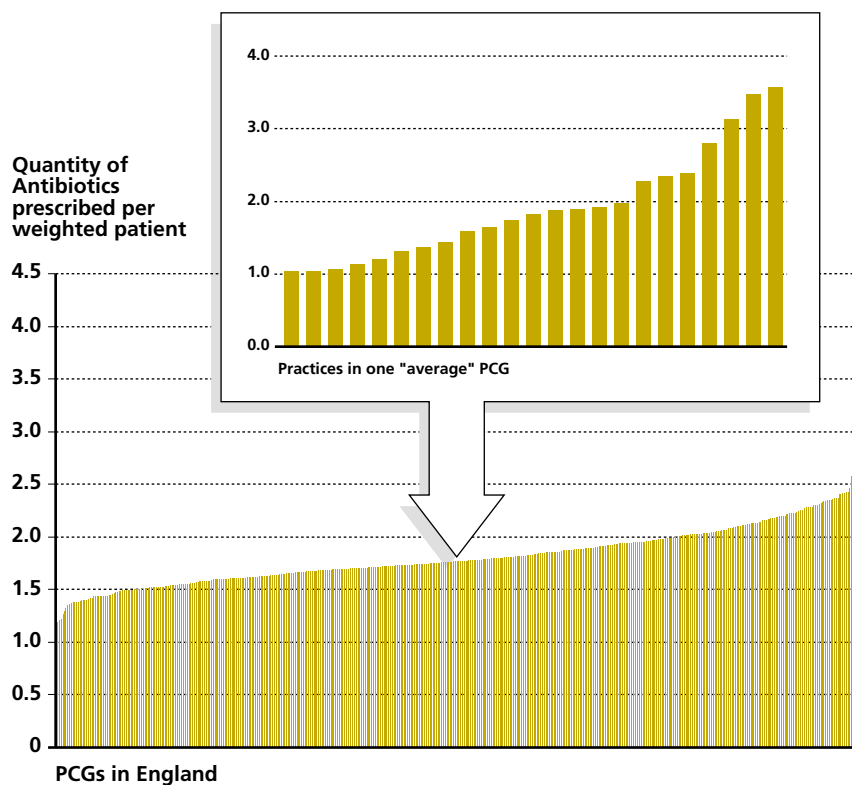
- the expenditure consequences of increased prophylactic prescribing
- policy on drugs that may be prescribed by GPs on behalf of hospital consultants under mutually agreed 'shared care' arrangements
- policy on reversal of changes to repeat prescriptions that prove unacceptable to individual patients or which reduce 'concordance'
- 'black listing' of drugs of questionable cost-effectiveness.

Only 1 in 6 PCGs have prescribing leads who also lead on clinical governance.

## EXHIBIT 9

**Prescribing of antibiotics**

There is typically as much variation between individual practices within a PCG as between PCGs across the country. This is true for most indicators of prescribing.



Note: Quantities are expressed in 'ADQs per STAR-PU(5)'. In this way, quantities of different antibiotics can be summed and an allowance, specific to this type of drug, is made for differences between PCGs, or between practices, in their mix of patients by age and sex.

Source: Audit Commission from Prescription Pricing Authority data (12 months to September 1998)

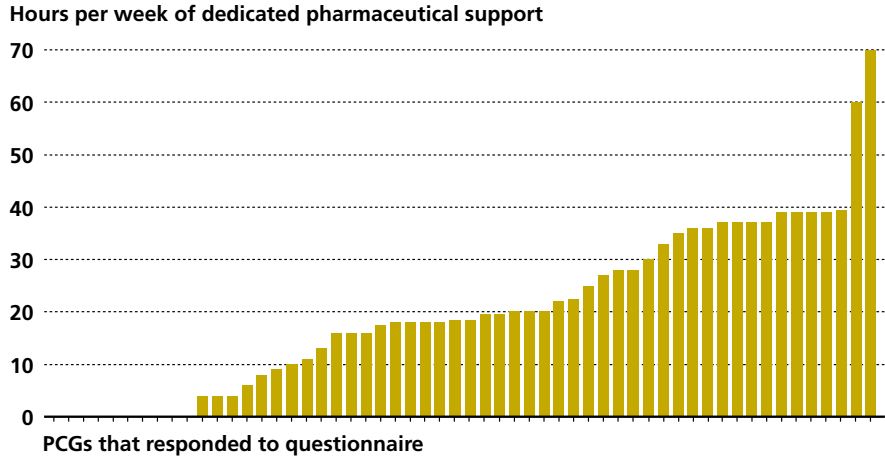
54. Four-fifths of PCGs that responded to the Audit Commission survey were already supported by their own dedicated pharmaceutical adviser; most of the others planned to appoint a pharmacist. Indeed, after the chief executive, a pharmaceutical adviser was the most common member of PCG staff. However, the availability of this support to the PCG varied widely, from just 4 to 70 hours, the average being 20 hours per week [EXHIBIT 10, overleaf]. NHS Executive guidelines state that the salaries of prescribing advisers should not count towards management cost limits. However, although much of this support was funded by top-slicing practice prescribing budgets, one in three PCGs paid for some or all of the advice from their own management budgets.

55. PCG boards should agree how pharmaceutical support can best be used to support their budgetary and clinical governance objectives. GPs have many calls on their time and may be reluctant to make the considerable sustained effort required to achieve significant savings in prescribing expenditure. It is therefore appropriate that PCG pharmacists are most commonly employed to provide practical support to the PCG and its practices in identifying and implementing changes, both to save money and to improve patient care. Most are also involved in monitoring prescribing spend and in review meetings with practices; these activities require a different sort of relationship with GPs. Similarly, over one-half of PCG pharmacists have been involved in setting practice prescribing budgets this year, and many more will set them in future years.

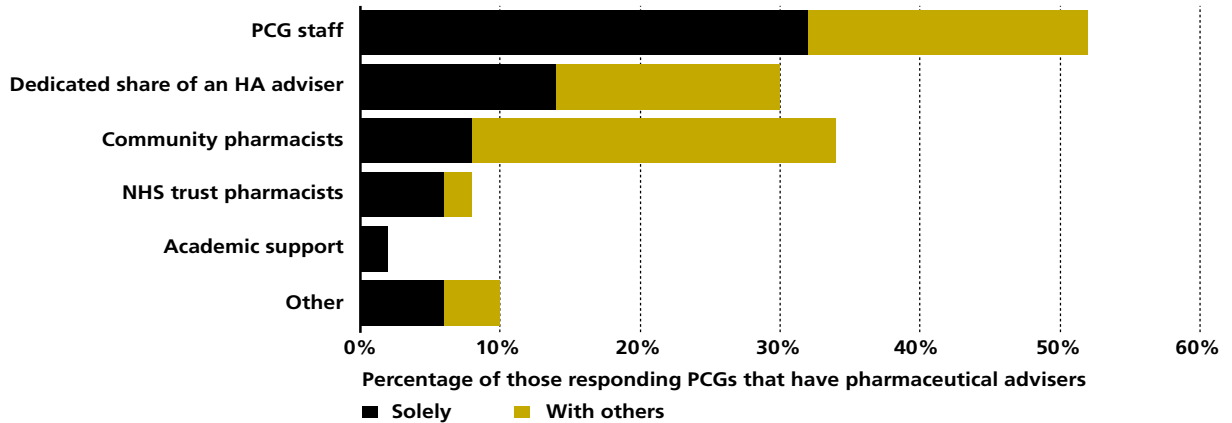
EXHIBIT 10

**Pharmaceutical Advice for PCGs**

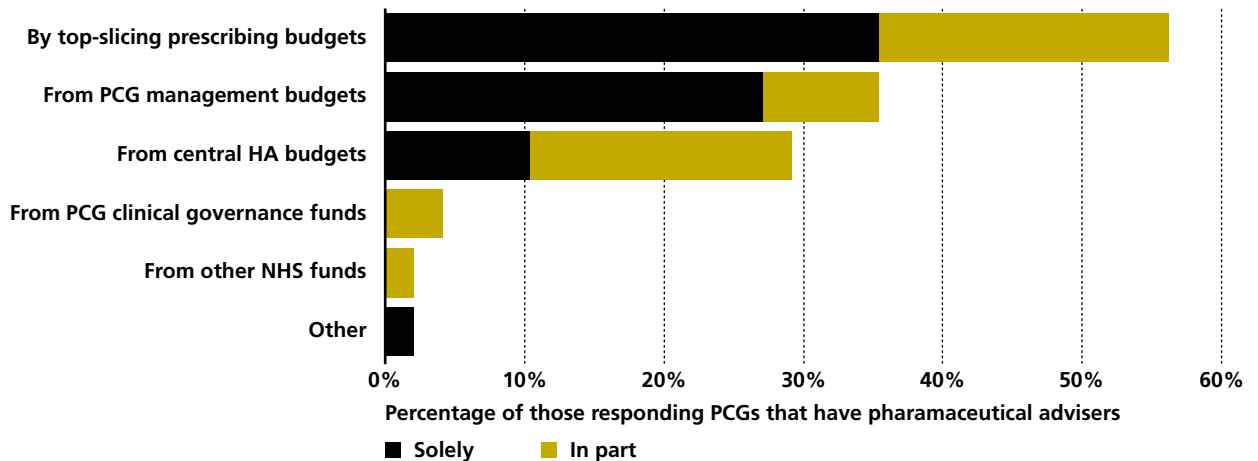
The hours of pharmaceutical support available to PCGs vary considerably.



Of PCGs with pharmaceutical advice, one-half employ a pharmacist directly and one-third have a dedicated share of a HA pharmaceutical adviser or supplement these resources with community pharmacists retained on a sessional basis.



The majority of PCGs funded this support by top-slicing practice prescribing budgets, but one in three PCGs funded some or all of the advice from their own management cost budgets.



Source: Audit Commission survey (July to September 1999)

56. Reviewing individual patient's medication records is a good way to identify both potential savings and ways to improve the effectiveness of prescribed drugs. However, one in three PCGs said that their pharmacists would be involved with medication review *clinics* this year and a further one in four thought that they would be in future years. Such face-to-face reviews typically take 20 minutes or more per patient, or longer still if a visit to a residential home or individual patient is required. Although such reviews can be valuable for improving the care of individual patients, they are unlikely to make a substantial short-term impact on prescribing costs. They should therefore come about as the result of a considered PCG policy rather than 'by default'.

57. Hospital prescribing has a major impact on drug expenditure in general practice. For example, medicines initiated in hospital are often continued after discharge. Drugs are sold to NHS trusts at very different prices from those reimbursed to community pharmacists and it is vital to ensure that hospital drug purchasing decisions do not inadvertently increase costs to the NHS as a whole. Some PCG prescribing leads have jointly negotiated with local hospital consultants that more cost-effective drugs should be prescribed to patients on discharge [CASE STUDY 3]. Nearly all responding PCGs have an area prescribing committee or joint therapeutics advisory group covering their area. These groups were set up with membership from NHS trusts, a HA and general practice to address issues arising at the interface between primary and secondary care prescribing. There need to be effective channels for disseminating decisions. Since PCGs were formed, most groups have reviewed their membership to ensure that each local PCG is represented; three in every four PCG prescribing leads now attend.

### CASE STUDY 3

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

Prescribing leads of PCGs in West Surrey have jointly negotiated with some local hospital consultants that the heart drug 'isosorbide mononitrate' should not be prescribed as standard in its much more expensive once-a-day 'modified release' form to patients on discharge from hospital. There could, of course, still be instances in which the more expensive formulation would be used on clinical grounds. If all were to adopt this change, it would offer a potential saving of up to £250,000 per year for PCGs across this HA. Such changes have been mooted for some years, but it has taken a co-ordinated approach by primary care clinicians to secure agreement.

## Giving all clinicians an incentive to promote cost-effective use of available resources

58. The satisfaction of improving the effectiveness of care given to individual patients is a sufficient reward in itself for most clinicians. Improvements to cost-effectiveness, particularly those requiring a substantial input of practice time and effort, may be a different matter. It may be some time before all identify with the budgetary problems of a PCG or local health community as a whole. Prescribing incentive payments provide a direct link between economic practice and visible improvements to facilities and patient care, as did fundholder savings, and are likely to remain important motivating factors.

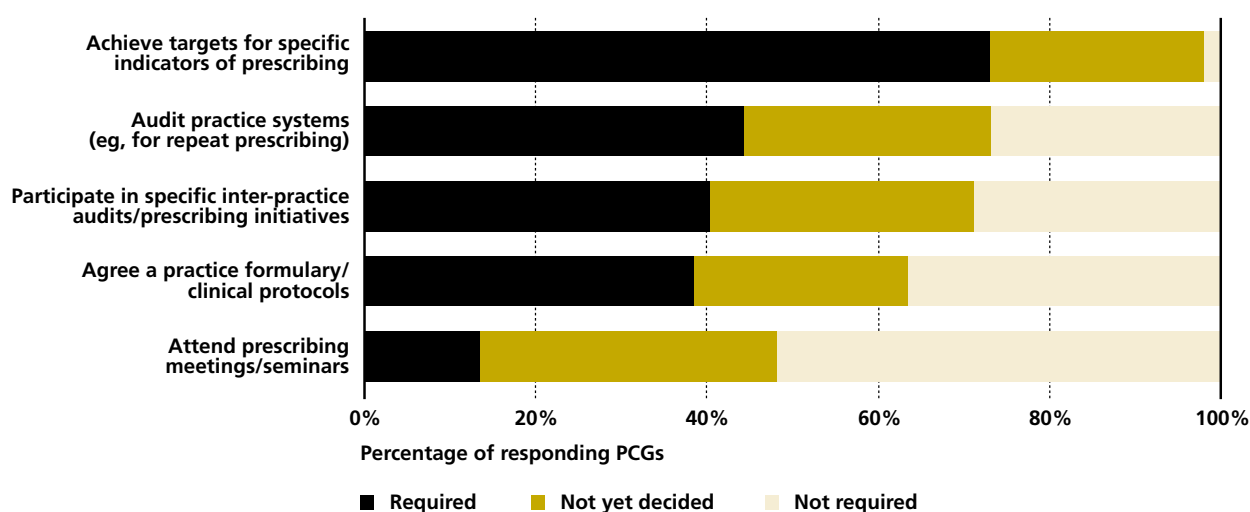
59. An issue for some PCGs has been whether incentive payments to practices should be related to the achievement of individual practices or to that of the PCG as a whole. The survey found that only three of the 57 respondents had decided to share all savings made across the PCG as a whole. However, one in five of those PCGs that had decided on the issue would have a mixture of individual practice and whole group incentives.

60. Nearly all PCGs (91 per cent) intended to run a prescribing incentive scheme this year. In the past, many HAs have attached conditions to non-fundholding prescribing incentive payments beyond the achievement of savings on indicative prescribing budgets. Many PCGs will do likewise [EXHIBIT 11]. Almost three-quarters of PCGs will definitely require practices to achieve targets for specific indicators of prescribing (in many cases this could just be a target generic prescribing percentage); most other respondents had not yet decided. About two in five will require practices to audit practice systems (eg for repeat prescribing), to participate in specific inter-practice audits and prescribing initiatives, or adopt a practice formulary or clinical protocols before they can qualify for incentive payments.

EXHIBIT 11

### Additional requirements for prescribing incentive scheme payments

Many PCGs will attach conditions beyond the achievement of savings on indicative budgets.



Source: Audit Commission survey (July to September 1999)

61. Initially, incentive schemes are likely to continue to be based on prescribing costs, key indicators and procedures, and perhaps achievement of health promotion targets. But a longer-term goal is to put in place incentives which reflect a more equal balance of PCG objectives, including participation in clinical governance, practice accreditation, primary care development and appropriate referral behaviour. The latter is not straightforward to assess. Interpretation of differences in numbers of referrals is difficult, as the cause of practice variations in use of specialists is insufficiently well understood. And assessing compliance with referral protocols could be both time-consuming and intrusive.

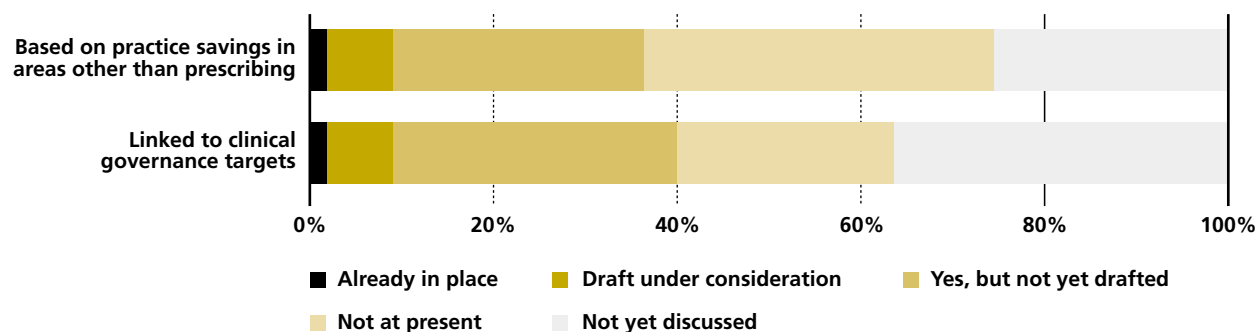
62. Two in five PCGs have agreed to consider incentive payments to practices based not solely on prescribing targets, but also on attainment of clinical governance goals [EXHIBIT 12]. Almost as many would consider schemes based on practice savings on the costs of referrals or general practice running costs. A few PCGs were also considering incentives that did not involve monetary payments to individual practices. In each of these cases, only one survey respondent would have such a scheme in place for 1999/00.<sup>11</sup>

<sup>11</sup> The June 1999 Audit Commission publication, *PCGs: An Early View*, gave an example of another incentive scheme linked to attainment of clinical governance targets planned by North East Lincolnshire PCG. That PCG now aims to fund the scheme in 2000/01.

EXHIBIT 12

**Incentive schemes that are broader than prescribing**

About 40 per cent of PCGs have agreed to introduce practice incentive schemes linked to attainment of clinical governance targets. Nearly as many plan to develop incentives based on practice savings in areas other than the prescribing budget. However, few PCGs have yet drafted or introduced such schemes.



Source: Audit Commission survey (July to September 1999)

## RECOMMENDATIONS (1iv)

**PCGs should:**

- employ pharmacists (and lay assistants) to provide practical support and advice to practices so as to facilitate rational prescribing and make cost-effective use of the PCG budget
- secure board agreement of priorities for the work undertaken by PCG prescribing advisers and for prescribing changes to be targeted
- co-ordinate policies with neighbouring PCG prescribing leads and make joint approaches to hospital consultants on issues such as choice of drugs prescribed on discharge
- co-ordinate the work of their prescribing and clinical governance sub-committees
- devise prescribing incentive schemes that recognise high quality as well as economic prescribing
- ensure that incentives form part of an integrated package of clinical governance advice, audit, education, information and support agreed HImP related objectives
- work towards incentives that are broader than prescribing.

**HAs should:**

- retain expertise to advise the authority on drugs strategy and performance management
- continue to provide specialist information and data to PCGs in areas where this can be done more effectively at health authority level
- facilitate risk management schemes to cushion the unpredictable effects for PCGs of high cost patients or courses of treatment
- co-ordinate HA-wide prescribing initiatives and liaison with NHS trusts
- ensure that PCGs have sufficient resources to reward practices that achieve clinical governance targets and make economical use of resources.

**The NHS Executive may wish to:**

- continue to ensure that there are mechanisms at regional level for agreeing policies on the use and introduction of new drugs and preparations, which complement NICE and other national guidance.

63. There are a number of key principles that any incentive scheme should meet [BOX F]. In particular, it is important that they should reward practice that meets high standards of quality, as well as being economic. Other ways in which PCGs are working to improve the quality of patient care are discussed in the next section.

## BOX F

## PCG INCENTIVE SCHEMES

These should conform to a number of key principles

Incentive schemes should:

- form part of an **integrated package** of clinical governance advice, audit, education, information and support
- be relevant to achievement of targets in the PCG's annual accountability agreement with the HA and its primary care development plan
- relate to a mixture of areas of potential in-year **economy**, longer-term **cost-effectiveness** and other **process quality** improvements
- include a **manageable number of targets** and offer practices regular monitoring information on their progress against them
- balance reward for continuing **improvement, achievability** for all practices and continuing recognition of a **record** of above-average achievement in previous years
- have an **assured source of funding** and clearly specify any exceptional circumstances in which incentive 'payments' might have to be deferred; the credibility of the scheme could be destroyed at the outset if in the event no incentives can be paid to practices
- include a clear agreed policy distinguishing windfall savings from those resulting from effective clinical management
- offer all practices (including dispensing practices which earn income from medicines supplied) the prospect of **non-derisory net benefits** for attaining targets
- **avoid** economies achieved by under-prescribing, by denying treatments which are clinically appropriate and cost-effective, or by shifting costs to others (including NHS trusts)
- make imaginative use of **non-financial incentives** (recognition, consideration of pet schemes etc)

Any indicators used, whether of prescribing or other clinical interventions, should:

- encourage behaviours for which there is good **clinical evidence** (or reasonable professional consensus) of **increased cost-effectiveness**
- be **understandable** and **accepted** by both GPs and clinical governance leads as **relevant**, useful and soundly based markers of good practice
- be based on **accurate** and **comparable** data. This includes the list size data used as denominators for many indicators of prescribing and health promotion
- relate to circumstances or conditions which are sufficiently **common** even in small practices that they are not unduly affected by a single decision
- be **responsive** to changes in clinical behaviour
- be **appropriately weighted**. Practices should not be denied any incentive payment simply because they have failed in one minor respect
- have **discriminatory power**.

Source: Department of Health (including Prescribing Indicators Group) and Audit Commission

## v. Quality

*... shifting the focus onto quality of care so that excellence is guaranteed*

64. PCGs are uniquely placed to break down pockets of professional isolation in primary care, span the interface with secondary care and social services, develop and spread good practice and, where necessary, harness peer pressure to improve quality of care. They need to ensure that all of these efforts are co-ordinated and are informed by HIMP priorities. They should be supported with any service developments needed to facilitate the desired changes, and with appropriate linked incentives for achieving good practice.

65. PCGs should:

- become a driving force for promoting clinical governance in primary care; and
- ensure that PCG members and staff have the requisite knowledge and skills, and that education and training are prioritised in accordance with agreed local development needs.

As previously discussed, PCGs should also ensure that clinical expertise informs the quality assurance of commissioned services.

### A driving force for clinical governance

66. Extending clinical governance to primary care as one way of ending the clinical isolation of some general practices is a key priority for improving quality of patient care. Clinical governance in PCGs embraces:

- agreeing clear standards and responsibilities;
- multidisciplinary clinical audit and follow-up;
- improving the quality of clinical data;
- supporting evidence-based practice and implementation of national guidelines;
- dissemination of good practice;
- dealing with poor clinical practice;
- ensuring that adverse events are investigated and lessons applied; and
- programmes to reduce clinical risk.

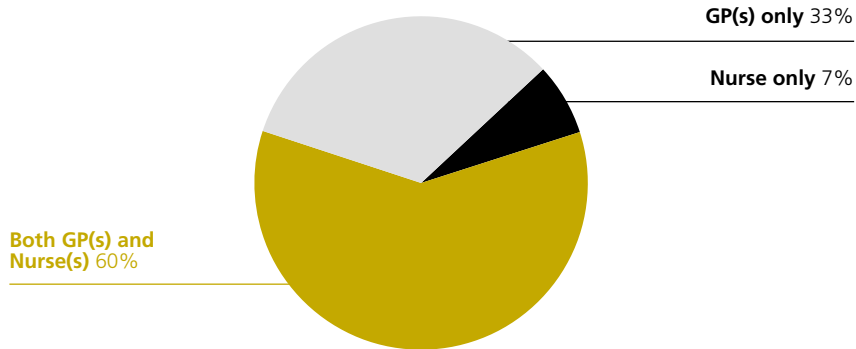
67. All PCGs are required to appoint a clinical governance lead to take this agenda forward. A majority of PCGs have appointed both a nurse and one or more GPs as leads. In three out of every four PCGs surveyed, all or most practices had also appointed their own clinical governance leads [EXHIBIT 13]. Most PCGs have set up a clinical governance subcommittee.

68. About three-quarters of surveyed PCGs felt they could also call upon day-to-day support for clinical governance from such areas of their HA as public health, and a similar proportion from a medical audit advisory group (or clinical governance support unit). Other sources of regular support for clinical governance available to some PCGs included continuing professional education or training consortia, academic bodies and, in some cases, industry-funded organisations. However almost one in ten PCGs said that no support was regularly available to them. It is important that available support is used efficiently. For example, although individual PCGs will wish to set protocols and formularies in consultation with their own local clinicians to maximise local relevance and acceptance, they should act collaboratively when compiling the evidence on which these are based.

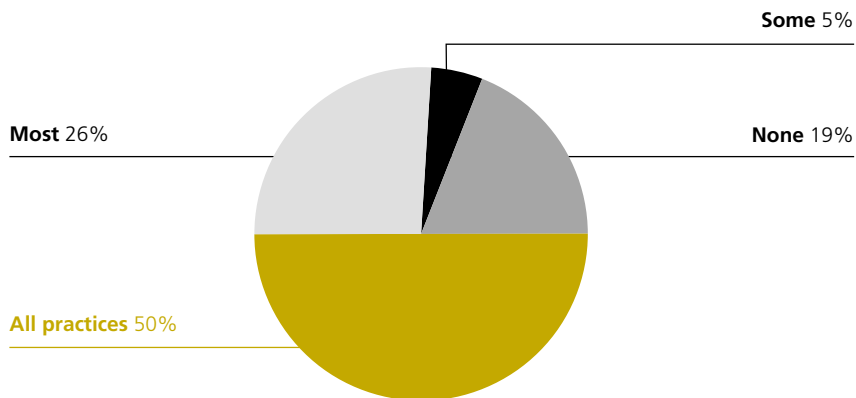
EXHIBIT 13

**Who is leading clinical governance in PCGs?**

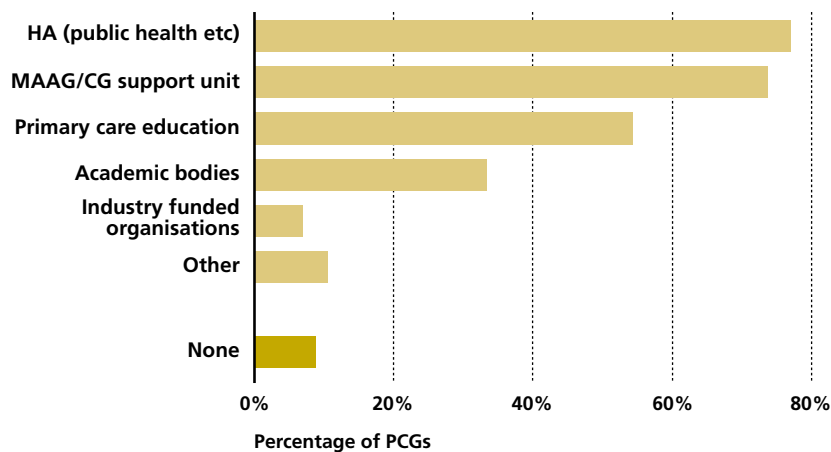
A majority of PCGs have appointed a nurse clinical governance lead as well as one or more GPs.



In over three quarters of PCGs, all or most practices had appointed their own clinical governance leads by the time that the survey was completed.



A majority of PCGs felt that they could call upon day-to-day support for clinical governance in public health and other areas from their health authority and from a medical audit advisory group; but almost one in ten said that no support was regularly available.



Source: Audit Commission survey (July to September 1999)

**69.** Unlike secondary care, where clinical audit has taken place for some years (albeit arguably not always effective), audit and other clinical governance related activity in general practice has been distinctly patchy in the past. A survey in 1998 by one NHS Executive regional office of GPs' readiness for clinical governance concluded that only half of respondents engaged in any sort of relevant activity. Thus clinical governance in many PCGs has started from a very low base. A quarter of the PCGs surveyed had not agreed their top clinical governance priorities for 1999/00. One in eight of the priorities listed by PCGs were essentially baseline assessments while a further one in five related to establishing working or reporting methods or simply drawing up a strategy for clinical governance.

**70.** There were wide differences between the amounts that the surveyed PCGs planned to spend on clinical governance this year. These ranged from £5,000 to £200,000 (averaging £20,000), equating to between £150 and £9,450 (average £1,550) per practice. Because of concerns over potential PCG spending in support of clinical governance, one HA studied was insisting that its PCGs fund all clinical governance activity, except for prescribing advice, within a locally set management cost limit. The survey confirmed that a substantial number of PCGs plan to fund some clinical governance activities out of their management budgets.<sup>1</sup>

**71.** All the PCGs studied have rightly tried to adopt a non-threatening facilitative approach to clinical governance. Most GPs remain independent contractors. PCGs cannot direct; only (in partnership with other bodies) advise, educate, and apply peer pressure. But many GPs do not readily acknowledge professional 'leaders' and a minority may not co-operate. Many PCG clinical governance leads said that their approach would be to offer practices additional resources that would help them to collect key data, conduct audits, and rectify practice organisational problems. It is not clear how this support will be funded. There is also a lack of clarity as to dividing lines between such activity and core general medical services.

**72.** Clinical governance activity should be part of an integrated package focused on HImP priorities. Seven out of every ten PCGs confirmed that their clinical governance programme this year would include inter-practice audit of treatment and/or referral for one or more of the conditions prioritised in their HImP [EXHIBIT 14]. A similar proportion intended to assess and improve the quality of data generated and received by practices on patients with these conditions. About six out of ten PCGs would try to agree common treatment and/or referral protocols for one or more of the prioritised medical conditions. Four out of ten PCGs intended to establish systems for sharing within the PCG information on any adverse events and their resolution. Clinical governance needs to actively involve all clinicians, not just GPs. However only one in three PCGs would try to agree any evidence-based protocols for nursing interventions common to community and practice nursing.

**73.** Much of this relies on the willingness of general practices to share information. Less than one in four PCGs had yet secured agreement that clinical audit data could be shared between practices within the PCG without first being anonymised [EXHIBIT 15]. In one area studied, the Local Medical Council has supported the right of individual practices not to provide data required for clinical governance or to be identified as non-complying practices. The survey confirmed that, although uncommon, this was not an isolated instance. One PCG said that their GPs would not agree even that anonymised audit data could be shown to other practices. This is unacceptable.

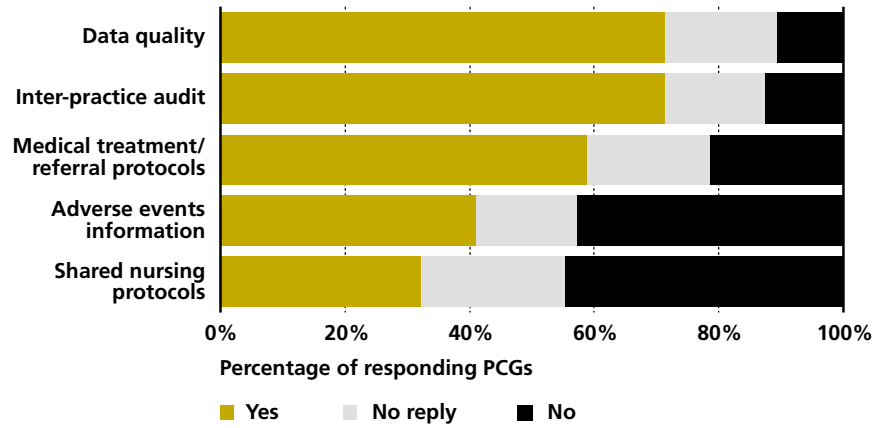
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<sup>1</sup> It is not clear from survey responses whether these sums are, as recommended by national guidance, outside the ambit of the management cost envelope as defined by the NHSE.

EXHIBIT 14

**Coverage of PCGs' 1999/00 clinical governance programmes**

Seven out of ten PCGs will audit conditions prioritised in their HImP and improve data quality.

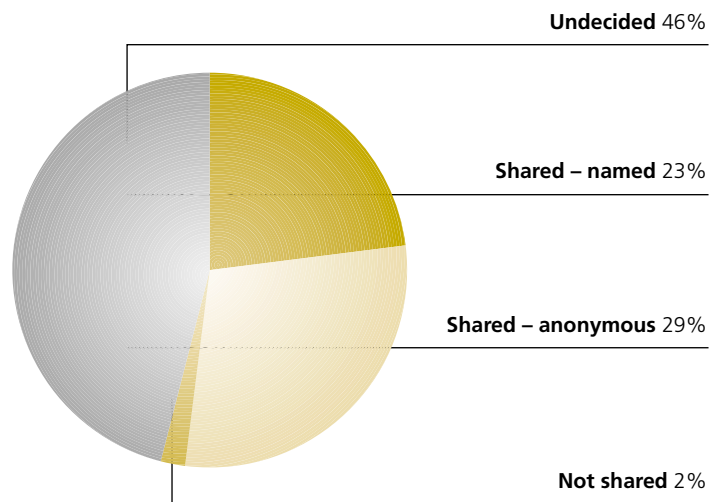


Source: Audit Commission survey (July to September 1999)

EXHIBIT 15

**Sharing clinical audit data**

Less than one in four PCGs had yet secured agreement that clinical audit data could be shared between practices within the PCG without first being anonymised. One PCG said that their GPs would not agree even that anonymised audit data could be shown to other practices.



Source: Audit Commission survey (July to September 1999)

74. It is important that clinical audit is not confined to medical issues or treatment of specific conditions, but also explores total packages of care available to groups of patients. The clinical governance priorities listed by responding PCGs can be broadly categorised as follows:

- over one-half of PCGs named topics of which one or more were predominantly disease related;
- one in three named topics which were more centred on practice systems, training or education;
- one in six included topics specifically focused on prescribing costs or systems; and
- one in eight included topics related to the overall treatment of a group of patients.

75. Of the disease related priorities, cardiovascular topics – a mix of coronary heart disease, stroke, hypertension, and anticoagulation -were the most frequently mentioned, with diabetes as the second most popular area for work; this reflects national priorities. The ‘practice systems’ category included such diverse topics as setting up information systems needed for clinical governance, continuing professional development and education, critical events monitoring, risk assessment, assistance with practice standards, and unspecified audit activity. ‘Patient groups’ included the elderly (for example, rehabilitation), palliative care patients, mental health, suicide risk and teenage pregnancies.

76. At some point PCGs will need to tackle the issue of the small percentage of ‘problem practices’ that may continue to provide poor patient care, despite offers of developmental help and assistance. It has been very difficult to prove or rectify such unacceptable performance in the past. Although PCGs have the advantage of being able to exert strong peer pressure, this is likely to remain one of their greatest challenges.

## Developing knowledge and skills

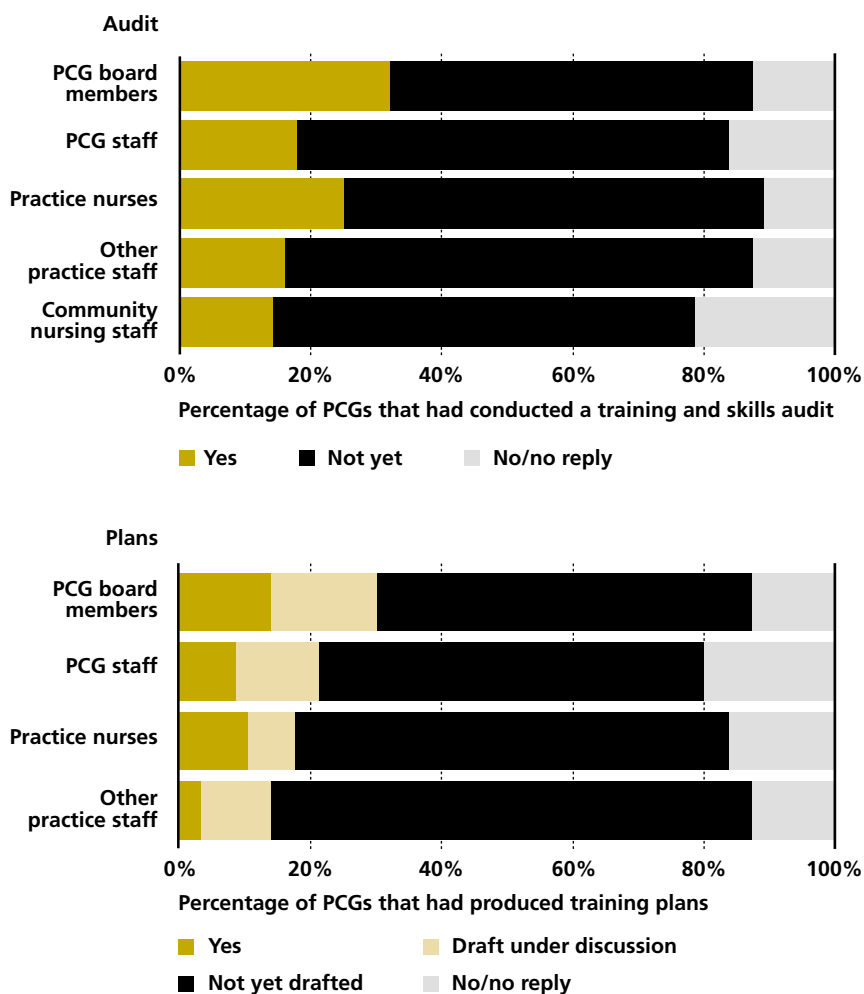
77. Continuing development of professional knowledge, clinical leadership skills and staff is integral to clinical governance and should focus on agreed local priorities. PCG members and staff may also need additional skills to administer and develop the PCG organisation. Most PCG board members received some initial training to ensure that they all had enough basic knowledge about the NHS to discharge their responsibilities. Some have also completed self-assessment forms to determine future training needs within frameworks produced by the NHS Executive, and have attended a variety of university facilitated events commissioned by regional offices. However, only one-third of survey respondents said that their PCG, or its HA, had audited the skills and training needs of board members. One in ten had no intention of doing so.

78. PCGs will also need to assess the skills and training needs of key PCG and practice staff. One in four PCGs had done this for practice nurses, in some cases also covering other practice staff or attached community nurses [EXHIBIT 16]. It has been suggested that each PCG then draw up a staff development plan, as a basis for co-ordinating individual training plans. As yet only a minority have done this. However, each practice in one PCG studied was producing a practice development plan incorporating personal development plans for GPs, practice managers and practice nurses. Seven out of ten PCGs had nominated one or more people with specific responsibility for leading on education and training, and most of the others planned to do so. Only a third of those nominated were also clinical governance leads. However, only one in four PCGs were separately represented on their local Education and Training Purchasing Consortium, and one in eight by their education and training lead. One in seven PCG chief executives did not know who represented their PCG on this body.

EXHIBIT 16

**Activity to develop skills in the PCG and primary care**

Only a minority of PCGs has yet audited skills and training needs or produced training plans.



Source: Audit Commission survey (July to September 1999)

79. Increasingly, PCGs may be held accountable for the quality of care delivered by their practices. Some PCGs are promoting mentorship arrangements for specific aspects of practice administration, as well as for clinical practice. There should be agreed minimum acceptable standards for practice administration, for facilities and key clinical areas. Where appropriate, the HA and PCG should consider developing plans for general practice accreditation.

**RECOMMENDATIONS (1v)****PCG clinical governance leads should:**

- ensure that clinical governance forms part of an integrated package of development, training and communication focused on HImP priorities
- encourage all practices to appoint their own clinical governance leads, and provide them with training and support
- negotiate sharing of clinical audit findings and data on a named practice basis
- make efficient use of (eg) public health support by collaborating with other PCGs when requesting evidence for protocols and formularies
- agree with boards the approach to be taken to any current or future 'problem practices'
- assess the skills and training needs of PCG, community nursing, and practice staff
- draw up a PCG skills development plan to inform individual training plans
- agree minimum acceptable standards for practice administration, facilities and key clinical areas
- consider mentorship arrangements for aspects of practice administration and, where appropriate, clinical practice.

**HAs should:**

- ensure that funding for clinical governance is sufficient to meet its objectives and that PCGs have access to adequate support and advice
- support PCGs in dealing with unacceptable practice
- survey the skills and training needs of PCG board members
- support PCGs in formulating development and training plans
- consider whether a general practice accreditation scheme would be appropriate.

**NHS Executive regional offices should:**

- continue to support skills development programmes for key members of PCGs.

## vi. A public service

*... accountable to patients, open to the public and shaped by their views*

**80.** As public bodies, PCGs have special responsibilities for demonstrating strict standards of probity and accountability for their own corporate actions and that of their individual members. In addition to establishing a secure foundation of corporate governance based on clearly documented standing orders, financial frameworks, and statements of delegated responsibilities [BOX G]. PCGs should:

- in common with other members of the local health community, work within clear, agreed accountability frameworks;
- open up their decisions to public scrutiny; and
- actively seek to engage patients, carers and the wider local public and take their views into account in decisions about service planning and delivery.

**81.** Board members must demonstrate a corporate approach rather than appearing to represent individual professional or geographic constituencies or interest groups. Chairs must ensure that no one professional group dominates the discussion.

**82.** The length of time it takes for PCG boards to start working together effectively may be affected by the history of co-operation (or lack of it) between local practices and with NHS trusts, philosophical differences, and past GP-HA relationships. Both the former manager of a large multifund and that of a locality commissioning project estimated that it would take a minimum of 18 months to start to think collaboratively. PCGs are structured rather differently and do not have the luxury of this length of time to develop effective working processes.

### BOX G

#### A secure organisational foundation

PCGs should by now have agreed with their HA a sound set of basic procedures for corporate governance including:

- standing orders
- a scheme of delegation of authority to PCGs and terms of reference
- standing financial instructions
- protocols and procedures governing sponsorship of PCG activity by commercial bodies
- procedures for declaration of interests
- personnel policies
- codes of openness (publications and meetings)
- controls assurance and audit arrangements.

There should be:

- a register of business (or relevant charitable) interests of board members and of their partners (in practice or domestic), to include services provided to community hospitals and other hospitals with which the PCG has a contractual relationship
- an agreed code of practice regarding disqualification from voting on decisions on which a board member has a potential vested interest.

83. Some PCGs are considering sponsorship offered by commercial concerns such as pharmaceutical companies. These may, for example, offer to sponsor meetings or educational events, train practice nurses, provide a nurse to help run clinics for specific diseases or co-ordinate audits, sponsor pharmacists to identify potential savings on prescribing, or even fund medicines management packages for certain conditions. Although not all such arrangements are inappropriate, many PCGs seemed to have given little thought to the wider implications. Each PCG should agree a policy governing relationships with the pharmaceutical industry and other commercial bodies [BOX H].

#### BOX H

##### Sponsorship of PCG activity by commercial bodies

###### PCGs will need a policy on relationships with the pharmaceutical industry:

1. There should be procedures to direct approaches from pharmaceutical industry and other commercial bodies to one or more nominated people within each PCG (to ensure an appropriate co-ordinated response and to avoid duplication of effort).
2. They should organise seminars to raise GP and nurse awareness of issues such as pharmaceutical company promotional strategies, potential conflicts, expectations of openness and declaration of interests, as well as the potential benefits of constructive collaboration and sponsorship.
3. Procedures are needed to ensure that GPs, nurses and trusts inform the PCG and HA of commercial sponsorship or involvement with any body or charity in which they have an interest. Declaration of interests should be built into the contracting process for provider trusts and the annual accountability agreement for PCGs.
4. Any sponsorship or benefit to individuals must be acceptable to the requirements of corporate governance and must be open to inspection.
5. All sponsorship agreements must be capable of immediate cancellation by either party.
6. PCG clinical governance leads should work with local ethics committees to guard against the unwitting promotion of drugs of unproven quality which may be the subject of quasi-scientific research.
7. PCGs and HAs should not accept commercial sponsorship for meetings unless it is sure the products involved are in line with its approach to rational prescribing, and the methods employed are acceptable.
8. PCGs and practices should only accept drug company sponsorship for training (eg of nurses or dispensing staff) if it can be assured that such training is impartial and in line with PCG strategy and training needs assessments.
9. The PCG, through its prescribing subcommittee or clinical governance lead, should monitor carefully changes to relevant prescribing patterns in practices with commercially sponsored nurses.
10. The HA, with PCG assistance, should ensure that there are no promotional messages contained in patient information leaflets handed out by agencies or on display in community pharmacies or surgeries.
11. Where possible, the PCG should explore options for working through an independent 'honest broker' to achieve an 'arms length' working relationship with commercial bodies for mutual benefit.

*Source: Freely adapted from a draft policy governing relations with the pharmaceutical industry prepared by Northamptonshire HA with additions from similar policies developed by other HAs.*

## Agreed accountability frameworks

84. PCGs work within annual accountability agreements negotiated with their HAs. These agreements should represent just one dimension of a framework of agreements between interdependent members of the local health community.

85. Unlike many of the other organisations involved, PCGs have a very small directly managed staff which cannot deliver change in large areas of its responsibility without the willing participation of independent contractors. In these areas, PCG management can only be held to account for the vigour, subtlety and inventiveness with which it goes about securing co-operation and ownership of its policies and initiatives.

86. However, on another level, each PCG also exists as a collective body of general practices and other stakeholders. For them, involvement in the process of compiling and securing agreement on targets in the accountability agreement, particularly those related to the development of primary care, could influence change to a greater extent than the completed document itself. To minimise the time burden of such involvement, it would be helpful if the process of agreeing such accountability targets was concurrent with (or flowed smoothly on from) stakeholder input to other plans such as the PCG contribution to the HImP or primary care development plan. And, although accountability agreements are single-year documents, it would help stakeholders to see targets in context if they were presented as just the first milestones of an ongoing development programme.

87. Clearly, to be effective, targets should be agreed as early as possible in the year. But only a third of PCGs had finalised 1999/00 annual accountability agreements by the time that they responded to the Audit Commission survey (July to September 1999). A further quarter of PCGs had reached a provisional agreement. But a few PCGs had not yet drafted an agreement, or received a suggested draft from their HA. The areas in which PCGs were most likely to have agreed specific measurable targets this year were: promoting appropriate, cost-effective prescribing and clinical governance [EXHIBIT 17, overleaf]. However, one in five of the PCGs surveyed reported that they had not agreed specific targets in *any* of these areas.

88. As PCGs develop and PCTs are formed, targets are likely to focus more on outputs and less on processes. The mix should reflect the current stage of organisational maturity of the PCG. Ideally, accountability agreements should include a manageable number of specific, appropriate, measurable targets for the year reflecting key organisational developments and a balance of HImP priorities. But they should also leave the PCG adequate scope for local discretion over how these targets are delivered.

89. Most HAs will continue to support their PCGs this year with:

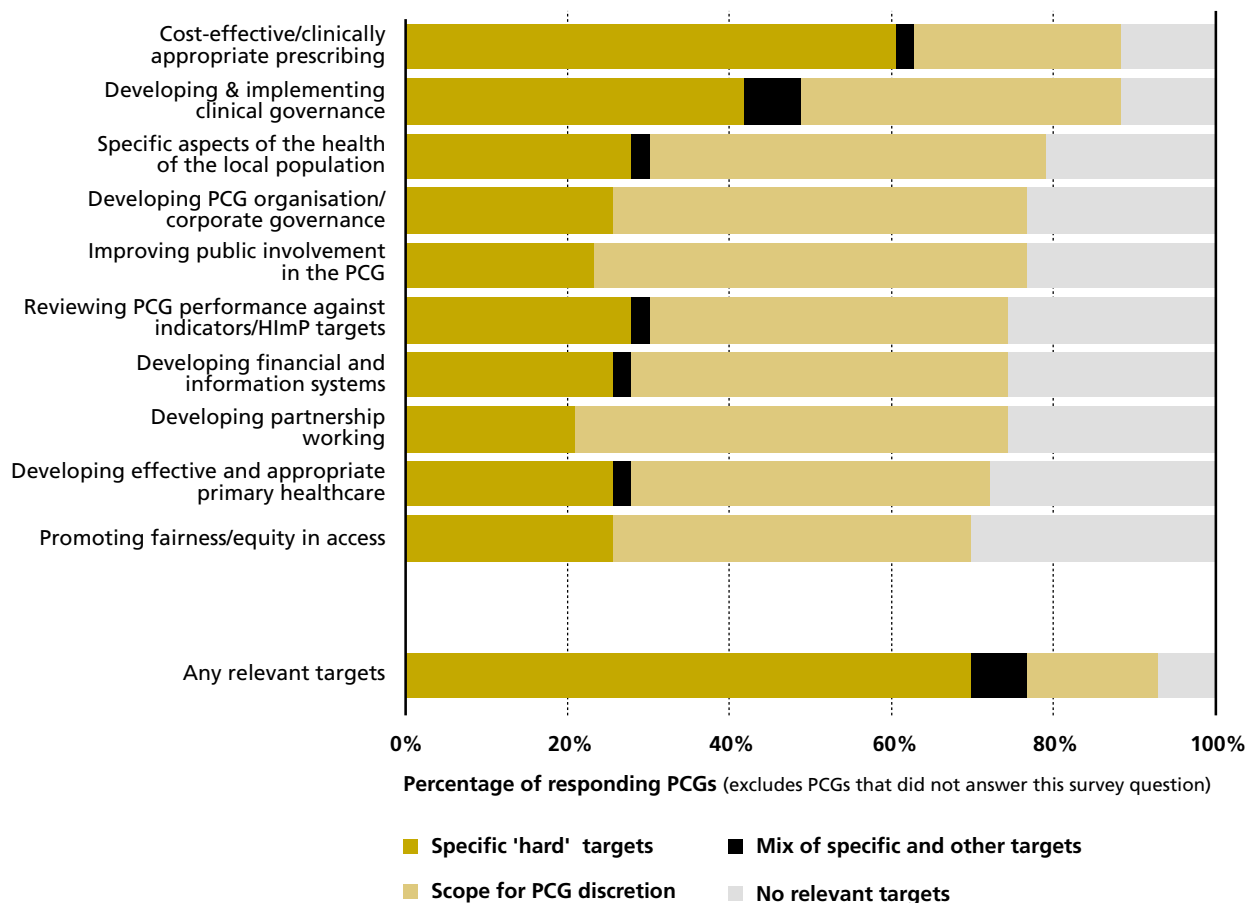
- information;
- commissioning expertise;
- public health support;
- prescribing advice; and
- developmental activities.

The nature and scope of this support should be documented in performance agreements that should be regarded as part of the annual accountability agreement. Only 15 per cent of respondents yet had such agreements for all key areas of HA support. Suffolk Health's partnership agreement with its PCGs goes further by documenting against each objective agreed by the PCG, the supporting action that will be taken by the HA.

EXHIBIT 17

**Types of target included in PCG-HA accountability agreements**

Most PCGs with accountability agreements had some sort of targets for at least prescribing and clinical governance. However, almost one in four PCGs had agreed no specific (hard) targets.



Source: Audit Commission survey (July to September 1999)

**Open to public scrutiny**

90. PCGs face public scrutiny through board meetings, consultation, and other communications with the public. They are also scrutinised by others, as diverse as CHCs and auditors, acting on the public’s behalf. In all their dealings, PCGs need to present a competent, professional face that demonstrates balanced and open consideration of all stakeholders’ interests. PCG chairs carry a particular responsibility for ensuring the smooth running of meetings. Any who lack previous experience of running public meetings will need to acquire these skills rapidly. Lay members too, as the patients’ appointed representatives on the board, have a duty to ensure that board discussions exclude unnecessary clinical jargon and are comprehensible to members of the public.

91. Nine out of ten PCGs permit public attendance for at least part of each main board meeting. A majority of PCGs hold monthly board meetings, but one in five meet more frequently, and a one in ten bimonthly or quarterly. Some PCGs hold closed board meetings, or ‘workshops’ in between those that are open to the public.

92. Although open board meetings are an important element of public accountability, they are not necessarily the best way either to inform and involve the public, or to improve public perception of the responsiveness of the NHS. Most PCG board meetings attended by members of the study team attracted only two or three observers. Understandably, many were held in the afternoon, at times and locations convenient to board members rather than to potential observers. Some were poorly publicised. They were conducted in a variety of styles and degrees of formality, some chairs welcoming pertinent questions from observers, others permitting no public contribution [CASE STUDY 4]. If the latter approach is adopted, there need to be alternative, well publicised ways for patients to question board members and put forward their views.

**CASE STUDY 4**

**PCG board meetings – Examples**

PCG A	THE IDEAL?	PCG B
<ul style="list-style-type: none"> <li>• Quarterly, afternoon meetings. No information available in local central library.</li> <li>• No papers available for observers at the meeting or information on how to obtain them in advance.</li> <li>• No name plates or introduction of board members. PCG chief executive absent (on a course).</li> <li>• Discussion dominated by 2-3 GPs. Little or no involvement of nurse, lay member, social services. Co-opted HA member suggesting financial fait-accompli – no PCG budgetary freedom or discretion on timing. CHC member reporting individual patient experiences.</li> <li>• No date agreed for next meeting.</li> </ul>	<ul style="list-style-type: none"> <li>• A list of dates and locations of public meetings displayed in practices, clinics, local libraries etc. Meetings advertised in high circulation local newspapers with an indication of the main issues to be discussed and information on how to obtain copies of papers. An accessible public venue of suitable size. At least some evening meetings.</li> <li>• Copies of papers available at the meeting with brief explanation of common jargon and a form to request minutes.</li> <li>• Name plates, stating affiliation.</li> <li>• Each topic 'sponsored' or introduced by a nominated board member, co-opted member</li> <li>• Chair ensures well paced but balanced discussions resulting in either firm decisions or a working group remit.</li> <li>• Observers have opportunity for informal discussion with board members at end of meeting and express interest in topics.</li> <li>• Rapid communication of board decisions to practices and other stakeholders.</li> </ul>	<ul style="list-style-type: none"> <li>• Monthly public board meetings</li> <li>• Copies of agenda and papers provided for observers on chairs.</li> <li>• Name plates, but without job titles.</li> <li>• Friendly atmosphere. Reasonably informal setting and conduct of meeting. Somewhat bland discussion led by the chair and chief executive. Few resolutions passed. Input mainly from GPs but feeling that everyone had ample opportunity to express an opinion. Relaxed but well paced.</li> </ul>

Source: Audit Commission

### Consulting and involving the public and voluntary bodies in planning services

93. PCGs need to enlist the support of patients, carers and the broader public if they are to deliver their huge service development agenda within available resources. All PCGs have a lay member on their boards and just over one-half have also co-opted a representative of the Community Health Council. Many have consulted more widely, although often to seek comments on plans that have already been made rather than to seek active suggestions on how to improve service delivery. But nearly all need to do more in future to involve service users and to keep the wider public (as opposed to specific interest groups) informed and involved. This is neither cheap nor straightforward. Most PCGs will need to act in collaboration with individual practices or other authorities.

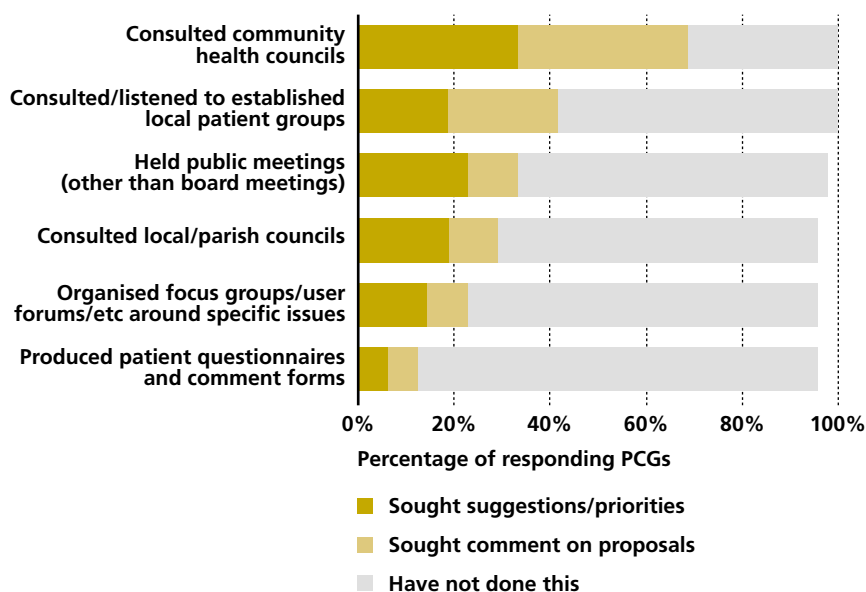
94. This year most PCGs had limited opportunity for substantial **consultation of patients**, carers or the wider local public, for example when drawing up priorities for primary care investment [EXHIBIT 18]. Of those PCGs that replied to this question:

- 70 per cent had consulted their CHC, but a majority of these asked for comments on PCG proposals rather than proactively seeking suggestions or priorities;
- 42 per cent had consulted or listened to established patient groups, although only 18 per cent had actively sought their suggestions;
- 34 per cent had held public meetings (in addition to board meetings), 22 per cent to seek suggestions;
- some others had consulted local or parish councils, or organised focus groups or user forums around specific issues (but often to seek comment rather than new ideas); one mentioned the formation of Local Health Partnership forums to set the agenda; and
- a few had used questionnaires to seek suggestions and help establish patient priorities.

EXHIBIT 18

#### PCG consultation of the public on investment priorities

Most PCGs had only limited opportunity for public consultation this year.



Source: Audit Commission survey (July to September 1999)

95. Each PCG should formulate a strategy for communicating with stakeholders and for gathering the views of a broad range of patients, carers and local people. This strategy should cover how their views will be used in evaluations of new developments as well as circumstances in which forthcoming decisions will be considered for wider consultation, how this will be done and in what timescales. Principles of effective community consultation should be taken into consideration [BOX 1]. One PCG surveyed had appointed a part-time 'public involvement project manager'. Most PCGs, however, will need to identify somebody from a HA, local authority or other body with the requisite experience to support them in this difficult area.

96. It may sometimes be appropriate for PCGs to focus consultation through individual practices or clinics as these will have the most direct relevance to many. This will depend on the types of issues on which they are consulting and whether the focus is on the views and suggestions of current service users or a wider constituency. Consultation on some service delivery issues may be focused on a small, defined group of existing users. In such cases, an objective of the consultation may not just be to obtain views but to involve consultees as equal partners in the specification of service changes so as to increase user championship of the proposals.

#### BOX 1

##### Consulting and involving patients, carers and the local community

Effective Community Consultation (Ref.8):

- is an **exchange** of views and information
- is related to real forthcoming **decisions** that the PCG has to take
- may seek peoples' views as **patients or carers** (current or potential), **local citizens** or, perhaps less relevant to PCGs, as **taxpayers**
- **concentrates** on policy decisions where there is little existing information about local people's views, that are controversial, that have a significant impact on users, or major financial implications, as well as those on which there is a statutory decision to consult.
- is part of a **coherent programme or strategy**
- **builds** on existing information
- is **competently carried out**, using consultation techniques that are appropriate to the complexity of the issue
- is carried out **jointly** with other organisations if their plans bear upon the issue, or if this could make the costs of consultation more manageable for a small organisation
- is **inclusive**, involving a wide range of people, not just vocal minorities
- does **not raise unrealistic public expectations**
- provides **feedback** to consultees on how their views have been taken into account
- is **evaluated** as a process.

### RECOMMENDATIONS (1vi)

#### PCGs should:

- ensure that their accountability agreement with the health authority contains measurable targets/milestones that fit with longer-term development programmes
- generate stakeholder ownership by engaging as many as possible in agreeing targets
- try to agree targets as early as possible in the year
- formulate a strategy for communicating with stakeholders and for consulting a broad range of patients, carers and local people
- ensure that the views of patients, carers and the wider local public are taken into account in decisions about service planning and delivery.

#### HAs should:

- assist by suggesting a range of possible appropriate measurable targets/milestones for each PCG
- recognise that, as PCGs mature organisationally, targets should focus on outcomes rather than processes
- encourage inclusion of some accountability targets reflecting PCG as well as national/HA priorities
- document the scope and nature of the support to be provided by the HA to PCGs
- ensure that PCGs are supported in their efforts to consult with and involve patients and the local community.

#### The NHS Executive may wish to:

- provide guidance on how to set appropriate measurable targets
- allow maximum scope for local discretion on targets and the timing of action
- consider how the collective profile of PCGs can best be raised.

97. Thus far, this report has described PCG progress in helping to implement 'The New NHS'. In doing so, it has mentioned challenges specific to particular areas of PCG activity. The next section draws together a number of broader concerns raised by chief executives with suggestions on how they might be overcome.

## 2. Moving on

98. Many PCGs will wish to maximise the potential benefits of their current status and to consolidate the organisation before moving on to decide whether to apply for trust status. Future mergers with neighbouring PCGs, community health trusts and eventually with other health and social work services may also be a possibility. A clear development path and agreed timescale will be needed by all organisations that contribute to the local health economy. This should also inform HA plans for restructuring and refocusing on its new roles, while still providing the necessary development support.

### i. Maximising the benefits of PCG status

99. Responses to the Commission's survey of chief executives suggested 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 targets.

Certain of these issues have already been discussed and are mentioned only briefly below.

#### Overcoming time pressures

100. A majority of PCG chief executives commented on consequences of the rapid pace of organisational development expected of PCGs. They felt, for example, that there had not been sufficient time to develop the capacity of the board, involve clinicians, or to engage with other stakeholders before being expected to set and achieve care development targets to which all subscribed.<sup>1</sup> As important were time pressures on individual clinicians and managers.

101. As previously noted, most PCGs have a very small administrative staff. A number of respondents believed that work levels for key individuals tackling such a broad and complex agenda were unsustainable. Pressures are compounded in areas where there are few existing local primary care strategies or systems. The handful of staff in each PCG is also expected to master and action a range of circulars and directives which in HAs had been the responsibility of many more. There is a danger that the resulting paperwork will leave little time for PCG development. HAs should support PCGs in actioning relevant NHS Executive circulars and co-ordinate their own requests. HAs must pace their own reorganisation to reflect changing responsibilities and development needs, and release to each PCG a commensurate share of total permitted management costs.

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<sup>1</sup> This accords with findings of research on Total Purchasing Projects and Multifunds that suggested two years were required before they matured as an organisation.

**102.** There are even greater constraints on the time that clinicians' can devote to PCG matters. Concern was expressed about 'burn out' of those most heavily involved due to a lack of support. PCGs will need to ensure that the time of clinicians serving on PCG boards and subcommittees is used efficiently. All board members should have clear lead responsibilities. It may also be useful to establish a formal executive group to take forward PCG business between board meetings. One in three PCGs have done this. However rather more have no intention of doing so; some consider that it would be potentially divisive. In particular, it would seem inappropriate for the membership of an executive group to be confined to GPs and officials with no representation from nurses or other stakeholders, as was the case at a few surveyed PCGs.

**103.** PCGs should make a virtue of remaining compact organisations by devolving planning and development work to practices and other stakeholders. Drawing them into project groups and subcommittees could improve local ownership of problems and plans. And 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.

**104.** There would be advantages in developing some PCG initiatives in collaboration with other organisations or neighbouring PCGs. Issues could be researched and documents or frameworks drafted jointly as a basis for initial discussion and amendment to reflect more local considerations. Although PCG managers need to be multi-skilled, it may be better to share certain more specialist type of expertise with other PCGs, trusts or local bodies, or to buy it in from, for example, community trusts. Short term secondments between the PCG and HA or provider trusts could build experience and understanding as well as filling short-term needs. Certain functions could be carried out on an agency basis by an NHS trust or authority, perhaps for a number of PCGs.

**105.** PCGs should also try to link with, and involve, other local bodies, educational establishments and service users that may be willing to offer their resources, expertise and experience 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.'

### **Living within funding constraints**

**106.** The barrier to success most commonly mentioned was that PCG budgets were too small to deliver the agenda. For example, no funds were available for supporting work in general practices such as development of the practice information needed for clinical governance. A number commented on lack of adequate funding or resources for services, and the lack of GMS growth funds. The problem has been compounded by recent unpredicted pressure on prescribing budgets caused by rising generic drug prices. PCG development, some said, was being inhibited by the overall financial deficit position of their HA. And not every acute provider had accepted its responsibility as a partner organisation to live within agreed budgets.

**107.** Examples have been given above of how some PCGs are successfully limiting rises in prescribing expenditure and in hospital referrals. However achieving savings is made more difficult by poor quality data and IT systems.

## Improving data quality, IT and communications

**108.** Poor data and inadequate electronic communications facilities were common themes in the survey responses. Their consequences, both clinical and managerial, are widespread.

- Deficiencies in the data needed for commissioning and how some PCGs are working to overcome them have been discussed above (paragraph 30).
- Inadequacies of planning data, practice data for clinical governance and data manipulation skills have also been mentioned.
- Communication between partners in the local health economy including general practices, other primary care centres, PCGs, NHS trusts, social services and the HA is often slow. This problem will have even more serious consequences with the expansion of joint working and provision of care in increasingly diverse settings. Some survey respondents complained that they were being afforded low priority when new IT links were installed.
- Not all clinicians have ready access to centrally held databases or to clinical reference material held on intra-nets or the world-wide-web.

**109.** To address these problems, seven out of ten PCGs have established subcommittees to develop IM&T within their PCG. 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, and over one-half of those surveyed named it as a top primary care development priority.

## Winning over general practices

**110.** Poor communication systems between practices and with the PCG can also affect GP attitudes and involvement. A number of PCG chief executives expressed concerns about GP suspicion, lack of involvement or vision and the scale of cultural change required. There was mention of tensions between 'reformers' and GPs unconvinced of the need for change. One commented on practices' lack of trust in the PCG board. 'Practice culture', GPs' independent contractor status and inflexibility in the deployment of support staff were seen by some as hurdles. There were also comments about barriers imposed by the politics of the local health economy and by the organisation of partners such as social services and community health.

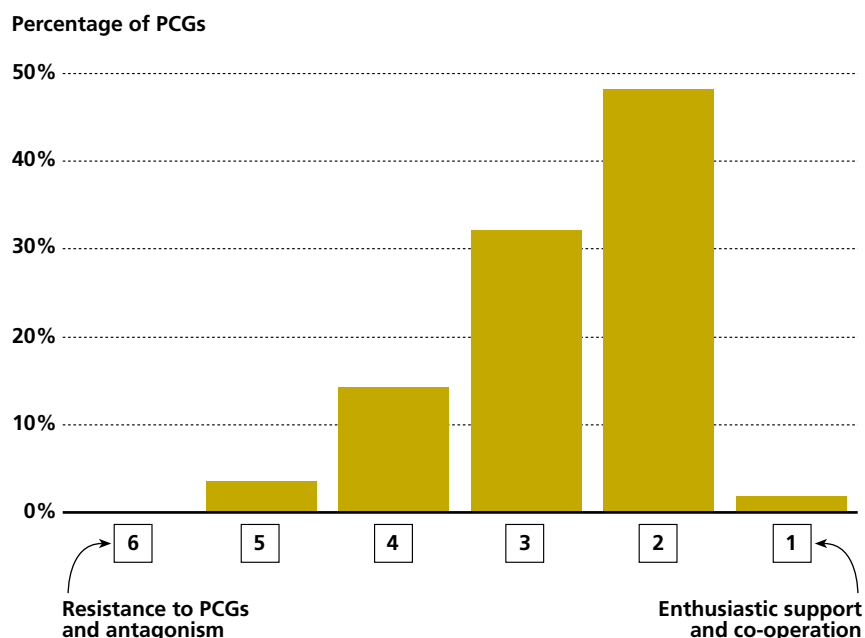
**111.** However, resistance to PCGs from GPs is not widespread. A majority of PCG chief executives perceive practices to be supportive [EXHIBIT 19, overleaf]. Support and involvement can be further increased by:

- securing ownership; consulting and involving all practices and their staff in working groups or informal discussion workshops, eg: on health needs assessment and contributing to the primary care investment plan;
- a grass roots approach to decision-making; practice-based planning; or distributing decision-making authority to locality groups;
- setting up a patch and cluster model of practice organisation and support. Survey findings confirmed that PCGs that had area sub-groups or primary healthcare team patches were more likely than others to report that practices were supportive;
- developing good communication through information and news sheets, setting up forums and practice managers meetings;
- spending the time to develop PCG values, principles and methods of working;
- establishing a constructive, supportive ethos for practices;

## EXHIBIT 19

**Perceived practice attitudes towards PCGs**

A majority of PCG chief executives perceived practices to be supportive.



Source: Audit Commission survey (July to September 1999)

- setting up a Primary Care Development Centre; and
- developing a corporate approach to a wide range of services; for example, one PCG mentioned that bringing all GPs into the out-of-hours co-op was a useful signal of a PCG wide approach to corporate governance.

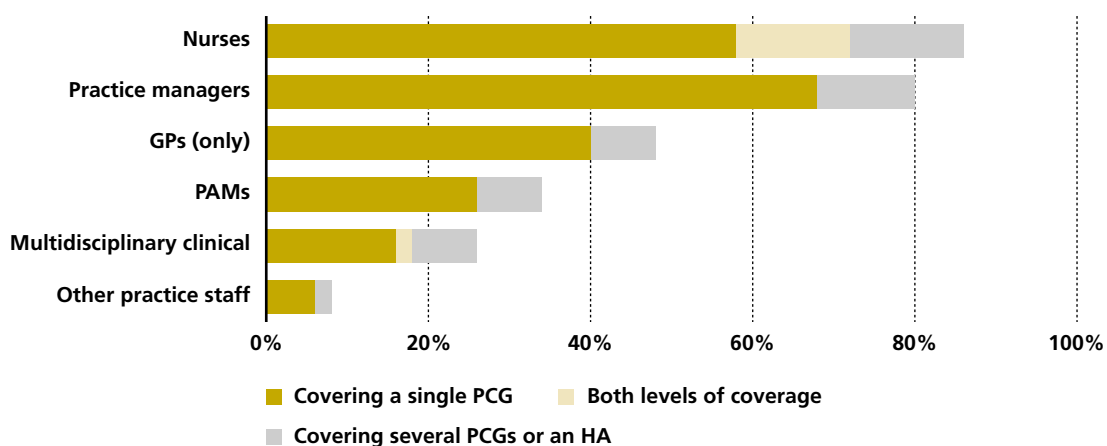
**112.** Professional forums have a vital role in collecting and disseminating information and good practice amongst practices and staff. Seven out of ten PCGs have set up forums for their own nurses (sometimes separate ones for different branches of nursing) and about half of the rest have joint nurses' forums with other PCGs or covering the whole HA [EXHIBIT 20]. Almost as many have PCG specific forums for practice managers, and a third of PCGs have set up forums for their own GPs. Attendance at such forums needs to be encouraged through provision of appropriate cover.<sup>1</sup> A majority of PCGs also reported groups offering chief executives and chairs opportunities for discussion with their counterparts in other areas, and one in four similar meetings for other PCG managers.

<sup>1</sup> For example, Totton & Waterside PCG has agreed that nurse forum expenses should be paid from its PCG Management Budget to allow more nurses to become involved.

## EXHIBIT 20

**Professional and managers' forums**

Such forums have a vital role in collecting and disseminating information and good practice. Seven out of ten PCGs have their own nurse forums and meetings for practice managers.



Source: Audit Commission survey (July to September 1999)

### Reconciling conflict between local initiative and central prescription

**113.** PCGs see it as vital that practices and other stakeholders feel 'ownership' of PCG policies and priorities. However HAs have wider preoccupations and are also charged with ensuring that national targets are met. It is perhaps not therefore surprising that the second most pervasive theme in the survey responses was PCGs' perceptions of HA attitudes, inertia or unwillingness to 'let go'. In some cases this has led to an inability to agree responsibilities between HAs and PCGs.

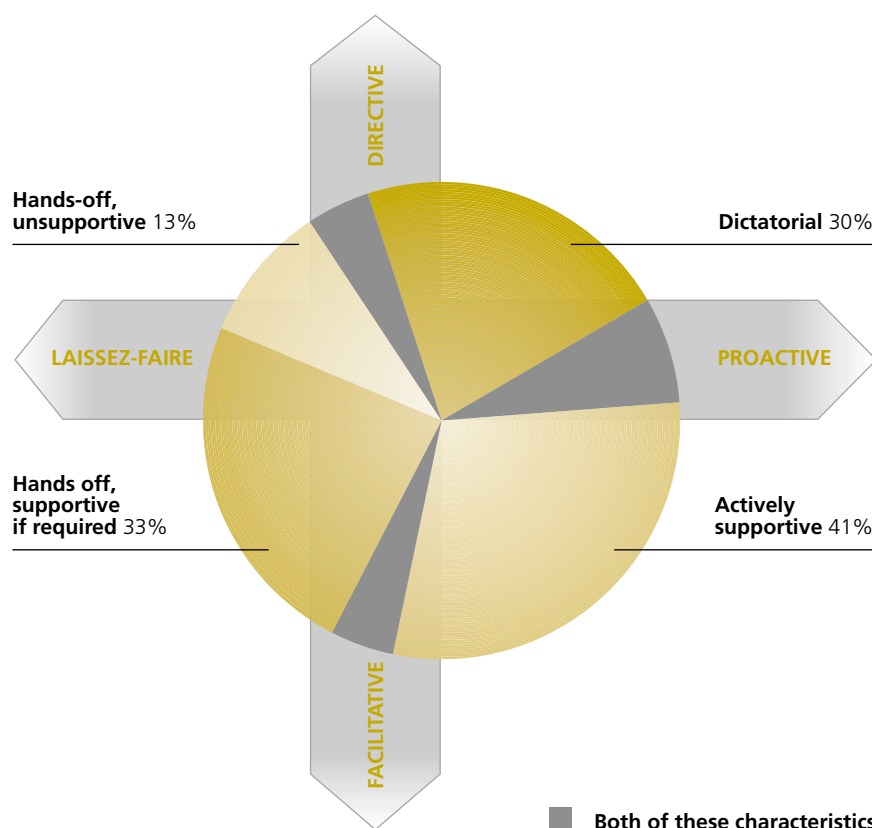
**114.** A majority of surveyed PCGs found their HA supportive, but a substantial minority was more critical [EXHIBIT 21, overleaf]. Three out of ten said that their HA was 'dictatorial'. Surprisingly, PCGs whose chief officers regularly attended HA senior management team meetings were, on average, no better disposed than those that did not report involvement in HA management! This may reflect the quality of their involvement.

**115.** There was also comment about conflicting guidelines, rhetoric and information received from HAs and conflict between local and national priorities. One respondent said that high level performance indicators and national requirements were side-tracking PCGs from addressing local issues; HA preoccupation with waiting lists would mean that the social intervention agenda would not be explored; another commented 'entirely a top-down approach with no real consultation with PCGs and apparently designed to maintain central control'. A somewhat different view expressed by another PCG was that HA emphasis on commissioning and the consequent lack of co-ordination and support provided for primary care development would increase inequality between PCGs.

EXHIBIT 21

**How PCGs view their health authority**

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



Source: Audit Commission survey (July to September 1999)

**116.** Each HA must ensure that its own organisation changes in parallel with the progressive transfer of functions and responsibilities to PCGs. The NHS Executive document, *Leadership for Health: The HA Role* (Ref.9) confirmed the government’s vision of the way forward. But although HA staffing will be reduced in areas where its responsibilities are declining, each HA will need to retain a balanced perspective over the entire spectrum of healthcare. It will require continued access to primary care expertise to inform strategy and ensure that PCG accountability arrangements are meaningful. And, in the shorter-term, it will also need to retain (or even recruit) sufficient relevant experience to support PCG development.

**117.** The sometimes strained relationship between PCGs and their HAs is one of the most frequently mentioned factors driving the move towards PCT status, and the mergers which some PCG consider inevitable if they are to attain greater independence.

## RECOMMENDATIONS (2i)

### PCGs should

- spend time to develop PCG values, principles and methods of working
- develop good communication through information and news sheets, forums and meetings
- encourage attendance at professional forums by funding cover, where appropriate
- establish a constructive, supportive ethos for practices
- adopt a grass roots approach to decision-making, with a patch and cluster model of practice organisation and support
- develop practice manager roles and devolve planning and development work to practices and other stakeholders
- develop a corporate approach to provision of new services
- ensure that all board members have clear lead responsibilities and make efficient use of clinicians' time
- collaborate with neighbouring PCGs to research issues and draft documents, and share, or buy in, specialist expertise
- involve other local bodies, educational establishments and service users that may be willing to offer their resources and experience
- consider short-term secondments between the PCG and the HA or provider trusts.

### HAs should

- ensure that PCG interests are represented on, for example, IM&T strategy groups
- support PCGs in actioning relevant NHS Executive circulars
- co-ordinate their own requests of PCGs
- pace their own reorganisation to reflect changing responsibilities and development needs, and release to each PCG a commensurate share of total permitted management costs
- retain a balanced perspective over the entire spectrum of healthcare and staff with the experience to support PCG development.

### The NHS Executive will, no doubt, wish to

- ensure that there are clear expectations for the content of the various planning documents required of HAs and PCGs, and that the timing of their completion follows a logical sequence
- research how differences in the levels of staff and support available to PCGs affect their pace of development and ability to discharge their responsibilities.

## ii. Trust applications and mergers

118. Up to 17 primary care trusts (PCTs) will formally come into existence on 1 April 2000 and, subject to the outcome of consultation, a further 44 may be established in October 2000. PCT status (Ref. 10) brings added freedoms and opportunities to develop integrated services responsive to patient needs, but at the expense of greater risks and uncertainties. And although there is no proscribed minimum size for a PCT, some PCGs believe that they would need to merge to make a trust application viable.

119. This section considers:

- the speed of PCG movement towards trust status;
- reasons for their decisions about future trust applications;
- how many prospective PCTs wish to provide community health, or other services currently commissioned from NHS trusts;
- the number and implications of potential mergers;
- whether HAs are driving these decisions in some areas; and
- what PCGs need to do to prepare for these changes.

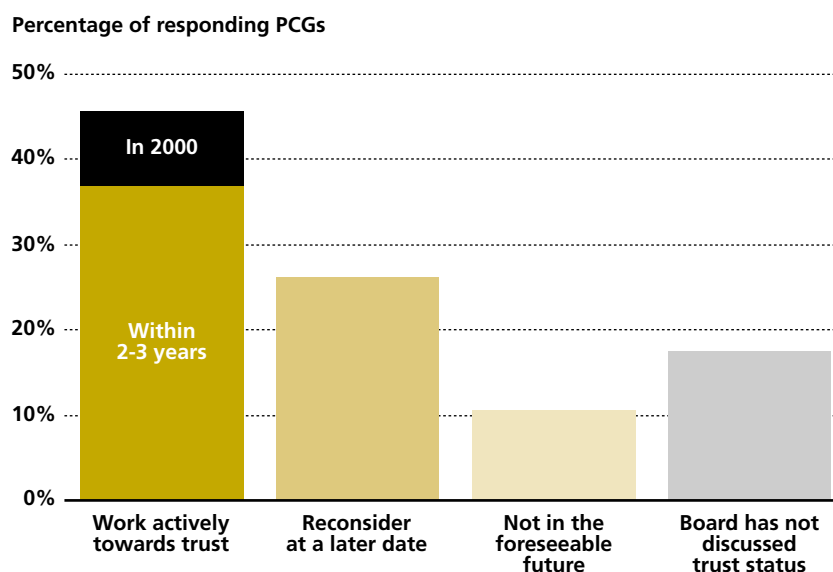
### The speed of movement towards PCT status

120. Although national policy is not driving conversion to trust status, numbers of PCTs seem likely to grow quickly. Almost one-half of the surveyed PCG boards had resolved to work actively to become a PCT [EXHIBIT 22]. Four out of every five had discussed whether or not to apply for trust status. 9 per cent of all survey respondents had decided to register an interest in attaining Trust status during 2000 and over one-third to work actively towards becoming a Trust within the next two or three years. Only one in ten PCGs decided that they would definitely not wish to seek trust status in the foreseeable future.

EXHIBIT 22

#### PCG Boards' Conclusions on Trust Status

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



Source: Audit Commission survey (July to September 1999)

## Reasons for decisions about future trust application

**121.** The consideration that was most frequently quoted *in favour* of trust status by surveyed PCGs was a desire for independence, or control of their own destinies. Some of these PCGs will need to develop a more positive case for greater autonomy than their sole current, apparently negative, motivation of 'escape from their HA's clutches'! Equally such decisions should not be influenced by the financial difficulties of any community NHS trust or driven solely by GP dissatisfaction with its current services. In a few places, the PCT agenda has been driven by previously planned local community trust mergers. Others have seen trust status as an inevitable consequence of central government pressures.

**122.** More positive reasons were also given, the most common of which was the perceived opportunity for further integration of local services. In particular, greater flexibility in linking with, and developing, community care was noted. Some viewed trust status as a natural consequence of a strong community spirit, a supportive coterminous local authority, proactive general practices and a desire to develop community hospitals. Some PCGs thought that it would help them to improve commissioning agreements. Others saw benefits in direct funding and budgets set on a fairer basis. One mentioned that extra resources might be made available to PCTs. There was mention of better opportunity to develop services, better primary care development, speedier implementation, control of staff, and fuller control over the local health economy [CASE STUDY 5, overleaf].

**123.** Some factors were noted by different PCGs as considerations *both in favour and against* PCT status. For example, one thought that the process of agreeing and preparing for PCT status would increase GP commitment, whereas others said that it would be divisive. Mergers with neighbouring PCGs to form a PCT were seen by some as beneficial in giving a town-wide approach to health improvement programme planning, while rather more PCGs viewed potential mergers as a threat.

**124.** The most frequently mentioned consideration *against* trust status was loss of GP control and dilution of professional input to the board. Although control over operational matters will remain with an executive with clinicians in the majority, PCTs will be under the strategic oversight of a board with a lay chair [EXHIBIT 23, overleaf]. There were worries that this could reduce active involvement by GPs. Some PCGs saw threats to GPs' independent contractor status. The potential cost of buying out the equity of any practices whose partners did opt for salaried status was also raised.

**125.** Others were worried about the pace of change and believed that more groundwork or PCG organisational development was needed first. Preparing for trust status could distract from the large primary care development agenda.<sup>1</sup> Although the NHS Executive is making available additional funds for preparation of trust bids, there was concern about the ability to prepare for trust status within management cost allowances, lack of adequate financial support and additional risk. PCTs were an unknown quantity and their advantages were as yet unclear.

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<sup>1</sup> The experience of early PCT candidates, many of which already command widespread support, may not be typical of later waves where any delays resulting from lengthy consultation could consume large amounts of scarce PCG management time. And after PCT status is gained, the demands of managing a relatively large number of PCT employees could continue to distract attention from PCT development objectives.

## CASE STUDY 5

**How one PCG hopes to benefit from trust status**

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 (PCHTs). Both community trust and social services officers have had periods of secondment to the PCG. However the PCG has inherited a budget deficit on commissioned care, a high proportion of single-handed GPs, some in less than ideal premises, and an ageing GP and nursing workforce. It has applied to become a first wave, level 4 PCT in April 2000.

In addition to general flexibilities, the chief executive identified a number of specific projects that would be greatly assisted by trust status:

- *Recruitment to ensure continuity of patient care as clinicians retire*

It is difficult to attract GPs to some parts of the area. The PCG therefore plans to develop flexible packages to attract doctors and nurses:

- some salaried GPs with specific skills to work across practices – this could improve waiting times for certain outpatient procedures and reduce the high number of 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;

The scheme will also facilitate further development of a robust integrated practice and community nursing team using common procedures, which can be deployed flexibly to provide continuity of care as nurses retire.

- PCT owned premises

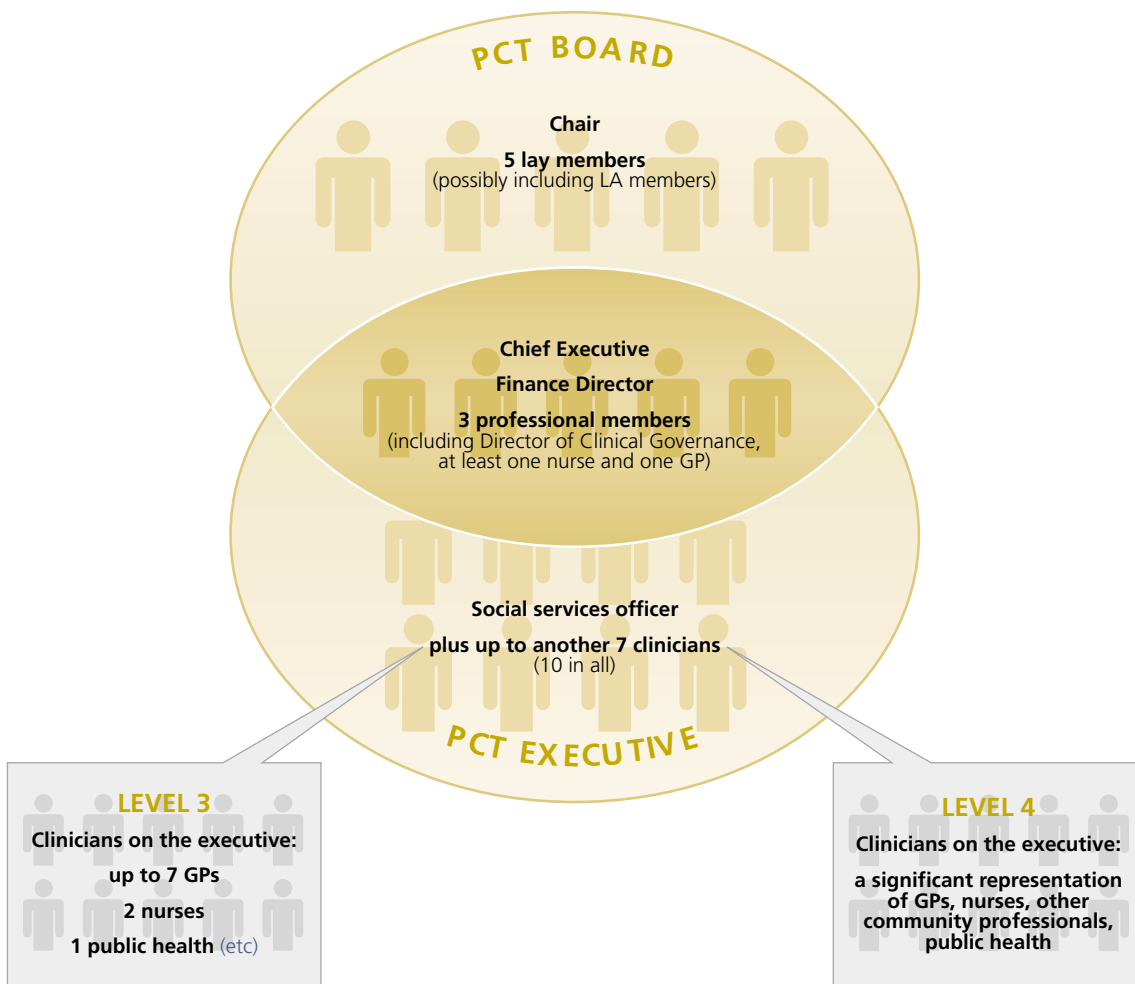
- One PHCT with mainly single-handed GPs would like to rationalise from 12 sites into 3 health centres so as to improve facilities, support staff and cover. The PCG is currently assessing the pay back period if, as a PCT, it were to buy out the equity of the practices involved.
- GPs could also use practice staff employed by the PCT on an agency basis. This would improve opportunities for training and development, skill mix and employment practices. However, such a scheme is not possible without PCT status as it is outside the provisions of the regulations governing general medical services.
- in time, if practices agree, practice nurses could all become PCT employees in some PHCTs.

- *Increased scope to develop and fund partnership action programmes* without having to seek permission from other authorities. 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 and making better use of more joint funding.

EXHIBIT 23

**PCT governance arrangements**

PCTs will be under the strategic oversight of a board with a lay chair.



Source: Audit Commission, from NHS Executive guidance

**Will PCTs provide services that are currently commissioned from NHS trusts?**

**126.** Almost one-half of respondents said that if they applied for trust status they would definitely wish to take over some community health services; most others said that they might possibly wish to do so. Only two wished to become 'level 3' trusts. Of the potential 'level 4' trusts, 43 per cent envisaged a merger with a community health trust and 25 per cent that the PCT would provide these services afresh, others being as yet undecided. One-third of potential 'level 4' PCTs also thought that they might possibly wish to take over provision of certain substantial services currently provided by a mental health or acute trust; (10 per cent definitely).

**127.** Any additional risks to probity if PCTs commission services in which their own GPs have a financial interest must be considered. PCTs will also need to scrutinise the value for money of providing services in-house rather than buying them in. HAs will wish to develop procedures to probe the clinical- and cost-effectiveness of services commissioned by PCGs from GP-run community hospitals and also of services provided by PCTs.

## Mergers

**128.** Even before they were operational, some PCGs were considering the possibilities of mergers with their neighbours. Often, but not exclusively, this was with a view to achieving the budgetary stability, commissioning leverage and size of management that they saw as necessary to becoming a PCT. In some areas there was a deliberate decision to set up small PCGs initially to encourage local ownership and involvement, with the intention that they should merge later. Elsewhere the realisation that existing PCGs had insufficient resources to cope on their own with the wide agenda that they faced came later.

**129.** One in eight respondents said that their PCG was definitely likely to combine with one or more other PCGs within the next few years and over one-half thought this a possibility. Despite worry that discussion of potential mergers could be divisive and distract from implementation of agreed improvements to primary care, less than one in five PCGs ruled out a future merger.

**130.** One in every three PCGs had already started discussions with other PCGs, and with the HA, on possible PCG mergers, although only one of those surveyed had yet reached agreement. One-half said that although the possibility had been raised with other PCGs or the HA, there had been no specific discussion; only one in six reported that the topic had not been raised at all. If the envisaged mergers occur, the average population of a PCG would rise from 107,000 to 157,000<sup>1</sup>. And the proportion of responding PCGs that would have a population less than 75,000 would fall from a quarter to one in ten [EXHIBIT 24].

**131.** PCGs, and especially aspiring PCTs, should therefore try to ensure that strategies, structures, protocols and procedures, and commissioning decisions develop in parallel with those of their neighbours. They might wish to consider the development of complementary specialist skills and roles and of integrated skills databases. However, merged PCGs will need to ensure they retain their sensitivity to local issues, for example by creating area sub-groups.

**132.** 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 or services;
- delays occasioned by greater controversy and more prolonged public debate;
- disparate cultures, conditions, uncertainty;
- importation of a possibly lacklustre trust management, simply because it is cheaper and quicker than starting afresh; and
- distraction from pursuit of core PCT objectives if also managing a large directly employed workforce.

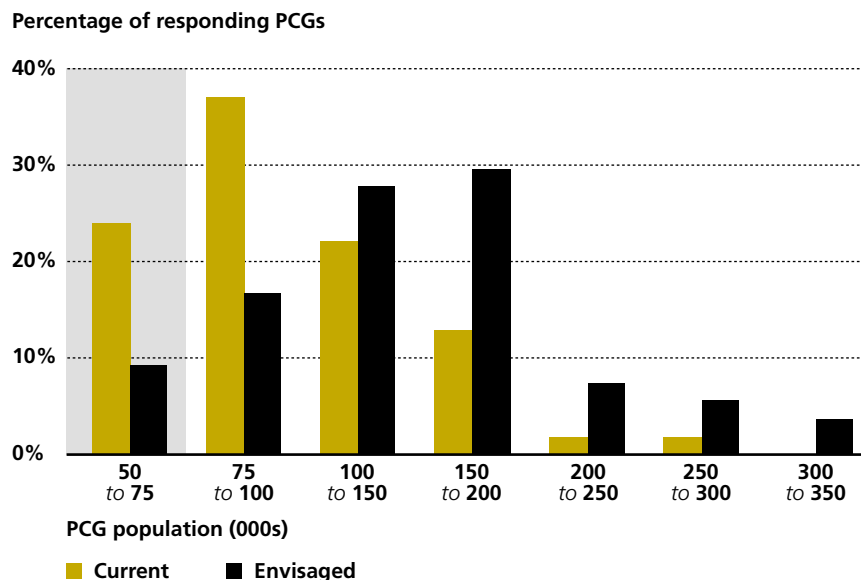
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<sup>1</sup> A somewhat higher average population (185,000) would be served by each of the merged PCGs.

EXHIBIT 24

**Proposed PCG mergers**

If all of the mergers envisaged by responding chief executives occur, the proportion of PCGs with a population under 75,000 will fall from 24 per cent to 9 per cent.



Source: Audit Commission survey (July to September 1999)

**Are these changes being driven by HAs?**

**133.** The NHS Executive has stressed that there is no national policy on whether, or in what time-scale, PCGs should become trusts. Nevertheless, some have suggested that PCGs' decisions on this issue have been heavily influenced by certain HAs.<sup>1</sup> However, the survey found that this was not a widespread concern. One in ten PCGs said that their HA had set the trust agenda, but a similar percentage that the HA was resisting the PCG's decision. The majority said either that their HA was, at this stage, happy to go along with the PCG's decision, or that the issue had never been raised.

**134.** However, there are circumstances in which it would be appropriate for HAs to influence the timing of PCT decisions. A move to 'level 4' status could have far reaching consequences for the NHS trust currently providing community and mental health services in the area, and which may also serve neighbouring PCGs. Its efficiency, or even continuing viability, could be affected. Particular concerns could arise if a PCT decided to provide community health services selectively. It is also possible that a PCT might bid to provide certain services outside its own area. At present, the timing of future change may be unclear and not fully co-ordinated. A firm timetable, agreed by all involved, is needed. There also needs to be a shared understanding of circumstances that would trigger delay and contingency plans for how such delay would be handled.

<sup>1</sup> All PCGs in 8 of the 99 HAs wish to become PCTs in April or October 2000, and a further 25 HAs contain some early PCT applicants. 66 HAs have no PCGs that have expressed interest in trust status during 2000.

**135.** Prospective PCTs should start discussions at an early stage of their thinking with all service providers that would be affected. One potential first wave PCT studied has worked closely with the local NHS trust in preparing its trust application. However, this appears not universally to be the case. Only two of the chief executives of surveyed PCGs that wished to take over community health services within the next two or three years had yet discussed this possibility with their current provider.

## Preparing for PCT status or mergers

**136.** Prospective PCTs will need:

- a clear and realistic view of the pros and cons of trust status, including the potential benefits for patients and service efficiency;
- a strategy for communicating these considerations to stakeholders (including the public). Potential PCTs should take the opportunity to re-examine existing services in the light of any concerns that emerge from the public consultation, whatever the outcome of the trust application;
- appropriate systems for managing premises, payroll, supplies, IM&T, accounting, budgets and risk, clinical governance support. Potential PCTs may wish to consider whether it would be more efficient to join with others to establish a jointly managed agency, or pay HAs or provider trusts to undertake some of these functions on their behalf; and
- human resource plans, including provision for appropriate training and development.

Many will at the same time be planning a merger with parts of an NHS trust or other PCGs [BOX J].

**137.** In one area, the four prospective first wave PCTs have agreed with their HA to pool PCT preparatory cost budgets to form a project group. Systems and strategies will be provided through a consortium led by a community health trust. Another prospective PCT envisages using an agency to set up such systems in a very limited timescale and without major expansion of PCG staffing.

**138.** The mergers and trust applications currently envisaged are unlikely to be the last structural changes that PCGs face. In some parts of the country there are already moves towards more administrative integration between health and social care.

### BOX J

#### Considerations for merging PCGs and NHS trusts

PCGs planning to merge or to take over community trust functions should note the advice contained in the Commission's management paper, *Less Dangerous Liaisons: Early Considerations for Making Mergers Work* (Ref.11). For example:

##### *Early leadership:*

- How soon can the chair, members of the new board be appointed?
- When will the PCT chief executive (whether the current PCG chief executive or a new appointment) be in post?

##### *Defining and communicating the benefits of a merger or Trust application:*

- What should be the balance of PCG board and management time between attention to primary care development/PCG business and successful transition to trust status?
- Is there a communications plan in place covering all stakeholders?
- How will general practices and other stakeholders be involved in defining the PCT's objectives and identifying specific actions that will lead to early benefits?

**BOX J (continued)***Involving staff and stakeholders:*

- How will key players in any NHS trust that could be affected by the proposal be involved in the transition process and, as far as possible, reassured about their future?

*Critical systems*

- If the PCT will provide services which are currently the responsibility of an NHS trust, have arrangements been made for the continuance of key systems, for example on a agency basis?

*Reconciling different cultures*

- If a merger is envisaged, have any cultural differences between the PCGs and/or NHS trusts involved been identified and how will they be reconciled?
- Can membership of working groups be used to build teams and help develop the culture of the new organisation?

**RECOMMENDATIONS (2ii)****Prospective PCTs should:**

- ensure that preparation for trust status does not distract from primary care development
- hold early discussions with all service providers that would be affected by the PCT application
- scrutinise the value for money of buying in services rather than providing them in-house
- ensure that strategies, structures, protocols and procedures, and commissioning decisions develop in parallel with those of neighbouring PCGs
- form a clear view of the relative advantages of Trust status, including potential benefits for patients and service efficiency
- develop a strategy for communicating these considerations to stakeholders (including the public)
- re-examine existing services in the light of any concerns that emerge from the public consultation
- set up systems, or agency arrangements, to manage premises, payroll, supplies, IT, accounting, budgets and risk, and clinical governance support
- make provision for training and development.

**HAs should**

- agree a firm timetable for changes to the organisation of local healthcare, circumstances that would trigger delay, and contingency plans for how such delay would be handled
- probe the clinical and cost-effectiveness of services commissioned by PCGs from GP-run community hospitals and also of services provided by PCTs.

**Nationally, the NHS Executive may wish to**

- keep under review whether the present diversity of PCG/PCT structures and aspirations is contributing to inequity of access to care for patients in different parts of the country.

### 3. In Conclusion

**139.** It is too early to judge the effectiveness of PCGs. Nor is it possible to generalise about their progress. A few PCGs, generally building upon a history of collaboration between practices, have already made some demonstrable impact. Others appear still to be struggling to establish themselves. The accuracy and timeliness of information are universal concerns, as is the breadth and complexity of the agenda to be addressed with very limited resources. Many PCGs are considering mergers or trust status which, whatever their potential longer-term benefits, are likely to distract attention from their core agendas over the next few years. And it remains to be seen whether the present diversity of PCG/PCT structures and aspirations can continue indefinitely. It could perpetuate inequity of access to care for patients in different parts of the country. Meanwhile, the majority of NHS users remain barely aware of the existence of PCGs.

**140.** However, there are also many positive signs for the future. PCG chief executives' own assessments of their effectiveness in areas such as contributing to HImPs, and of the relationships between PCGs and HAs, improved during the course of the Commission's study. The majority of GPs are said to be supportive, although more needs to be done to canvass their active involvement. PCGs have made a generally enthusiastic start on formulating clinical governance plans and rationalising the planning of primary care investment. And the vast majority of those PCGs surveyed or interviewed by the Audit Commission could list projects or initial achievements that their chief executives thought worthy of emulation.

**141.** 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.

## Recommendations

### Key recommendations

PCGs/PCTs should:

- have scope to pursue local as well as national priorities
- set measurable milestones against which achievement is monitored
- secure GP 'ownership' of plans by devolving more local planning and decisions to practices
- have the resources to reward practices that achieve clinical governance targets and make economical use of resources
- collaborate to make efficient use of staff and HA support
- involve patients, carers and the public more meaningfully in decision-making
- have systems to ensure the probity and cost-effectiveness of their services.

### Recommendations in full

RECOMMENDATIONS			
	PCGs should	HAs should ensure that	Nationally or Regionally the NHS Executive/Department of Health may wish to ensure that
<b>HImP</b>	involve as many practices and stakeholders as possible in developing the PCG's contribution to the HImP so as to improve local 'ownership'.	PCGs have sufficient public health and analytic support to make a meaningful contribution to the HImP; planning data are available on PCG boundaries;  the HImP leaves scope for local initiative by PCGs;  milestones are established for achievement of HImP priorities.	the number of national 'must-dos' is commensurate with available resources and leaves scope for HAs and PCGs to address local priorities.
<b>Co-ordination</b>	develop all policies in parallel with neighbouring PCGs, unless in any particular instance there are sound reasons to do otherwise, and begin to develop dialogue with neighbouring/similar PCGs in other HA areas.	committees representing all PCGs have clear, agreed responsibilities and authority, and that there is no duplication of activity.	
<b>Primary care development</b>	compile a database of skills available to each practice, services currently provided, practice facilities and computerisation;  project future skill shortages and plan how these could be addressed;		

RECOMMENDATIONS			
	PCGs should	HAS should ensure that	Nationally or Regionally the NHS Executive/Department of Health may wish to ensure that
<b>Primary care development</b> (continued)	<p>agree a methodology for assessing practice bids against data on current and future provision and needs</p> <p>evaluate current practice-based services and agree how those that are cost-effective can be accessed by patients of other local practices.</p>	<p>PCGs are supported in evaluating the cost-effectiveness of practice-based services</p>	
<b>Commissioned services</b>	<p>develop the skills needed for effective commissioning in collaboration with neighbouring PCGs</p> <p>collect key monitoring data directly from main providers, for validation by referring practices;</p> <p>provide primary care alternatives to secondary care referral for appropriate conditions, supporting their use through referral protocols, training, audit and indicative levels;</p> <p>find ways to involve clinicians in commissioning cost-effectively.</p>	<p>PCGs pursue a co-ordinated approach to commissioning in accordance with the Annual Planning Statement/SaFF;</p> <p>PCGs are provided with adequate support and advice on commissioning;</p> <p>the data that PCGs need to monitor waiting times, referrals and expenditure are accurate and timely;</p> <p>PCGs are supported in developing alternatives to hospital referral, and advised on how such services could be funded.</p>	<p>roll-out of NHSnet connections to GPs and PCG offices is prioritised to facilitate timely collection and validation of monitoring data for commissioned services;</p> <p>PCGs have the flexibility to develop appropriate primary care alternatives to hospital referral, using waiting list monies and other funding.</p>
<b>Partnership</b>	<p>encourage reorganisation of community care around clusters of practices;</p> <p>agree evidence-based protocols for nursing interventions, common to practice and community nursing, and audit them periodically;</p> <p>promote cover arrangements for practice nurses to facilitate their continuing education and continuity of patient care when they are on leave;</p> <p>involve service users and local people with appropriate expertise in working groups;</p> <p>liaise with LA departments and local bodies whose work bears on health or access to healthcare;</p>		

RECOMMENDATIONS			
	PCGs should	HAs should	Nationally or Regionally the NHS Executive/Department of Health may wish to ensure that
<b>Commissioned services</b> (continued)	ensure that any partnership enterprises with other bodies meet the principles of effective joint working and that their cost-effectiveness is evaluated.		
<b>Supporting cost-effective primary care</b>	<p>employ pharmacists (and lay assistants) to provide practical support and advice to practices so as to facilitate rational prescribing and make cost-effective use of the PCG budget;</p> <p>secure board agreement of priorities for the work undertaken by PCG prescribing advisers and for prescribing changes to be targeted;</p> <p>co-ordinate policies with neighbouring PCG prescribing leads and make joint approaches to hospital consultants on issues such as choice of drugs prescribed on discharge;</p> <p>co-ordinate the work of their prescribing and clinical governance sub-committees.</p>	<p>retain expertise to advise the authority on drugs strategy and performance management;</p> <p>continue to provide specialist information and data to PCGs in areas where this can be done more effectively at health authority level;</p> <p>facilitate risk management schemes to cushion the unpredictable effects for PCGs of high cost patients or courses of treatment;</p> <p>co-ordinate HA-wide prescribing initiatives and liaison with trusts.</p>	there are mechanisms at regional level for agreeing policies on the use and introduction of new drugs and preparations, which complement NICE and other national guidance.
<b>Incentives</b>	<p>devise prescribing incentive schemes that recognise high quality as well as economic prescribing;</p> <p>ensure that incentives form part of an integrated package of clinical governance advice, audit, education, information and support agreed HImP related objectives;</p> <p>work towards incentives that are broader than prescribing.</p>	ensure that PCGs have sufficient resources to reward practices that achieve clinical governance targets and make economical use of resources.	
<b>Clinical governance</b>	ensure that clinical governance forms part of an integrated package of development, training and communication focused on HImP priorities;	<p>ensure that funding for clinical governance is sufficient to meet its objectives and that PCGs have access to adequate support and advice;</p> <p>support PCGs in dealing with unacceptable practice.</p>	

RECOMMENDATIONS

	PCGs should	HAS should	Nationally or Regionally the NHS Executive/Department of Health may wish to
<b>Clinical governance</b> (continued)	<p>negotiate sharing of clinical audit findings and data on a named practice basis;</p> <p>make efficient use of (eg) public health support by collaborating with other PCGs when requesting evidence for protocols and formularies;</p> <p>agree with boards the approach to be taken to any current or future 'problem practices'.</p>		
<b>Training</b>	<p>assess the skills and training needs of PCG, community nursing, and practice staff;</p> <p>agree a skills development plan to inform individual training plans;</p> <p>agree minimum acceptable standards for practice administration, facilities and key clinical areas;</p> <p>consider mentorship arrangements for aspects of practice administration and, where appropriate, clinical practice.</p>	<p>survey the skills and training needs of PCG board members;</p> <p>support PCGs in formulating development and training plans;</p> <p>consider whether a general practice accreditation scheme would be appropriate.</p>	<p>continue to support regional skills development programmes for key members of PCGs.</p>
<b>Accountability</b>	<p>ensure that their accountability agreement with the health authority contains measurable targets/milestones that fit with longer-term development programmes;</p> <p>generate stakeholder ownership by engaging as many as possible in agreeing targets</p> <p>try to agree targets as early as possible in the year.</p>	<p>assist by suggesting a range of possible appropriate measurable targets/milestones for each PCG;</p> <p>recognise that, as PCGs mature organisationally, targets should focus on outcomes rather than processes;</p> <p>encourage inclusion of some accountability targets reflecting PCG as well as national/HA priorities;</p> <p>document the scope and nature of the support to be provided by the HA to PCGs.</p>	<p>provide guidance on how to set appropriate measurable targets;</p> <p>allow maximum scope for local discretion on targets and the timing of action.</p>

RECOMMENDATIONS			
	PCGs should	HAs should	Nationally or Regionally the NHS Executive/Department of Health may wish to
<b>Public involvement</b>	<p>formulate a strategy for communicating with stakeholders and for consulting a broad range of patients, carers and local people;</p> <p>ensure that the views of patients, carers and the wider local public are taken into account in decisions about service planning and delivery.</p>	<p>ensure that PCGs are supported in their efforts to consult with and involve patients and the local community.</p>	<p>consider how the collective profile of PCGs can best be raised.</p>
<b>PCG management</b>	<p>spend time to develop PCG values, principles and methods of working;</p> <p>develop good communication through information and news sheets, forums and meetings;</p> <p>encourage attendance at professional forums by funding cover, where appropriate;</p> <p>establish a constructive, supportive ethos for practices;</p> <p>adopt a grass roots approach to decision-making, with a patch and cluster model of practice organisation and support;</p> <p>develop practice manager roles and devolve planning and development work to practices and other stakeholders;</p> <p>develop a corporate approach to provision of new services;</p> <p>ensure that all board members have clear lead responsibilities and make efficient use of clinicians' time;</p> <p>collaborate with neighbouring PCGs to research issues and draft documents, and share, or buy in, specialist expertise;</p> <p>involve other local bodies, educational establishments and service users that may be willing to offer their resources and experience;</p>	<p>ensure that PCG interests are represented on, for example, IM&amp;T strategy groups;</p> <p>support PCGs in actioning relevant NHS Executive circulars;</p> <p>co-ordinate their own requests of PCGs;</p> <p>pace their own reorganisation to reflect changing responsibilities and development needs, and release to each PCG a commensurate share of total permitted management costs;</p> <p>retain a balanced perspective over the entire spectrum of healthcare and staff with the experience to support PCG development.</p>	<p>ensure that there are clear expectations for the content of the various planning documents required of HAs and PCGs, and that the timing of their completion follows a logical sequence;</p> <p>research how differences in the levels of staff and support available to PCGs affect their pace of development and ability to discharge their responsibilities.</p>

RECOMMENDATIONS			
	PCGs should	HAs should ensure that	Nationally or Regionally the NHS Executive/Department of Health may wish to ensure that
	consider short-term secondments between the PCG and the HA or provider trusts.		
	Prospective PCTs should	HAs should	Nationally or Regionally the NHS Executive/Department of Health may wish to
<b>Movement to PCT status</b>	<p>ensure that preparation for trust status does not distract from primary care development;</p> <p>hold early discussions with all service providers that would be affected by the PCT application;</p> <p>scrutinise the value for money of buying in services rather than providing them in-house;</p> <p>ensure that strategies, structures, protocols and procedures, and commissioning decisions develop in parallel with those of neighbouring PCGs;</p> <p>form a clear view of the relative advantages of Trust status, including potential benefits for patients and service efficiency;</p> <p>develop a strategy for communicating these considerations to stakeholders (including the public);</p> <p>re-examine existing services in the light of any concerns that emerge from the public consultation;</p> <p>set up systems, or agency arrangements, to manage premises, payroll, supplies, IT, accounting, budgets and risk, and clinical governance support;</p> <p>make provision for training and development.</p>	<p>agree a firm timetable for changes to the organisation of local healthcare, circumstances that would trigger delay, and contingency plans for how such delay would be handled</p> <p>probe the clinical and cost-effectiveness of services commissioned by PCGs from GP-run community hospitals and also of services provided by PCTs.</p>	keep under review whether the present diversity of PCG/PCT structures and aspirations is contributing to inequity of access to care for patients in different parts of the country.

## 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?
-

## Appendix 1 – Acknowledgements

The Audit Commission wishes to thank chief executives of the following PCGs for completing the Commission's PCG questionnaire and for the supporting documents that many of them also supplied:

Alt Valley (Liverpool N E) PCG	North Lewisham PCG
Bath PCG	Northolt and Greenford PCG
Bebington and Wirral PCG	Oxford City PCG
Bolton West PCG	Pendle PCG
Breckland PCG	Pontefract PCG
Brierley Hill and Kingswinford PCG	Redditch PCG
Bromsgrove PCG	Restormel PCG
Carlisle and District PCG	Rochdale PCG
Central Suffolk PCG	South Brent PCG
Charnwood North PCG	South East Oxfordshire PCG
Cheltenham and Tewkesbury PCG	South East Sheffield PCG
City and Hackney PCG	South Waveney PCG
Coventry North PCG	Southport and Formby PCG
Derby W PCG	Stockton PCG
Derwentside Locality PCG	Stroud and Berkeley PCG
East Lindsey PCG	Sunderland North PCG
Eden Valley PCG	Sutton Coldfield PCG
Epping Forest PCG	Totton and Waterside PCG
Exeter PCG	Upminster PCG
Feltham PCG	Warrington N E/South PCG
Forest of Dean PCG	West Bristol PCG
Guildford PCG	West Gateshead PCG
Halesowen PCG	West Mid Bedfordshire PCG
Kingston PCG	West Walsall PCG
Lewisham South PCG	Weymouth and Portland PCG
Liverpool Central West PCG	Wycombe Town PCG
Mid Surrey PCG	
Nelson PCG	
New Forest PCG	
New Norwich PCG	
North Camden PCG	

In particular the study team would like to thank chief executives of the following PCGs for piloting the questionnaire and for their helpful comments:

Castle Point PCG

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Ridgeway Downs PCG

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British Medical Association

General Medical Council

National Association of Primary Care

National Audit Office

NHS Executive

Royal College of General Practitioners

Royal College of Nursing

The National Assembly for Wales

UNISON

NHS Joint Unions

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Dr Steve Gillam (King's Fund)

David Reynolds (Northumberland HA)

Barbara Smith (Ridgeway Downs PCG)

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Oxford City PCG

Tower Hamlets PCG

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Dorset HA: *Blackmore Vale, Bournemouth Central, Bournemouth North, North East Dorset, Poole Bay, Purbeck & Blandford PCGs; also Bournemouth Social Services, Dorset Social Services, West Dorset CHC.*

East Lancashire HA: *Blackburn & Darwen, Rossendale PCGs.*

Iechyd Morgannwg HA: *Bridgend, Neath & Port Talbot, Swansea LHGs.*

North Cheshire HA: *Castlefields Practice, Runcorn PCG; also Halton Social Services.*

Northumberland HA: *Alnwick & Berwick, Blyth & Cramlington, Morpeth & Wansbeck PCGs.*

South Essex HA: *Southend, Thurrock PCGs. Also Thameside NHS Trust.*

South Humber HA: *North East Lincolnshire, North Lincolnshire PCGs.*

Wakefield HA: *Pontefract, Wakefield PCGs,*

West Surrey HA.

## Appendix 2 – Glossary of abbreviations

<b>APC</b>	Area Prescribing Committee
<b>CHC</b>	Community Health Council
<b>CHD</b>	Coronary Heart Disease
<b>GMS(CL)</b>	General Medical Services (Cash-Limited)
<b>GP</b>	General Medical Practitioner
<b>HA</b>	Health Authority
<b>HAZ</b>	Health Action Zone
<b>HImP</b>	Health Improvement Programme
<b>IM&amp;T</b>	Information Management & Technology
<b>JIP</b>	Joint Investment Programme
<b>LA</b>	Local Authority
<b>LHG</b>	Local Health Group (Wales)
<b>MAAG</b>	Medical Audit Advisory group
<b>NICE</b>	National Institute for Clinical Excellence
<b>PAMs</b>	Professions ancillary to medicine
<b>PCG</b>	Primary Care Group: <ul style="list-style-type: none"> <li>– level 1: mainly advisory subcommittee of HA</li> <li>– level 2: HA subcommittee with substantial delegated budgetary responsibilities</li> </ul>
<b>PCIP</b>	Primary Care Investment Plan
<b>PCT</b>	Primary Care Trust: <ul style="list-style-type: none"> <li>– level 3: free-standing body responsible for commissioning services, developing local healthcare and promoting health</li> <li>– level 4: free-standing body with authority to provide as well as to commission community and secondary care in its area</li> </ul>
<b>PHCT</b>	Primary Healthcare Team
<b>PMS Pilot</b>	Personal Medical Services Pilot (supersedes PCAPs)
<b>SaFF</b>	Service and financial framework (part of the annual planning statement)
<b>TPP</b>	Total Purchasing Pilot
<b>WTE</b>	Whole time equivalent

## Appendix 3: Audit Commission surveys of PCGs

In February 1999 the Commission conducted a first survey of shadow PCGs completed by HAs which collected information on such topics as their size and practice composition, previous commissioning experience, proposed management costs, the background of the chief executive, and board membership.

In July 1999, the Commission conducted a second survey, this time of a representative sample of one in six PCGs and completed by their chief executives, focusing on their organisational development, early progress on key objectives, the resources available to them for this work and future plans. The present report is largely based on data and comments from the 57 PCGs that responded to the survey.

About half of these returns were completed between mid July and the Commission's deadline of the first week of August. Others were received between that date and late September. In total this was a 70 per cent response rate. Returns were broadly representative of the totality of PCGs by region, size, level and deprivation.

The questionnaire covered:

- Health improvement
- Accountability agreements
- Primary care investment
- Clinical governance
- Prescribing advice
- Practice incentives
- Education and training
- Commissioning
- Budgets (primary care investment, clinical governance, commissioning, management)
- PCG staffing
- Decision-making (chair, board, executive, overarching groups, forums, subcommittees)
- Future intentions
- Perceived attitudes of practices and HAs
- Barriers to success, achievements and innovative practice.

Detailed comparative data on surveyed PCGs' intended staffing are shown below.

# Staffing profile of 51 PCGs

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB		
Size	L	L	L	L	L	L	M	M	L	L	M	L	L	M	M	S	M	S	M	M	S	M	M	S	M	M	S	M		
Level	2*	2*	2*	2*	2*	2*	2	2	2*	2	2*	2	2	2*	2*	2	2	2	2	2	2	2	2	2	2	2	2	2		
Chief Executive	1	1	1	1	1	1	1	1	1	0.8	1	1	1	0.8	1	1	1	1	1	1	0.8	1	0.8	1	1	1	1	1		
Deputy/Acting CE/GM	1																													
Administrator / PCG Co-ordinator	1	1		1					1			1							1	1			0.8							
Human Resources / Personnel Manager									0			0																		
Business/Development Manager	1			1+p	[pc]	1	1	1						1	1			0.4					1					+p		
Office Manager	1															1														
Stakeholder Liaison Manager	1			0.5	0.2[j]																									
Locality / Patch Co-ordinator	4			1.95					0				1																	
Finance manager	1	1	1	1	1	1	1	0	0.5	0.55	1	1	1	1	1	0	0.55	0.3	0.5	0.5	0.5	0.5	0	0	1	1	0	0		
Finance / Accountancy Support	2			0							0	0	0	0	0.5	0	0	0	0	0.5	0.5	0.5	0	0	0	0	0	0	0	
Commissioning manager	1	1	[fc]	1.2	1[pc]		1[ci]	1			1	1	1	0.6	0.6	1	1	1	1	0.3	0.3	0.3	1	0.5	0	0	0	0		
Commissioning Support / Link	2	1						[fp]						0			1	1	0	0.5	0.3	0.3	0	0	0	0	0	0		
Primary Care Development Manager	1	1	1	1	0.2	1	1	1	1	1	1	1	1	1	1	1	1	0.2	1	1	1	1	1	1	1	1	0.4	0		
Practice Development Manager									1													1						1[s]		
Integrated Service Manager																														
Health Development / Improvement Manager							2					1		0.5	1		1			1	0	1.3								
Project / Support Manager				+s	+z									0							0.6									
Public Health Manager				0	0	0								0							0	+e	0	0	0	0	0	0	0	
Public Health Support														0							0									
Health Promotion Officer / Healthy Living Adviser					0.2			0						0																
IM&T / IT / Information Manager	2	1	0	0.2				[ci]		0.5+1	1	1	0	1.4	0	0	0	0	0									0	0	
Information Analyst / Support / Facilitator	1	1	0				1							0			0.55				0.5	0							0.6	
Data Clerk	1													0.3																
Pharmaceutical / Prescribing Adviser	2	1	2.7	1	2.6	1	1	1	1	0.8	1	1	1	1.4	0.45	1	0.5	0.4	1	0.6	0.5	0.5	0.2	0	1	0.4	1	0.6	1	0.6
Clinical Governance/Quality Lead/Educator					+g	0.5	1.4	0	0																					
Practice Nurse Adviser/Primary Care Devt Nurse								0										1												
Practice Manager Adviser								0																						
Education / Training Manager					0.2								0																	
Audit Facilitator / Manager								0																						
PA/Senior Secretary/Admin Assistant	1	1	2	1	1	1	1	1	1	1	1	1	1	1.5	1	1	1	1	0.7	1	1	1	1	1	1	1	1	1	1	1
Junior Secretary / Clerical Assistant	2	1				1		0.45	1	3				0.5		0.6	0						0.15	0.6						
<b>TOTAL listed (excluding HA support)</b>	25	10	9.15	8.2	7.6	7.5	7.4	6.95	6.6	6.55	6	6	5.6	5.25	5.1	5.1	5.1	5.1	5	5	5	5	4.85	4.6	4.5	4.4	4.4	4.2	4.2	
Staff in post \$	24	8	5	6.2	6	4	1	7	3.6	5	4.7	10.5	5.2	4.1	3.6	3	2.8	2	2	2	2	2	2	1	2	3	4.4	1.6	1.6	
Proposed staff \$	30	10	9.5	8.2	8	4	7.5	7	6.6	7	5.7	13.5	5.7	3	5.1	5.1	5.1	5	3.67			5	5	3	4	4.4			3.6	

**Notes (continued overleaf):**

- 0 Additional resource available to PCG
- [b] (including) Board Secretary
- [&c] Primary and Community Services Development
- [ci] Commissioning and Information Manager
- [fc] Finance and Commissioning Manager
- [ff] Finance and Performance Manager
- [ij] Public Involvement Manager
- [p] service and performance manager
- [pc] Planning and Commissioning Manager
- [s] Clinical Services Development Manager
- [y] (including) pharmacy adviser
- [z] HAZ project manager



## References

1. Secretary of State for Health: *The New NHS: Modern, Dependable*, The Stationery Office Cm.3807, December 1997.
2. NHS Executive: *NHS Performance Assessment Framework*, Department of Health, June 1999
3. Audit Commission: *PCGs: An Early View of Primary Care Groups in England*, Audit Commission, June 1999.
4. Arora S, Davies A, Thompson S: *Developing Health Improvement Programmes: Lessons from the First Year*, King's Fund, 1999
5. Audit Commission: *First Assessment: A Review of District Nursing Services in England and Wales*, Audit Commission, March 1999.
6. Audit Commission: *A Fruitful Partnership: Effective Partnership Working*, Audit Commission, 1998
7. Audit Commission: *A Prescription for Improvement, Towards More Rational Prescribing in General Practice*, Audit Commission, 1994.
8. Audit Commission: *Listen Up!: Effective Community Consultation*, Audit Commission, 1999.
9. NHS Executive: *Leadership for Health: The Health Authority Role*, NHS Executive, September 1999.
10. Department of Health: *Primary Care Trusts: Establishing Better Services*, NHS Executive, 1999.
11. Audit Commission: *Less Dangerous Liaisons: Early Considerations for Making Mergers Work*, Audit Commission, 1995.

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