The National Tracker Survey of Primary Care Groups and Trusts 2001/2002: Taking Responsibility?

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The National Primary Care Research and Development Centre (NPCRDC) is a multi-disciplinary centre for health service research and development in primary care. The work of the centre is based on three themes:

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- Primary care organisations: governance, budgets, workforce and partnerships.
- Quality in primary care.

The centre is leading research on the development of Primary Care Groups and Trusts and projects include:

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- National database of Primary Care Groups and Trusts.
- A series of focused studies on more specific issues which include:
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  - Partnerships with local authorities
  - IM&T
  - Health Act flexibilities
  - Organisation and governance
  - Budgets and incentives
  - Organisational culture

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We would like to thank the 68 PCG/Ts who helped us with the study this year. Particular thanks are due to the chairs, chief executives and PCG board / PCT executive committee members who were generous with their time, experiences and views. We are also grateful to PCG/T administrative and secretarial staff for helping arrange interviews with the relevant personnel.

Research Team

Many researchers in the National Primary Care Research and Development Centre (NPCRDC), the King’s Fund, and the Centre for Health Economics (CHE) have contributed to the design, fieldwork and analysis of the Tracker Survey over its three year duration. Each section of the report is credited to the researchers who analysed the data and drafted the report this year.

Those who have contributed to the research in this third round are:

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NPCRDC: Carl Simms.
This briefing summarises conclusions and selected findings from the third, and final, National Tracker Survey of Primary Care Groups and Trusts (PCG/Ts). The Tracker Survey is led by the National Primary Care Research and Development Centre and supported by the Department of Health.

PCG/Ts have continued to build on their early achievements in establishing infrastructures and their capacity to improve services. They have continued to improve access to care, extend the range of services available in primary care settings and raise quality standards. Although progress in developing their commissioning role has been less marked, most have made substantial progress towards developing inter-agency and inter-professional partnership working. However, there are signs of a gap between expectations and the capacity of PCTs to deliver change in the short-term. There is also a tension between the demands of national policies and targets and the need for PCTs to address local issues and priorities.
National Tracker Survey of Primary Care Groups and Trusts

Three-year longitudinal survey of a nationally representative sample of 72 PCGs established in April 1999.

Aims to: Describe how PCGs and PCTs tackle their core functions against national and local policy goals. Identify features associated with success.

1999/2000 Survey: October to December 1999. Face-to-face interviews with chief executives, chairs, and health authority leads. Postal questionnaires to clinical governance leads, prescribing leads, IM&T leads, GP board members, nurse board members, and social services representatives.


Dissemination: In addition to this report, findings from the survey are presented in scientific and professional journals, conferences, workshops and seminars. Copies of reports and details of other publications can be obtained from our web site (www.npcrdc.man.ac.uk).
Organisational Development and Governance

Over the past three years, PCGs have undergone massive and rapid organisational change, including the transition to PCT status, mergers and greatly increased responsibilities. Such upheaval could have diverted attention from core functions and policy goals towards internal organisational concerns. Inadequate staffing levels, limited engagement of professional and community stakeholders and a perceived imbalance between local and national priorities continue to present serious problems and challenges.

Selected findings

• Over the past year, the average number of managerial, financial and administrative staff employed by PCGs increased from 6.8 to 11.3, and from 15.8 to 31.5 in PCTs, but 61% of chief executives felt that current staffing levels were inadequate.

• Ninety per cent of PCG board and PCT executive committee chairs wanted more opportunities to focus on local health needs and service development priorities.

• Almost all chairs said that professional support was important to success, but only 61% felt that a majority of their local GPs positively supported the organisation. Despite efforts to engage local communities only 10% of chairs felt that their interests were well represented.

• Two thirds of PCG/Ts (66%) were involved in mergers, resulting in an increase in the average size to 200,000. Half (49%) had established locality groups, but only 38% of these had devolved any budgets to these groups.

• Forty five per cent of our sample had become PCTs by April 2001 and the remainder became PCTs in April 2002. PCTs were taking responsibility for providing a wide range of community health services.

Budgets and Incentives

PCG/Ts appear to be consolidating their budgetary plans and priorities. Early ambitious plans to devolve budgets to practice level have been tempered, but there is evidence of strategic thinking in shifting expenditure and increased use of incentive schemes. Priorities for the future should include improved information systems, enhanced managerial capacity, carefully designed incentive schemes and careful expansion of indicative practice budgets.
Selected findings

- Most PCG/Ts (83%) expected to keep expenditure within 5% of target spending levels.
- There is evidence pointing to some strategic thinking about shifts in expenditure within PCG/Ts.
- Two thirds (65%) were using financial incentive schemes linked to quality improvement but only 10% had schemes linked to expenditure on hospital and community health services.
- Just 7% of PCG/Ts have devolved indicative hospital and community health services budgets to practice level.

Information Management and Technology

PCG/Ts have made progress in achieving connectivity, increasing the use of information management tools, implementing data quality standards and collecting data to support implementation of the National Service Framework for coronary heart disease. However, information to support the core functions of PCG/Ts continues to be perceived as inadequate, shortages of staff and funding remain problems.

Selected findings

- Many PCG/Ts are now collecting data on GP referrals, waiting times for GP appointments, and out-of-hours calls.
- Access to NHS Net, email and Internet by PCG/T staff and practice-based staff has now been achieved.
- Almost all PCG/Ts (95%) had at least half of their practices using Read codes, 60% data entry and extraction protocols, and 56% disease management guidelines.
- Fifty seven per cent of PCG/Ts were participating in the PRIMIS initiative to support the development of information systems, but only a third had developed an education and training policy for IM&T.
- Major obstacles to progress were a lack of staff (80%), a lack of money (75%), and too many priorities (71%). Many IM&T leads were not confident of meeting national targets for IM&T development.
Primary Care Development

Primary care development clearly remains at the forefront of the agenda for PCG/Ts. They are focusing investment and development on improving access to services, extending the range of services and providing a more integrated service. There was considerable variation between PCG/Ts in the number and range of initiatives being promoted. There was no evidence that PCTs were achieving more than PCGs or that larger PCG/Ts were achieving more than smaller PCG/Ts.

Selected findings

- Almost all (95%) PCG/Ts had introduced some form of incentive for practices to promote improvements in primary care provision.
- Over half (56%) had nurse-led services to improve access to primary care, 54% had reduced waiting times for appointments, and 53% had extended the role of pharmacists.
- There had been substantial increases in the numbers of schemes to extend the range of services available in primary care, including counselling (74%), specialist nurses (67%), and specialist GPs (62%).
- Four fifths (82%) of PCG/Ts had PMS schemes in operation and many were using these to target groups with poor access to services.

Clinical Governance

PCG/Ts have demonstrated significant achievements in clinical governance, particularly in the areas covered by the NSFs. They have promoted a culture of quality improvement that is underpinned by the collection and sharing of information on the quality of the services provided. However, inadequate resources, a rapidly growing agenda and continuing organisational change were felt to be obstacles to progress.

Selected findings

- PCG/Ts continued to adopt an educational and supportive approach to clinical governance, using personal learning plans, significant event reporting, incentives, feedback to practices and training events. Methods for dealing with poor performance were mainly educational and supportive. Only 20% had used disciplinary procedures.
- NSFs had a major influence on the priorities of PCG/Ts, with 89% identifying coronary heart disease as a priority, 48% mental health, 48% diabetes, and 39% care of older people.
- More than two thirds (69%) had identified clinical guidelines that they were implementing in all practices.
• Four fifths (81%) were sharing information on quality between practices, and a third (33%) shared practice identifiable information. Forty per cent were making some information on quality available to the public, but only 7% identified practices in this information.

• Forty two per cent of PCG/Ts did not have a dedicated budget for clinical governance, and 31% received little or no professional support.

Prescribing

Prescribing subgroups have continued to be a strong feature of PCG/Ts and are taking increased responsibility for managing prescribing. The level of pharmaceutical support has continued to increase and most PCG/Ts involve community pharmacists. NSFs and guidance from the National Institute for Clinical Excellence were increasingly influential, but prescribing leads were concerned about their ability to manage the increased cost of improved prescribing.

Selected findings

• All PCG/Ts had pharmaceutical posts dedicated to prescribing support, and two thirds were using community pharmacists in specific initiatives related to prescribing.

• The numbers of PCG/Ts identifying prescribing targets for increased generic prescribing, improved management of coronary heart disease, reduced antibiotic prescribing, and reduced use of proton pump inhibitors had declined.

• Forty four per cent had developed and adopted prescribing formularies and 75% were using prescribing guidelines.

• Eighty-nine percent of PCG/Ts were using PACT data and 59% the prescribing toolkit.

Commissioning

PCG/Ts had taken increased responsibility for commissioning in advance of the abolition of health authorities, usually working in collaboration with neighbouring PCG/Ts. While most were aiming to improve services through the commissioning process, few felt that they had strong leverage over providers.

Selected findings

• Eighty-three percent of PCG/Ts have established commissioning subgroups, and the same number had employed senior managers with responsibility for commissioning.

• Key factors in shaping commissioning decisions were achieving financial balance (95%), patients’ access to services (93%), national policy targets (93%),
and NSFs (89%).

- Almost all (94%) PCG/Ts were involved in commissioning acute services, 76% in commissioning accident and emergency services, and 61% were involved in commissioning mental health services.
- Only 17% held long-term service agreements with any providers. Very few PCG/Ts had changed providers for any of the hospital specialist services.
- A third of PCG/Ts (33%) have developed integrated care pathways for coronary heart disease and most are developing care pathways for a range of other conditions.
- Over two fifths (44%) of commissioning leads believed they had little leverage over NHS providers of hospital services.

Partnerships

PCG/Ts are involved in a wide range of strategic and operational partnerships with many local authority departments, and the process of working across agency and professional boundaries is widely regarded as a success. However, boundary differences between health and local authority services remain problematic and there is considerable potential for greater collaboration at the operational level.

Selected findings

- Seventy per cent of PCG/Ts had appointed staff to develop partnerships with local authorities, and 58% had jointly appointed co-ordinators to develop intermediate care services.
- Fifty five per cent of PCG/Ts were involved in partnership initiatives using Health Act flexibilities.
- Joint staff training for health and local authority staff had occurred in 89% of PCG/Ts and 89% had made changes to the organisation of front line health and social care staff to improve collaboration.
- Two thirds (67%) were jointly providing intermediate care facilities with social services and 79% were jointly providing community rehabilitation for older people.
- One in seven (15%) of social services representatives reported no routine liaison with social services departments and wider local authorities about PCG/T business.
- Half (49%) of social services representatives thought that boundary differences were continuing to create barriers to closer collaboration.
- Forty eight per cent of social services representatives reported encountering problems in trying to improve collaboration between PCG/T and local authority staff.
• All PCG/Ts were working with community development/regeneration departments and most were working with leisure (80%), housing (77%), and education (76%).

Health Improvement

Over the past three years, PCG/Ts have made significant progress in establishing an infrastructure for health improvement. PCG/Ts have started to implement health improvement initiatives that should in time yield significant health gains. However, they may be at the limit of their capacity given current activity and the volume of central guidance.

Selected findings
• Almost two thirds (63%) of PCG/Ts had a health improvement subgroup and 92% had a designated health improvement lead.
• Two thirds (66%) had access to public health support, although additional support was rated as a high priority by more than half (55%) of chief executives.
• Twenty percent of chief executives reported inadequate information to support needs assessment.
• Most (85%) PCG/Ts were allocating resources to non-NHS initiatives aimed at improving health and the quality of life including community development, supporting carers, and accident prevention.
• Only 16% of chairs felt that they had achieved an improvement in the health of local people, but 56% expected a significant improvement in the longer-term.

Achievements, Obstacles and Key Tasks

As in the second year, chief executives most commonly identified achievements related to specific service development initiatives, general improvements in primary care provision, partnerships working and quality improvement. The main obstacles to progress were shortages of staff and resources. Key tasks for the year ahead were managing the consequences of continuing organisational change, balancing the budget, meeting national targets and the further development of primary care.
Selected findings

- Thirty nine per cent of chief executives identified specific service developments as achievements for the PCG/T, 35% highlighted primary care development, and 30% cited relationships with non-primary care agencies.

- Three fifths (61%) believed that inadequate infrastructure (such as staffing and premises) was an obstacle to success and half (49%) mentioned a lack of resources.

- A third (33%) of chief executives said that issues associated with mergers and making the transition to trust status were key tasks for the year ahead, and a further third mentioned organisational development. However many also mentioned achieving financial balance (32%), meeting national targets (27%), and continuing primary care development (26%).

Taking Responsibility

By the third and final year of the Tracker Survey, PCG/Ts remain faced with a range of demanding responsibilities to deliver the modernisation agenda for the NHS. Rapidly changing organisations, new ways of working and a host of targets and objectives are key features of the modernisation process, and the question is how well and how quickly PCTs can respond. Over the past three years, PCG/Ts have made great strides and have responded quickly to the challenges presented to them. Infrastructures have been established and initiatives have been implemented to improve health and tackle inequalities, often in partnership with other stakeholders and agencies. Measures have been taken to extend primary and community services, and improve the quality of care.

In each of our reports we have pointed to a gap between expectations and capacity and of the need to ensure that the initial commitment to promoting local ‘ownership’ and participation is sustained. Most PCTs are well aware of the importance of these problems and are making efforts to address them. But they must also be recognised and addressed by government through:

- the provision of adequate resources to manage change.
- realistic expectations and a sensible timetable for achieving targets.
- a willingness to accept that for devolution to become a reality there must be greater scope for PCTs to determine what is most important for their patients.
1. Overview of the National Tracker Survey of Primary Care Groups and Trusts

David Wilkin and Anna Coleman

National Primary Care Research and Development Centre

Introduction

1.1 In the five years since the publication of the government’s white paper the New NHS: Modern, Dependable (Secretary of State for Health, 1997) the National Health Service (NHS) has undergone a radical organisational restructuring. In April 1999, 481 Primary Care Groups (PCGs) were established throughout England. They were charged with delivering three core functions (Department of Health, 1998):

- To improve the health of local people and address health inequalities.
- To develop primary and community health services.
- To commission community and hospital services.

1.2 PCGs brought together local providers of primary and community services under a board representing local GPs, nurses, the local community, social services and the health authority. They were expected to evolve over time, building upon existing arrangements, gaining experience and developing expertise, to become independent Primary Care Trusts (PCTs). By April 2000, 17 Primary Care Trusts had been established and the NHS Plan (Secretary of State for Health, 2000) stated that by April 2004 all PCGs were expected to have become PCTs. By April 2001, 164 PCTs were delivering health care to 24.3 million people (or 47.7% of the population) and by April 2002 all but one PCG had become PCTs. At the same time, the total number of Primary Care Groups and Trusts (PCG/Ts) has declined as many of the smaller PCG/Ts have merged with their neighbours.

1.3 The publication of Shifting the Balance of Power within the NHS (Department of Health, 2001a) in summer 2001 reasserted and strengthened the role of PCG/Ts in the reorganised NHS. Existing health authorities were replaced in April 2002 by larger strategic health authorities serving around 1.5 million people. PCTs will hold 75% of the total NHS budget and will take responsibility for securing the provision of the full range of services for their registered populations as strategic health authorities step back from a hands-on commissioning role. PCTs will have responsibility for the management, development and integration of all primary care services including medical, dental, pharmaceu-
tical and optician services. They will also take lead responsibility for developing and sustaining partnerships with other agencies including local authorities, voluntary organisations and private sector providers. All of these developments are intended to give increased power and responsibility to frontline workers. PCTs will be responsible for commissioning services and improving health, while strategic health authorities will broker solutions to local problems, hold local services to account and encourage greater autonomy for NHS trusts and PCTs.

1.4 Delivering the NHS Plan (Secretary of State for Health, 2002) published in April 2002 set out progress made so far in delivering the objectives of the NHS Plan and how these objectives will be taken forward. Box 1.1 provides examples of some of the key policy aims and targets which PCTs and others will be expected to deliver.

**BOX 1.1: DELIVERING THE NHS PLAN – KEY POINTS (FORWARD PLANS)**

- Waiting times will fall from a maximum of 15 months now to 6 months by 2005 and to 3 months by 2008.

- By 2008 15,000 more GPs and consultants, 30,000 more therapists and scientists and 35,000 more nurses, midwives and health visitors.

- PCTs to have 75% of the NHS budget by April 2003 and gain funding in 3-year blocks.

- Primary Care services to be expanded.

- Increased role of incentives to improve performance.

- PCTs able to purchase care from the most appropriate provider – public, voluntary or private.

- Introduction of a system of explicit patient choice – information provided on alternative providers, PCTs to publish patient prospectus etc.

(Secretary of State for Health, 2002)
Alongside the organisational changes and the modernisation agenda, the past two years have seen the establishment of the National Institute for Clinical Excellence (NICE), evaluating new treatments, the Commission for Health Improvement to carry out inspections of NHS trusts, and the publication of the first in a continuing series of National Service Frameworks (NSFs).

**National Tracker Survey of Primary Care Groups and Trusts**

In April 1999 the Department of Health commissioned the National Primary Care Research and Development Centre (NPCRDC) and the King’s Fund to undertake a longitudinal survey of a representative sample of PCG/Ts in order to support the development of PCG/Ts and inform policy formulation and implementation. PCG/Ts included in the survey have been followed during their first three years of development. The research is led by NPCRDC under the overall direction of Professor David Wilkin. The first survey was completed in December 1999, the second in December 2000 and the third in March 2002.

**Aims**

1. Overall the National Tracker survey of PCGs and PCTs aims to:
   - Describe how PCG/Ts tackle their three principal functions.
   - Evaluate their achievements against nationally and locally determined goals with respect to their principal functions and describe problems encountered.
   - Identify features of PCG/Ts and their ways of working, which are associated with successful delivery of their principal functions, including organisational factors, developing partnerships and management of budgets.

1.8 The first National Tracker Survey (Wilkin et al, 2000) was carried out 6 months after PCGs were established. In that survey we described how PCGs were approaching their core functions, their priorities for service development and their goals for the future. Results showed that PCGs had made considerable progress within a short period of time. Most PCGs had begun the process of building relationships with key local stakeholders, had set up structures for effective decision-making and had established policies and priorities to meet core functions. Some PCGs had begun the process of implementing policies to improve health care provision and the health of the local population.
1.9 Our second survey was carried out one year after the first survey in autumn 2000 (Wilkin et al, 2001). We monitored progress against a range of success criteria and indicators of performance. The second survey showed that the emphasis had shifted since the first year, when much effort was devoted to simply getting the organisation in place, to focus on the implementation of policies to achieve the core functions. The second survey showed that PCG/Ts had made substantial progress in developing and extending primary care provision and establishing processes to support quality improvement. Progress in developing the commissioning role, building partnerships and improving the population’s health had begun but was slower. A need to keep professional stakeholders involved and increase the involvement of local communities was highlighted and we noted considerable concerns about the lack of infrastructure and managerial capacity to deliver NHS modernisation in the time scale expected.

1.10 In this, the third report, based on our latest survey conducted between January and March 2002, we again describe progress made in PCG/Ts’ key functions in the context of policy and performance targets.

**Study Design and Methods**

**Sample**

1.11 The National Tracker Survey of PCGs is based on a random sample of 72 PCGs in England (15% of the 481 established in 1999) stratified by NHS region. At the request of the Department of Health, an additional five PCGs that were expected to become early PCTs were included in the sample (for years one and two) in order to describe the progress of early trusts. By the time of our third survey, almost half of our original sample had become PCTs, and we decided that it was unnecessary to retain the additional sites. However, one of the five was included in the third survey as it formed part of a sample for a more detailed case study drawing on data from the survey.

**Representativeness**

1.12 The original sample of PCGs was broadly representative of all PCGs in England in terms of geographical location, characteristics of general practice, population registered with practitioners, age groups of registered populations and deprivation payments (Wilkin et al, 2000).
1.13 Since the first Tracker survey, the original random sample of 72 PCGs became 71 by year 2 and 68 by the time of the most recent survey. This was due to mergers between PCG/Ts within the original sample. By January 2002, our sample consisted of 37 PCGs and 31 PCTs. The 68 PCG/Ts who participated in the survey are shown in Box 1.2.

Methods

1.14 Data were collected using survey methods (interviews and questionnaires). A set of core questions is repeated in each annual survey but the overall content and coverage varies yearly reflecting the development of PCG/Ts and changing policy.

1.15 In the first survey face-to-face interviews were carried out with PCG chief executives, chairs and representation from health authorities. Postal questionnaires were completed by other board members.

1.16 The second survey collected data via structured telephone interviews with PCG/T chief executives, health authority leads and PCG board chairs / PCT executive committee chairs plus, for the trusts, the PCT board chairs. Postal questionnaires were completed by other board members plus the chief executive of the PCG/Ts’ associated Community Health Council.

1.17 The third survey collected data from PCG board / PCT professional executive committee chairs and trust board chairs. Unless otherwise stated, the term ‘chair’ in the main text of chapters relates to the chairs of PCG boards and PCT executive committees (as stated in the introductory section of chapters).

• Structured telephone interviews with PCG/T chief executives, PCT board chairs / PCT executive committee chairs and PCT board chairs.
• Self-completion postal questionnaires to clinical governance, prescribing, commissioning and IM&T leads and social services representatives.

1.18 It should be noted that due to the restructuring of health authorities and expected abolition of Community Health Councils at the time of this survey, the decision was made not to interview health authority leads or chief executives of Community Health Councils as we had done in the second survey.

1.19 Questions covered all of the principal functions of PCG/Ts as well as organisational and financial information.
### BOX 1.2: PCG/Ts IN THE TRACKER SAMPLE AT TIME OF FIELDWORK (2002)

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<td>Leicester(City West)*</td>
</tr>
<tr>
<td>Barnsley</td>
<td>Barnsley West</td>
</tr>
<tr>
<td>North Nottinghamshire</td>
<td>Rother Valley</td>
</tr>
<tr>
<td>Rotherham</td>
<td>Great Derby</td>
</tr>
<tr>
<td>Southern Derbyshire</td>
<td>SW Sheffield*</td>
</tr>
<tr>
<td>Sheffield</td>
<td>North West Lancashire</td>
</tr>
<tr>
<td><strong>West Midlands</strong></td>
<td></td>
</tr>
<tr>
<td>Coventry</td>
<td>Coventry West</td>
</tr>
<tr>
<td>Birmingham</td>
<td>Birmingham (SW)</td>
</tr>
<tr>
<td></td>
<td>Birmingham (SE)</td>
</tr>
<tr>
<td></td>
<td>The Heart of Birmingham</td>
</tr>
<tr>
<td>South Staffordshire</td>
<td>Cannock Chase</td>
</tr>
<tr>
<td>Dudley</td>
<td>Staffordshire (East)</td>
</tr>
<tr>
<td>Shropshire</td>
<td>Dudley</td>
</tr>
<tr>
<td></td>
<td>Shropshire County</td>
</tr>
<tr>
<td><strong>North West</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tameside and Glossop</td>
</tr>
<tr>
<td></td>
<td>Morecambe Bay*</td>
</tr>
<tr>
<td></td>
<td>East Manchester*</td>
</tr>
<tr>
<td></td>
<td>Stockport*</td>
</tr>
<tr>
<td></td>
<td>Wyre</td>
</tr>
<tr>
<td></td>
<td>Central and South Knowsley</td>
</tr>
<tr>
<td></td>
<td>St Helens North</td>
</tr>
<tr>
<td></td>
<td>Salford North</td>
</tr>
<tr>
<td></td>
<td>Salford*</td>
</tr>
<tr>
<td></td>
<td>South Cheshire</td>
</tr>
<tr>
<td></td>
<td>Chester City</td>
</tr>
</tbody>
</table>

Note: * Denotes PCTs
Fieldwork

1.20 Questionnaires and data collection methods were piloted in two PCGs and two PCTs, outside the main Tracker sample, during September and October 2001. In early December researchers contacted the main sample to check willingness to participate, contact details, personnel changes and to arrange the telephone interviews.

1.21 Interviews for the main survey began in early January 2002 and were completed by early April 2002. Postal questionnaires were sent out in January and February 2002 with the last responses arriving at the beginning of April 2002.

Response rates

1.22 Response rates for telephone interviews were excellent and acceptable for all of the postal questionnaires, although in most cases they had decreased slightly on the previous year (Box 1.3).

BOX 1.3: RESPONSE RATES FOR QUESTIONNAIRES

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>%</td>
<td>Number</td>
</tr>
<tr>
<td>Chief executive</td>
<td>72</td>
<td>100</td>
<td>69</td>
</tr>
<tr>
<td>Chair PCG board / PCT executive</td>
<td>70</td>
<td>97</td>
<td>69</td>
</tr>
<tr>
<td>Health authority lead</td>
<td>45</td>
<td>98</td>
<td>46</td>
</tr>
<tr>
<td>PCT board chair</td>
<td>-</td>
<td>-</td>
<td>6</td>
</tr>
<tr>
<td>Clinical Governance lead</td>
<td>53</td>
<td>74</td>
<td>58</td>
</tr>
<tr>
<td>Prescribing lead</td>
<td>52</td>
<td>72</td>
<td>57</td>
</tr>
<tr>
<td>IM&amp;T lead</td>
<td>38</td>
<td>53</td>
<td>51</td>
</tr>
<tr>
<td>Commissioning lead</td>
<td>-</td>
<td>-</td>
<td>51</td>
</tr>
<tr>
<td>Social services representative</td>
<td>52</td>
<td>72</td>
<td>43</td>
</tr>
</tbody>
</table>
Analysis and dissemination

1.23 The results were analysed using the Statistical Package for the Social Sciences (SPSS) following data entry and cleaning. This report contains only a descriptive analysis of the data in each of the main areas covered by the survey. More detailed analysis is being undertaken and results will be published in scientific and professional journals.

1.24 In presenting our results, response rates set out in (Box 1.3) show the number and percentage responding to interviews and postal questionnaires. In the chapters that follow percentage figures only have been provided – the numbers to which they relate are available from the research team on request. Percentages are calculated on the basis of the number of valid responses to individual questions. Variation in response rates to different questionnaires, and to particular questions within questionnaires, mean that the totals used for the calculation of percentages may vary.

Limitations of the methodology

1.25 Rapid organisational change – including emergence of PCTs (many of which entail mergers), the replacement of health authorities by strategic health authorities plus the fast changing policy environment within the NHS, necessitate difficult choices given the practical limitations to the data that can be collected.

1.26 A survey of this nature suffers certain shortcomings. The use of closed questions limits the contextual detail that can be gleaned from respondents. Deeper understanding of the circumstances shaping PCG/Ts’ achievements will be derived from the related case studies.

1.27 Despite excellent response rates to most of the questionnaires used, sample sizes are not large enough to allow for detailed statistical analyses or statistical comparisons between subgroups in the sample.

1.28 Some baseline questions used in years 1 and 2 were dropped to make way for new material (e.g. questions on access and use of incentives).

1.29 The study relies heavily for its assessments of PCG/Ts’ progress on the testimony of those most closely involved in their development. While best placed to judge achievements, they may not always exercise detached or objective opinions.
2. Organisational Development and Governance
Keri Smith, Anna Coleman, Bernard Dowling and David Wilkin

National Primary Care Research and Development Centre

Introduction

2.1 Shifting the Balance of Power within the NHS (Department of Health, 2001a) reiterated the government’s commitment to putting patients and staff ‘absolutely at the heart’ of the NHS, giving greater authority and decision-making power to patients and grass roots staff, accompanied by major changes in organisational roles, relationships and organisational culture. The NHS Plan (Secretary of State for Health, 2000) places PCG/Ts firmly at the centre of its ambitious strategy for modernising primary and community services.

2.2 Since they were established in 1999, PCGs have undergone rapid organisational change and development. Our first survey showed that much of their energy was devoted to establishing an appropriate infrastructure and system of governance. Our second survey showed that the pace of organisational change had not slowed and for many PCGs involved in mergers and making the transition to trust status it had actually increased.

2.3 Our third survey provides an up to date picture of the PCG/Ts in our sample in terms of staffing levels, the balance between national and local needs and priorities, relations with key stakeholders, and the changes occurring as a result of mergers and making the transition from PCG to PCT. Evidence presented in this chapter is derived mainly from interviews with chief executives and chairs of PCG boards or the professional executive committees of PCTs. Sixty-six chief executives (97%) and 61 chairs (90%) were interviewed in this third survey.

Progress and Problems

Staff employed by PCG/Ts

2.4 The capacity of PCG/Ts to deliver improvements in services will depend to a considerable extent on the availability of key managerial, professional and administrative staff. Over the past three years, they have experienced a rapid growth in the number of staff employed in all categories. In 1999/2000, more than half of the PCGs in our sample employed four or fewer staff. By the time
of our second survey this had fallen to 3% and 52% employed more than eight staff. This rapid growth in staff numbers has continued over the past year. Box 2.1 shows the numbers of staff employed to support core PCG/T functions. These do not include the large numbers of clinical, managerial and support staff employed by PCTs to deliver community nursing and other services for which they have taken responsibility.

**BOX 2.1: NUMBERS OF STAFF IN POST (WHOLE TIME EQUIVALENTS)**

<table>
<thead>
<tr>
<th></th>
<th>Less than 2</th>
<th>2 – 3.9</th>
<th>4 – 5.9</th>
<th>6 – 7.9</th>
<th>8 – 9.9</th>
<th>10 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Managers</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2001/02</td>
<td>5</td>
<td>21</td>
<td>29</td>
<td>10</td>
<td>12</td>
<td>22</td>
</tr>
<tr>
<td>2000/01</td>
<td>10</td>
<td>54</td>
<td>22</td>
<td>4</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td><strong>Finance staff</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2001/02</td>
<td>37</td>
<td>29</td>
<td>20</td>
<td>5</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>2000/01</td>
<td>76</td>
<td>22</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Secretarial/Admin</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2001/02</td>
<td>3</td>
<td>29</td>
<td>28</td>
<td>21</td>
<td>5</td>
<td>14</td>
</tr>
<tr>
<td>2000/01</td>
<td>25</td>
<td>59</td>
<td>12</td>
<td>3</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

2.5 Although there was an overall increase in the number of staff available to support core functions, there was wide variation between PCG/Ts in the numbers of staff in different categories. The average number of managerial, finance and administrative staff employed by PCGs had risen from 6.8 in 2000/01 to 11.3 in 2001/02. The average for PCTs was 31.5 in 2001/02, compared with 15.8 in 2000/1 (for a sample of six PCTs in the second survey).

2.6 A substantial element of the variation in core staff (managerial, finance, administrative, IM&T, project officers, public health, etc.) was accounted for by the size of the PCG/Ts, with larger PCG/Ts employing more staff. Twelve of the 13 PCG/Ts employing more than 32 staff had populations over 150,000 and 17 of the 18 with fewer than 16 staff had populations less than 150,000. However, there was considerable variation in staffing levels, particularly in medium sized PCG/Ts. Three PCTs with populations of between 100,000 and 150,000 employed fewer than 24 staff, but another two employed 32 or more. The average number of core staff employed by PCG/Ts with fewer than 100,000 population was 16.5 compared with 46.1 for those with a population of more than 150,000.
2.7 PCTs had also taken on large numbers of clinical and administrative staff providing community based services. The numbers of such staff employed by PCTs ranged from 98 to 562 with a mean of 269. The overall size of these organisations had risen in the space of three years from around ten staff to more than 300.

2.8 Most PCG/Ts had strengthened their senior management teams by making director level appointments for key functions. Seventy-six per cent had appointed directors of finance, 85% primary care, 83% commissioning, 50% nursing, 42% community services, 41% public health, and 21% human resources.

2.9 Despite the rapid growth in the numbers of staff employed in all categories, most chief executives felt that current levels of staffing remained inadequate. Three-fifths (61%) believed their staffing levels to be inadequate, relatively unchanged since our previous survey when 68% reported that staffing levels were inadequate. Only 12% rated staffing levels as adequate (12% in 2000/01). This was reflected in the widespread opinion that insufficient staff was one of the major obstacles to progress (See Chapter 11: Achievements, Obstacles and Key Tasks).

Changes in leadership

2.10 In addition to experiencing rapid growth in the organisation, some PCG/Ts were also undergoing changes in the leadership of the organisation, which could create problems in terms of continuity and organisational stability. Twenty-eight chief executives (42%) had been appointed since 1999 (24 of these in 2001), normally associated with transition to trust status. There was less turnover among chairs of PCG boards/PCT professional executive committees. Seventy-three per cent of chairs had been in post since 1999, but 13 of the 17 newly appointed chairs were in PCTs. Twenty PCGs (55%) had retained the same chair/chief executive team throughout the three year period, compared with only 5 (17%) of PCTs.

Shifting the balance of power

2.11 One of the most important policy goals in the creation of PCGs and PCTs was to shift the locus of decision-making closer to front line primary care professionals, and facilitate a health service that is responsive and accountable to local communities and service users.
2.12 Chairs of PCG boards and PCT professional executive committees were asked to provide their assessments of the relative influence of national policies/targets and local needs and priorities. Only 5% rated local priorities as having a strong influence, but 69% rated national policies, targets and guidelines as having the strongest influence. Sixty-five per cent said that greater emphasis was needed on local priorities. The vast majority (90%) wanted greater opportunities to focus on local health needs and service development priorities, including mental health services, concentrating attention on deprived populations within the PCG/T, rural deprivation and associated transport problems, and ethnic minority groups. Only 15% considered that users and local communities had a strong influence, while 53% felt that the influence of NHS staff outweighed the views of local people.

2.13 Most attention relating to issues around devolution of power has focused on the balance between PCG/Ts and centralised decision-making. However, there are also important issues of devolution within the PCG/Ts themselves, which have become more apparent as organisations have merged, often more than doubling the population served and sometimes replacing three or more former PCGs. Half (49%) of the PCG/Ts in our sample had established locality groups in an attempt to retain local sensitivity and the engagement of front line health professionals. This was an increase from 35% in 2000/01 and 20% in 1999/2000. The formation of locality groups was, unsurprisingly, concentrated in the largest PCG/Ts and often accompanied a merger.

2.14 Most locality groups provided a mechanism for consultation, rather than fully devolved decision-making. While 63% had appointed locality managers to support the groups, almost two-thirds of locality groups (63%) had little or no freedom to make decisions and only 38% had delegated powers for managing budgets. Where budgets were at least partially devolved to locality groups these were most commonly for prescribing, primary care development and community health services.
Engaging stakeholders

2.15 Central to the policy of establishing PCGs and PCTs was the intention of engaging local stakeholders in decision-making, including front line health professionals, local communities and other agencies whose work has a bearing on health. The engagement and support of primary care professionals (GPs, nurses, therapists, managers) is crucial to the success of PCG/Ts and was reflected in the dominant role played by these professionals in PCG boards and PCT professional executive committees. Almost all chairs (97%) rated GP support as important or very important to the success of the PCG/T and 90% rated the support of nurses as important or very important. Box 2.2 shows that chairs’ perceptions of increased support from GPs and nurses between our first and second surveys were not continued in the third year. Only 61% felt that at least half of their GPs were supportive, almost the same as the 62% in the previous year. Chairs generally rated nurses as more supportive and there was a slight increase in the number reporting that more than half of their nurses were supportive. While only a minority of GPs was felt to be negative or antagonistic, 27% of chairs reported that at least one in five of their GPs were negative.

BOX 2.2: PERCENTAGES OF GPs AND NURSES RATED SUPPORTIVE OF PCG/T BY CHAIRS

2.16 Our earlier surveys showed that most PCG/Ts were consulting local GPs and nurses on all key areas of policy and service development. However, chairs were not always convinced that their consultation processes were effective. There was little change over the past year with 51% rating consultation with GPs as effective and 51% consultation with nurses, compared with 60% and 55% in 2000/01.
2.17 Three-quarters (77%) of PCG/Ts had public involvement working groups and 82% were employing staff to support public involvement. It was evident that PCG/Ts were using a range of approaches to consulting and informing their local communities, although use of these methods has not increased over time (Box 2.3). However, as with professional consultation, many chairs were not convinced that their efforts to consult communities were very effective. Twenty-eight per cent rated consultation ineffective and only 18% felt it was very effective. This scepticism was reflected in their judgement of the extent to which local people were aware of the PCG/T. Almost two-thirds of chairs (64%) felt that the local community was unaware of the existence of the PCG/T and 84% felt they did not know how to contribute to the process of decision-making about local services.

**BOX 2.3: METHODS OF INFORMING AND CONSULTING LOCAL COMMUNITIES USED BY PCG/Ts**

<table>
<thead>
<tr>
<th>Method</th>
<th>2001/02</th>
<th>2000/01</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consulted community health councils</td>
<td>85</td>
<td>87</td>
</tr>
<tr>
<td>Consulted local councillors</td>
<td>72</td>
<td>70</td>
</tr>
<tr>
<td>Public meetings</td>
<td>70</td>
<td>75</td>
</tr>
<tr>
<td>Consulted established patient groups</td>
<td>67</td>
<td>61</td>
</tr>
<tr>
<td>Focus groups or user forums</td>
<td>62</td>
<td>61</td>
</tr>
<tr>
<td>Produced patient questionnaires</td>
<td>51</td>
<td>48</td>
</tr>
<tr>
<td>Analysed complaints</td>
<td>48</td>
<td>40</td>
</tr>
</tbody>
</table>

2.18 Chairs were asked to rate the extent to which the views and interests of different stakeholders were represented in discussion and decision-making within the PCG/T (Box 2.4). It is of some concern that, in the opinion of the chairs, stakeholder views are less well represented now than they were in our last survey.
2.19 Chairs were also asked to rate the influence of key players on policies and priorities for the PCG/T. Almost all (98%) reported that these officers had considerable influence (4/5 on a five-point scale), 82% the PCG board/PCT professional executive committee, 28% GPs and 11% nurses. However, there were important differences between PCT executive committee chairs and PCG chairs. Seventy per cent of PCT executive committee chairs rated the officers as having great influence (5 on a five-point scale from 1 ‘no influence’ to 5 ‘great influence’) compared with 42% of PCG chairs. Fifty-five per cent of PCG chairs rated the health authority as having considerable influence (4/5) compared with 31% of PCT executive committee chairs; and 30% of PCT executive committee chairs rated GPs as having little or no influence (1/2) compared with 12% of PCG chairs. These differences suggest that, at least in the opinion of chairs, the transition to PCT status was resulting in changes in the influence exercised by key players.

Organisational change: mergers and the transition to trust status

2.20 Over the past three years the PCGs established in 1999 have had to develop new ways of collaborative working across primary and community health services, implement systems of governance, recruit staff and cope with the many challenges of establishing new organisations. Our first report (Wilkin et al, 2000) showed that they devoted much of their effort during the first year to establishing processes and patterns of working, while taking on increasing levels of responsibility and increasing numbers of targets and expectations. In
1999/2000, it was envisaged that PCGs would serve populations of around 100,000 and would move to PCT status as they acquired the necessary capacity and competence. The pace of organisational change has proved to be faster than might have been anticipated at the outset. By April 2002 all PCGs had become PCTs, the old health authorities that supported PCG/Ts had been replaced by strategic health authorities, and widespread mergers had resulted in a rapid increase in the average size of the new organisations.

**Mergers**

2.21 Twenty-three (34%) of the PCG/Ts in our sample had already merged by the time of our third survey in Spring 2002, and two of these were planning a further merger. A further 32% planned to merge either in April 2002 or 2003. Only a third (34%) of the PCG/Ts in our sample were not involved in mergers with neighbouring PCG/Ts. The scale of organisational change and upheaval is likely to be increased where mergers involve more than two organisations, and more than half (56%) of the mergers involved more than two PCG/Ts.

2.22 The overall effect of mergers on the size of PCG/Ts is quite dramatic. The average size in 1999 was around 100,000. By the third survey, the average had risen to 150,000 (ranging from 54,000 to 327,000). When all of the planned mergers are completed, the average population in our study sample will be 200,000 (ranging from 59,000 to 376,000). Only 10% of our sample will have populations below 100,000. **Box 2.5** shows that two-thirds of PCG/Ts will have populations of over 200,000. Many of the larger PCTs now cover populations as large as the health authorities they replaced.

**BOX 2.5: EFFECTS OF MERGERS ON POPULATION OF PCG/Ts**

<table>
<thead>
<tr>
<th>Population After Mergers</th>
<th>Less than 100,000</th>
<th>100,000 to 149,000</th>
<th>150,000 to 199,999</th>
<th>200,000 plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 100,000</td>
<td>41% (7)</td>
<td>-</td>
<td>18% (3)</td>
<td>42% (7)</td>
</tr>
<tr>
<td>100,000 – 149,000</td>
<td>-</td>
<td>-</td>
<td>14% (3)</td>
<td>86% (18)</td>
</tr>
<tr>
<td>150,000 – 199,999</td>
<td>-</td>
<td>-</td>
<td>69% (11)</td>
<td>31% (5)</td>
</tr>
<tr>
<td>200,000 plus</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>100% (14)</td>
</tr>
</tbody>
</table>

Note: Table shows all PCG/Ts in the sample, including those that have not merged and have no plans to do so.
Chief executives were asked to outline the advantages/benefits and the disadvantages/costs of mergers. Responses have been classified in Box 2.6. These perceived advantages were compared with 'reasons for merging' given in our second survey. The capacity to influence the local health economy, particularly through the commissioning process has clearly become a major factor in promoting mergers (e.g. ‘more leverage and better bargaining power through bigger budget’, ‘reducing commissioning complexities in terms of cutting the number of commissioners’, ‘impact on other service providers such as hospitals – more clout and leverage’). This and the belief that larger organisations will make better use of resources are seen as the main advantages to be derived from larger organisations. Examples of the disadvantages and costs were: ‘less local ownership of policy’, ‘some GPs feel disenfranchised because they had a lot of board representation on the old PCG’, ‘loss of ownership and local influence’, ‘two quite different localities in the new PCT, one rural one city and co-ordination between the two will be difficult’, ‘amount of effort involved in merging – will spend less time on service improvement’.

**BOX 2.6: CHIEF EXECUTIVES’ ASSESSMENT OF ADVANTAGES AND DISADVANTAGES OF MERGERS**

<table>
<thead>
<tr>
<th>Advantages/benefits of mergers</th>
<th>2000/01 %</th>
<th>2001/02 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical mass/influence/commissioning strength</td>
<td>18</td>
<td>57</td>
</tr>
<tr>
<td>Better use of resources/increased capacity/economies of scale</td>
<td>43</td>
<td>51</td>
</tr>
<tr>
<td>To achieve co-terminosity with local authority boundaries</td>
<td>22</td>
<td>23</td>
</tr>
<tr>
<td>Local circumstances / best for local population</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>Move to Primary Care Trust</td>
<td>38</td>
<td>12</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Disadvantages/costs of mergers</th>
<th>2000/01 %</th>
<th>2001/02 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPs becoming more remote/lack of GP support</td>
<td>N/A</td>
<td>35</td>
</tr>
<tr>
<td>Loss of local focus/working</td>
<td>N/A</td>
<td>30</td>
</tr>
<tr>
<td>Organisational change</td>
<td>N/A</td>
<td>30</td>
</tr>
</tbody>
</table>
2.24 PCG management budgets were initially allocated on a per capita basis, with a suggested level of £3 per head of population. This may have created a powerful incentive for PCGs to merge as a way of increasing managerial capacity. While management budgets have increased over the three years, there remains substantial variation. The average management budget per head of population was £8.02 for PCG/Ts that had already merged, £5.46 for those planning mergers and £10.98 for those not planning mergers. These differences suggest that PCG/Ts planning mergers were less well resourced.

2.25 Despite their concerns about local ownership, chief executives felt that most local stakeholders were supportive of mergers. Four-fifths (81%) rated social services departments as supportive or very supportive, 79% managers, 72% nurses, and 67% local authorities. However, they were less convinced that local GPs supported the merger. Although just 16% felt their local GPs were opposed to the merger, only 37% felt they were supportive. Health authorities, prior to their abolition, played an important role in promoting mergers. A few PCG/Ts (7%) said that the health authority had insisted on a merger, but another 48% said that they had actively promoted mergers.

Primary Care Trusts

2.26 By the 2001/02 survey, 31 (45%) of our sample had already made the transition from PCG to PCT (8 in 2000 and 23 in 2001). The remaining 37 were still PCGs, but preparing to become trusts in April 2002. The first survey in 1999/2000 showed that 38% of PCGs had made no decision about trust status and two PCGs had decided that they did not wish to make the change to trust status at all. However, it rapidly became apparent that all PCGs were expected to become PCTs and that all would make the change by April 2002.

2.27 Most of those chief executives of PCTs and PCGs about to become trusts reported high levels of support for the trust among local stakeholders (Box 2.7) The perceived level of support had increased for all stakeholders over the three years of the survey. However, it is notable that only just over half of the chief executives rated their GPs as supportive (55%), although only 7% reported that local GPs were opposed to the trust.
Chief executives of PCTs, and those about to become PCTs, were asked about changes in service provision enabled, or anticipated, by trust status (Box 2.8). These responses are compared with anticipated changes to service provision reported in our 2000/01 survey. This comparison suggests that the anticipated opportunities to reconfigure services may be more difficult to achieve in practice. While more than four-fifths (83%) of PCG chief executives anticipated greater integration of primary and community health services, only half of the longer established trusts reported that they had actually made such changes. However, it is also evident that changes to bring about closer integration of health and social care and improvements in the quality of primary care were rather more common than initially anticipated.
Unsurprisingly, given their increased responsibilities, PCTs had much higher levels of funding and staff than PCGs (Box 2.9). Despite this, many PCT chief executives still felt current levels of staffing were inadequate (64% in 2001, and 38% in 2000).

**Box 2.9: Average Staff and Management Budgets for PCGs and PCTs**

<table>
<thead>
<tr>
<th></th>
<th>PCGs</th>
<th>2000 PCTs</th>
<th>2001 PCTs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Managers</strong></td>
<td>£5.30</td>
<td>£10.89</td>
<td>£10.43</td>
</tr>
<tr>
<td><strong>Finance</strong></td>
<td>£1.93</td>
<td>£4.18</td>
<td>£4.99</td>
</tr>
<tr>
<td><strong>Administrative</strong></td>
<td>£4.10</td>
<td>£11.10</td>
<td>£18.01</td>
</tr>
<tr>
<td><strong>Management budget per head</strong></td>
<td>£5.18</td>
<td>£13.31</td>
<td>£11.63</td>
</tr>
</tbody>
</table>

Note: Respondents were able to select more than one service change
2.30 Most PCTs had taken over or were planning to take over provision of substantial elements of community health services (Box 2.10). All but one were providing district nursing and health visiting services. In some cases PCTs were taking over the provision of specific services on behalf of a number of local PCTs. These included children’s services, services for people with learning disabilities, speech and language therapy and palliative care. Specialist services mainly involved the use of GP specialists in areas such as dermatology, rheumatology and ophthalmology. One of the consequences of taking over the provision of community services was a rapid growth in the number of staff directly employed and managed by the PCTs.

**BOX 2.10: COMMUNITY HEALTH SERVICES PROVIDED OR PLANNED BY PCTs**

<table>
<thead>
<tr>
<th>Service</th>
<th>% of PCTs</th>
</tr>
</thead>
<tbody>
<tr>
<td>District nursing</td>
<td>99</td>
</tr>
<tr>
<td>Health visiting</td>
<td>99</td>
</tr>
<tr>
<td>Intermediate care</td>
<td>85</td>
</tr>
<tr>
<td>Health promotion</td>
<td>77</td>
</tr>
<tr>
<td>Chiropody</td>
<td>77</td>
</tr>
<tr>
<td>Public health</td>
<td>74</td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>67</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>61</td>
</tr>
<tr>
<td>Community services for specific groups</td>
<td>55</td>
</tr>
<tr>
<td>Community dental health</td>
<td>49</td>
</tr>
<tr>
<td>Specialist services</td>
<td>46</td>
</tr>
<tr>
<td>Community hospital</td>
<td>43</td>
</tr>
<tr>
<td>Community mental health services</td>
<td>18</td>
</tr>
<tr>
<td>Midwifery</td>
<td>8</td>
</tr>
</tbody>
</table>

**Conclusions**

2.31 PCG/Ts have undergone a massive and very rapid process of organisational change and development over the past three years. Evidence from our latest survey illustrates the scale of change and some of its effects.
There has been a rapid growth in the numbers and categories of staff employed as PCG/Ts have absorbed staff and their associated functions from the now defunct health authorities. Most now have senior managers in post to deal with their core functions. However, there remain wide variations in staffing levels between PCG/Ts. While some of these differences reflect the different functions and responsibilities of PCGs and PCTs, with the latter having substantially more staff, there was still considerable variation within each category. A substantial minority of PCTs has experienced changes of chief executives and chairs at the same time as handling the transition to trust status and the associated organisational upheaval. Despite the increases in staffing levels, chief executives remain concerned that their current staffing levels are inadequate to meet the demands placed on them.

Fundamental to the government’s decision to establish PCGs and PCTs was a desire to shift the locus of decision-making closer to front line health professionals and local communities, and this has been reinforced over the past year with the implementation of the changes set out in Shifting the Balance (Department of Health, 2001). However, most chairs of PCG boards and PCT professional executive committees feel that the balance is still weighted too heavily towards national policies and targets, allowing insufficient scope to address local issues and develop local initiatives.

PCG/Ts believe they have been largely successful in engaging professional stakeholders and ensuring that their interests are represented. However, there remains a significant minority of PCG/Ts where levels of support from health professionals are less than ideal. The fact that more than a third believe they do not have the support of a majority of local GPs is cause for concern. PCG/Ts have worked hard to consult and involve health professionals in decision-making, but there is some scepticism about the effectiveness of these consultation processes.

One of the biggest challenges facing PCTs will be to find effective ways of informing and involving local communities in decisions about local services. They have employed a wide range of techniques for informing and engaging the public, but chairs were not convinced that such processes were effective.

The large number of mergers that have taken place, or are planned, have had a dramatic effect on the size of PCG/Ts, doubling the average population and creating a group of ‘super PCTs’ with populations more than three times the 100,000 originally envisaged. The increasing use of locality groups within larger PCG/Ts reflects an attempt to counter the threat of a loss of local focus and engagement. However, relatively few such groups have much devolved deci-
sion-making power and even fewer hold devolved budgets. The rationale for mergers lies primarily in the belief that larger organisations will be able to exercise more influence and make more efficient use of resources. However, the evidence to support this is far from conclusive (Bojke et al, 2001; Wilkin et al, in press).

2.37 Since the completion of our third survey the remaining PCGs in our sample have made the transition to trust status. In doing so they have taken on additional responsibilities, more staff and a wide range of community health services. Responses from existing PCTs suggested that some of the changes to services that were anticipated from trust status may be more difficult to achieve in practice, particularly the integration of primary and community health services. Almost all PCTs have taken over the provision of community nursing services and most have also taken responsibility for a range of other community based services. At the same time they are implementing new governance arrangements that involve clarifying the respective roles of the board and professional executive committee.
3. Budgets and Incentives
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Introduction

3.1 The introduction of PCG/Ts has been associated with major changes in the budgetary framework:

- Resource allocation formulae have been extended from hospital and community health services expenditure to embrace prescribing and general practice infrastructure expenditure (includes practice staff and infrastructure).
- There has been increased devolution of budgetary responsibility from health authorities to PCG/Ts and in turn PCG/Ts are being encouraged to develop notional budgets for their practices.
- Although built up from separate formulae for prescribing, hospital, community health services and practice infrastructure PCG/T budget allocations are unified, so that the total pot of money generated by separate resource allocation formulae may be spent on any budget heading.

3.2 PCG/Ts thus have two key roles:

- Deciding whether to use the greater financial flexibility to shift financial resources between hospital and community health services, prescribing and general practice infrastructure budget.
- Establishing financial frameworks to control expenditure, provide incentives to practices, and manage risks.

3.3 In this chapter we consider the extent to which desired internal financial changes have been taking place, what mechanisms have been put in place to secure such changes, and the obstacles to securing change. In assessing performance to date, we focused on the following areas:

- The strategic management of the unified budget through the shifting of expenditure.
- The development of approaches to managing financial risk.
- The development of incentive schemes to promote desired change.
3.4 The evidence in this chapter derives mainly from interviews with PCG/T chief executives. Sixty-six (97%) were interviewed in this third survey, 69 (97%) in the second and 72 (100%) in the first survey.

Progress and Problems

Shifts in expenditure

3.5 The percentage of chief executives expecting their PCG/T’s actual expenditure to come within 5% of their target expenditure (nationally defined weighted budget) remains encouragingly high at 83% (77% last year). This may suggest a limited reliance on historical spending patterns. Moreover, expenditure appears to be moving closer to the actual unified budgets, with 46% expecting to be spending in line with budget in 2001/02, compared to the 17% that were on line with their 1999/2000 budget.

3.6 More PCTs (54%) than PCGs (35%) reported already changing expenditure within the four budget headings of prescribing, hospital and community health services, general practice infrastructure, and community services, perhaps a result of the greater financial independence that they had from health authorities. Box 3.1 shows the percentage of PCG/Ts in the Tracker sample planning strategic shifts in expenditure across four main budget headings. The main pattern is one of movement of resources away from hospital services towards community services, practice infrastructure and prescribing. Relative to their influence with health authorities, under PCG/Ts it is likely that GPs have a more prominent voice in the allocation of expenditure. So it is perhaps not surprising that planned expenditure shifts are in general towards primary care areas where GPs have direct control. This includes not only prescribing and practice infrastructure but also community services (many of which PCTs are taking responsibility for providing).
Risk management

3.7 As budgets are devolved to smaller organisational units, budgetary risk increases, in the sense that random fluctuations in demand or costs are less readily absorbed within the budgetary limit. As a result, risk management is likely to be an important element of the managerial apparatus associated with the new budgetary devolution.

3.8 Prior to their replacement by strategic health authorities, most health authorities appeared to have implemented some form of risk sharing or pooling arrangement with their PCG/Ts in respect of expensive cases. Many PCG/Ts said that either health authorities met the cost of such cases or that the risks were shared across health authorities and the PCG/T (who presumably would retain some money or top-slice from each PCG/T in order to handle these expenses). Whilst such arrangements shift the risks from individual cases they do not provide cover for PCG/Ts against unexpected overall shifts in demand.

3.9 Box 3.2 shows that many PCG/Ts (60%) are not permitted to bank underspends and even more are not permitted to carry forward overspends (82%). There is some asymmetry in respect of over and underspends with a higher proportion of PCG/Ts (39%) being able to carry forward underspends than overspends (17%). The apparent hesitancy in allowing PCG/Ts to carry forward financial surpluses and deficits from previous years could suggest a lack of management of the financial risks faced by PCG/Ts, at least in respect of them having incentives to manage their own financial position.
BOX 3.2: ARRANGEMENTS FOR DEALING WITH UNDER OR OVER-SPENDS (2001/02)

Budget setting within PCTs

3.10 When PCG/Ts were first proposed it was envisaged that indicative budgets would be extended to individual practices for hospital and community health services (Secretary of State for Health, 1997). Indicative practice budgets are one means by which PCG/Ts can attempt to control the expenditure implied by practice referral decisions and may become increasingly important as practices get greater freedom to refer patients under patient choice proposals (Secretary of State for Health, 2002).

3.11 Box 3.3 indicates that in the current Tracker survey, only 7% of PCG/Ts have already introduced indicative practice budgets for hospital and community health services, with another 50% intending to do so at some point in the future. Most of these PCG/Ts expect to introduce them in 2003/04 or later. This suggests slow progress by PCG/Ts, especially in light of the first Tracker survey when 55% of PCGs said they would have indicative hospital and community health services budgets for practices, with most intending to introduce them in the following two years. This has not materialised, and there are no significant changes in the numbers planning to introduce indicative budgets from the time of the second Tracker survey (51%). A larger percentage of PCTs (12%) had currently devolved such indicative budgets to practices than PCGs (3%), although this still represents only a small minority of the trusts in our sample.
Use of incentives by PCG/Ts

3.12 The reported use of financial incentives within PCG/Ts presents a mixed picture in terms of the extent to which they are used for different purposes.

Prescribing incentives

3.13 Prescribing is the second largest item of expenditure within the overall resource envelope and PCG/Ts are required to have a prescribing incentive scheme. Department of Health guidance leaves considerable scope for discretion in the design of such incentive schemes. Most PCG/Ts (83%) linked rewards to both budgetary and quality targets with only 10% and 6% respectively having schemes based solely on cost or quality targets.

Incentives associated with hospital and community health services expenditure

3.14 It has been the intention since PCG/Ts were first announced that indicative practice hospital and community health services budgets would be linked with financial incentives to restrain practice expenditure. However, as Box 3.4 shows, progress has been slow with only one in ten PCG/Ts already using incentives and three-fifths (59%) having no plans to introduce them.
BOX 3.4: FINANCIAL INCENTIVES FOR PRACTICES RELATED TO HOSPITAL AND COMMUNITY HEALTH SERVICES EXPENDITURE

Quality improvement

3.15 A majority of PCG/Ts appear to have in place or are planning to use incentive schemes related to quality improvement. Since the first Tracker survey, significant progress with respect to incentives around quality management seems to have been made. In the first survey 29% of clinical governance leads indicated the use of incentive schemes for clinical governance, and this increased to 51% in the second survey. This third survey indicates that two-thirds (65%) already use incentive schemes for quality improvement.

PMS contracts

3.16 Slightly less than half the PCG/Ts that responded in the third Tracker survey (48%) said that personal medical services contracts include financial incentives for practices linked to service improvements, compared with 38% in 2000/01.

Commissioning

3.17 Although a large number of PCG/T commissioning leads (57%) believed holding a budget for commissioning was an important source of leverage over providers, most PCG/Ts (88%) reported they had not introduced any financial incentives or penalties for providers in service level/long-term service agreements.

Conclusions

3.18 In general, PCG/Ts seem to be consolidating their plans and priorities regarding their budgets. Potentially more ambitious plans suggested in the first Tracker survey now appear to be tempered somewhat, suggesting less ambi-
tious PCG/T expectations concerning what they feel they are able to achieve. In many cases, plans to implement notional budgets and the operation of financial incentive schemes for hospital and community health service expenditure seem to be either abandoned or postponed for the time being.

3.19 Assessments of the progress achieved in the first three years of PCG/Ts must recognise the fundamental nature of the changes introduced and the managerial and financial baseline from which the new structure started. Achievements to date include:

- Improvement in keeping the overall unified budget in balance.
- The large majority of PCG/Ts are continuing to report keeping expenditure within 5% of target-spending levels.
- There is evidence of strategic thinking about shifts in expenditure within PCG/Ts.
- An increasing use of incentive schemes relating to clinical governance.

3.20 There has been slower progress in a number of other areas:

- Little movement on implementing greater budgetary flexibility, for example through carrying forward overspends and underspends and therefore a limited use of this mechanism to manage risk.
- Little movement on devolving indicative hospital and community health services budgets to practice level.

3.21 The NHS starts from a low base in terms of managerial and information infrastructure and decision-makers in PCG/Ts have had limited time to adapt to the new financial and budgetary environment.

3.22 Since our last report there have been some important policy developments that have profound implications for PCG/Ts. The two most important are the ‘next steps’ in the Shifting the Balance of Power initiative (Department of Health, 2001a) and the proposals contained in: Delivering the NHS Plan (Secretary of State for Health, 2002).

3.23 Shifting the Balance of Power (Department of Health, 2001a) entails the creation of 28 Strategic Health Authorities and a considerable strengthening of the central role of the PCT. There are good reasons to believe that this structural reform contains the potential for improved system performance. For example, PCTs will have increased freedom to determine how their budgets should be spent across all types of provider, and to forge stronger links with social care.
3.24 Delivering the NHS Plan (Secretary of State for Health, 2002) envisages a much greater role for giving providers incentives to increase output, and for patient choice based on information on alternative providers. This development places considerable additional accountability and managerial burdens on PCTs, and it is difficult to envisage successful implementation without considerable additional capacity, in the form of leadership training, information technology innovation and additional managerial expertise.

3.25 In the light of the results from the Tracker survey, we judge that the priority areas for future attention in the domain of budgets and incentives are:
- Rapid development of relevant and timely information systems.
- Dissemination of good budgetary practice.
- Enhancement of appropriate managerial capacity.
- More careful design and evaluation of incentive schemes, particularly in the domain of clinical governance.
- Careful expansion of indicative practice budgets into hospital and community health services.

3.26 Attention to these rudimentary managerial instruments appears to be a priority if PCG/Ts are to address successfully the recent policy priorities. Also, if PCTs have taken on ex-health authority staff in key financial positions, and if many strategic health authority chief executives previously held that post in the old health authorities, strategic health authorities might attempt to cling on to old health authority roles and ‘over-manage’ PCTs. For the sake of local autonomy, the Department of Health should try to avoid this happening.
4. Information Management and Technology
Diane Jones and David Wilkin
National Primary Care Research and Development Centre

Introduction

4.1 In 1998 the NHS launched its information strategy Information for Health (NHS Executive, 1998). The targets defined in this document were extremely ambitious, especially for the newly formed PCGs and subsequent PCTs. Since 1998 several documents, including The NHS Plan (Secretary of State for Health, 2000) and Building the Information Core (Department of Health, 2001b) have refined and modified the targets. Shifting the Balance of Power (Department of Health, 2001a) has had a major impact upon IM&T within PCG/Ts, particularly the abolition of health authorities. This has been most obvious where PCG/Ts were highly dependent on their health authorities for IM&T. Most recently, Delivering 21st Century IT Support for the NHS (Department of Health, 2002) has redefined the NHS information strategy, focussing attention on fewer targets but at the same time adding some major new developments, such as the provision of broadband access to clinicians and managers. Unlike Information for Health (NHS Executive, 1998), this new strategy highlights the substantial role PCTs will be expected to play in delivering the vision for NHS IM&T.

4.2 The challenge facing PCTs in developing IM&T is enormous. In the second Tracker survey we showed that PCG/Ts were making some progress in this area, but there were some serious concerns about their capacity to deliver both in terms of IM&T staff and budgets. Our third survey has continued to focus on evaluating the progress of PCG/Ts against the markers of progress identified in the second survey:

- Developing the infrastructure.
- Effective strategic planning.
- Developing IM&T within the PCG/T.
- Developing practice based systems.
- Education training and development.

4.3 In 2001/02, 44 IM&T leads completed the postal questionnaire (65%). There had been a significant change in the profile of respondents. In the second survey, 62% of IM&T leads were GPs. In the third survey only 32% were GPs, 27% were IM&T officers for the PCG/T, 23% were PCG/T managers and 21% were PCG/T directors or chief executives. This suggests that IM&T has
become more of a mainstream managerial function within PCG/Ts.

Progress and Problems

Developing the infrastructure

4.4 There has been no change in IM&T leads perceptions regarding staffing levels for IM&T. Seventy-one percent of PCG/T leads felt that current staffing levels for IM&T were inadequate or very inadequate. This is a fundamental problem if PCTs are to make a significant contribution to the delivery of the national IM&T strategy.

4.5 Previous surveys have highlighted a lack of financial information for planning IM&T developments and evidence from the third survey indicates little improvement. Only 13% of IM&T leads felt that the budget for PCG/T level IM&T was adequate and only 8% felt that GP IM&T budget was adequate. Sixty-three percent felt that the budget available for the PCG/T was inadequate or very inadequate and 58% rated the GP IM&T budget inadequate or very inadequate.

4.6 Many IM&T leads did not know what financial resources were available for development within the PCG/T. The 15 IM&T leads that responded reported widely varying budgets, which ranged from £1,100 to £429,000. Information regarding budgets for IM&T at practice level was equally poor. The 18 leads who identified budgets for practice based IM&T, reported budgets ranging from £19,000 to £410,000 for purchase, maintenance and training.

4.7 PCG/Ts may also obtain funding for IM&T developments through the Local Implementation Strategy process. However, 64% of respondents felt that this funding was inadequate or very inadequate and only 8% described it as adequate. Local implementation strategy funding ranged from £10,000 to £2,000,000.

Effective strategic planning

4.8 To develop IM&T, PCG/Ts must engage in effective strategic planning. The ability to plan effectively was clearly limited by poor funding, lack of financial information and low levels of staffing. Only 25% of PCG/Ts had an IM&T strategy separate from the local implementation strategy, compared with 44% in 2000/01. Less than a third (29%) of IM&T leads reported that the local implementation strategy met their needs well or very well, but a quarter (26%) felt that it did not meet their needs.
For the third consecutive year, IM&T leads were pessimistic about their ability to meet national targets by the appropriate deadlines (Box 4.1). Some targets, such as connecting all practices to NHS Net, have been met due to the additional resources devoted to them nationally. This has had an impact on other targets, such as access to the National Electronic Library for Health, which are facilitated by NHS Net connections. However, fewer IM&T leads than last year were confident of meeting key targets such as using NHS Net for booked appointments and laboratory results, transfer of electronic patient records, twenty-four hour emergency access to patient records and telemedicine.

**BOX 4.1: PERCENTAGE OF PCG/Ts MEETING THE SPECIFIED NATIONAL TARGETS**

<table>
<thead>
<tr>
<th>Target</th>
<th>Target deadline</th>
<th>1 &amp; 2 Likely to meet target</th>
<th>3</th>
<th>4 &amp; 5 Unlikely to meet target</th>
</tr>
</thead>
<tbody>
<tr>
<td>All practices connected to NHS Net</td>
<td>2002</td>
<td>86 89</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Use NHS Net for booked appointments</td>
<td>2002</td>
<td>35 17</td>
<td>41 38</td>
<td>24 45</td>
</tr>
<tr>
<td>Use NHS Net for laboratory results</td>
<td>2002</td>
<td>63 54</td>
<td>28 19</td>
<td>10 28</td>
</tr>
<tr>
<td>Access to National Electronic Library for Health</td>
<td>2002</td>
<td>74 82</td>
<td>18 13</td>
<td>8 5</td>
</tr>
<tr>
<td>Electronic patient record in use</td>
<td>2004</td>
<td>33 38</td>
<td>43 36</td>
<td>24 26</td>
</tr>
<tr>
<td>Electronic prescribing in use</td>
<td>2004</td>
<td>56 46</td>
<td>32 41</td>
<td>12 13</td>
</tr>
<tr>
<td>Electronic Transfer of Patient Records</td>
<td>2005</td>
<td>39 33</td>
<td>33 40</td>
<td>27 28</td>
</tr>
<tr>
<td>24 hour emergency access to patient records</td>
<td>2005</td>
<td>35 28</td>
<td>31 44</td>
<td>35 28</td>
</tr>
<tr>
<td>Telemedicine and Telecare options available</td>
<td>2005</td>
<td>37 23</td>
<td>33 33</td>
<td>31 45</td>
</tr>
</tbody>
</table>

Note: Rated on five point scale from 1 ‘definitely will’ to 5 ‘definitely will not’
Developing IM&T within the PCG/T

4.10 PCG/Ts need accurate, reliable, timely information to support effective decision-making. However, less than half (45%) had undertaken any information needs assessment. Key priorities for developing information were monitoring quality standards (52%), knowledge based information to support clinical governance (39%), prescribing cost data (34%), and GP referral rates 32%. Four-fifths (82%) were systematically collecting data to monitor care for coronary heart disease. Other national service frameworks fared less well, with just 26% collecting data on mental health and 19% collecting data on older people.

4.11 Access to information about the services provided by general practices is variable. Some PCG/Ts have information at individual GP level and others have information at practice level, but many either have no information or only aggregated PCG/T level information (Box 4.2). Almost three-quarters of PCG/Ts had information about GP referrals to specialists at the practice level, but only 39% could break this information down to individual GP level. Two-thirds (68%) obtained information on referrals from hospital systems, and only 21% obtained it directly from GP systems. PCG/Ts seem to be targeting information relevant to key national targets such as referrals and waiting times for GP appointments, but very few have begun to collect information about other important aspects of the service such as the number of consultations or the number of home visits.

BOX 4.2: PERCENTAGE OF PCG/Ts WITH ACCESS TO INFORMATION ABOUT GENERAL PRACTICE ACTIVITY

<table>
<thead>
<tr>
<th>Information available by GP</th>
<th>Information available by Practice</th>
<th>Aggregate information for PCG/T</th>
<th>Information not available/Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP referral to specialist</td>
<td>39</td>
<td>73</td>
<td>78</td>
</tr>
<tr>
<td>GP use of investigations</td>
<td>16</td>
<td>34</td>
<td>34</td>
</tr>
<tr>
<td>GP referral to community</td>
<td>21</td>
<td>53</td>
<td>62</td>
</tr>
<tr>
<td>No. of GP consultations</td>
<td>21</td>
<td>39</td>
<td>39</td>
</tr>
<tr>
<td>No. of GP home visits</td>
<td>18</td>
<td>34</td>
<td>34</td>
</tr>
<tr>
<td>Practice nurse contacts</td>
<td>11</td>
<td>22</td>
<td>24</td>
</tr>
<tr>
<td>Waiting times for GP appointments</td>
<td>7</td>
<td>59</td>
<td>59</td>
</tr>
<tr>
<td>No. of out of hours calls</td>
<td>25</td>
<td>55</td>
<td>55</td>
</tr>
</tbody>
</table>
4.12 Generally, IM&T leads still felt that information systems were not meeting the needs of the organisation (Box 4.3). There were significant improvements in a few areas, such as budget monitoring and monitoring service provision, but apart from prescribing and budget monitoring, only a small minority of respondents said that information systems were meeting their needs well.

**BOX 4.3: HOW WELL DO INFORMATION SYSTEMS MEET THE PCG/Ts NEEDS FOR INFORMATION TO SUPPORT CORE FUNCTIONS?**

<table>
<thead>
<tr>
<th>Function</th>
<th>Poorly or not at all</th>
<th>3</th>
<th>Well or very well</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2000/01</td>
<td>2001/02</td>
<td>2000/01</td>
</tr>
<tr>
<td>Health needs assessment</td>
<td>72</td>
<td>62</td>
<td>22</td>
</tr>
<tr>
<td>Commissioning</td>
<td>50</td>
<td>41</td>
<td>36</td>
</tr>
<tr>
<td>Monitoring service provision</td>
<td>55</td>
<td>39</td>
<td>36</td>
</tr>
<tr>
<td>Clinical governance</td>
<td>63</td>
<td>48</td>
<td>20</td>
</tr>
<tr>
<td>Budget monitoring</td>
<td>39</td>
<td>15</td>
<td>33</td>
</tr>
<tr>
<td>Workforce planning</td>
<td>70</td>
<td>63</td>
<td>23</td>
</tr>
<tr>
<td>Prescribing</td>
<td>29</td>
<td>20</td>
<td>31</td>
</tr>
</tbody>
</table>

Note: Rated on five-point scale from 1 ‘not at all’ to 5 ‘very well’

4.13 The quality of data from community systems and local authorities was still considered to be poor or very poor by most IM&T leads (76% and 70% respectively). Fewer (42%) rated the quality of data from GP systems as poor, compared with 62% last year. Similarly, data from hospital systems was felt to be poor or very poor by 45%, compared with 62% last year. However, only 21% felt that data from GP systems was good or excellent and 24% felt that hospital data was of this standard. The apparent improvement in the quality of data from GP systems may reflect the impact of the PRIMIS (Primary Care Information Services) initiative (see 4.22: Education, training and development).

4.14 Not surprisingly, the biggest changes in use of electronic links by PCG/Ts are associated with the NHS Net, the Internet and email (Box 4.4) which all PCG/Ts were using. Half of the PCG/Ts now had links to practices and to acute trusts, but electronic links to local authorities were rare.
4.15 The top priorities for IM&T development within the PCG/T were improving electronic links to practices (61%), IM&T training for PCG/T staff (57%) and increasing the availability of specialist IM&T staff (57%).

Developing practice based systems

4.16 Financial support for GP IM&T is crucial to its development. However, reimbursement policies varied widely, with practices in some PCG/Ts receiving 100% reimbursement, while others received no reimbursement or less than 50% (Box 4.5). Some IM&T leads said that, although they had a policy to reimburse up to 50%, there was no money available.

BOX 4.4: \PERCENTAGE OF PCG/Ts USING ELECTRONIC LINKS

BOX 4.5: \LEVEL OF REIMBURSEMENT FOR PRACTICE LEVEL COMPUTING (2001/02)
4.17 Almost two-thirds (64%) of PCG/Ts have now adopted standards for data entry/extraction. Last year only 20% had data entry standards. Half (50%) had adopted data coding standards and 43% had adopted standards for GP clinical software. This shows the priority PCG/Ts have placed on improving data quality in general practice.

4.18 Sixty-nine percent of PCG/Ts had all of their practices computerised, an increase from 59% last year. Twenty-eight per cent had between one and three practices not computerised and one had six practices not computerised. A quarter (25%) of PCG/Ts had only one or two clinical systems in use by practices, 48% three or four systems and 23% five or more systems. Single system policies, where PCG/Ts are aiming to get all practices using the same clinical software, were still rare. Seven (16%) PCG/Ts had single system policies, compared with 5 (10%) in 2000/01. However, a further 27% were restricting choice to two systems and 9% to three or more systems. The main reasons for standardising clinical systems were to make it easier to provide user support and training, to develop better information sharing and improve data quality. Furthermore, IM&T leads noted the advantages in terms of bulk discounts and the long-term reduction in maintenance costs. Forty-three percent of PCG/Ts had no policy on the number of clinical systems. However, it is interesting to note that 58% of these PCG/Ts had between two and four systems in operation. So in practice they already had a limited range of systems.

4.19 The use of a range of common information management tools by practices had increased significantly over the past year (Box 4.6). Read codes for describing the care and treatment of patients were being used by more than half of the practices in almost all PCG/Ts. There had been substantial increases in the use of MIQUEST (Morbidity Information Query Export Syntax), data entry and extraction protocols and computerised disease management guidelines. However, PRODIGY (Prescribing Decision Support System) is still only used in a minority of practices. The increases in the use of information management tools reflect the priority PCG/Ts are giving to improving data quality in general practice and their involvement in projects such as PRIMIS.
4.20 The proportions of PCG/Ts reporting more than half of their practices using various electronic links had also increased substantially (Box 4.7). Links for patient registration and items of service and access to NHS NET, email and the Internet were now more or less universal. There had been a substantial increase in electronic access to pathology results, although there is still some way to go to achieve the target in the NHS Plan. Telemedicine options are still not widely available, but almost a third (32%) had some practices using telemedicine links.
4.21 Priorities for developing IM&T in general practice were improving data quality (75%), training (71%) and developing the electronic patient record (36%). Percentages identifying these priorities last year were 75%, 60% and 21%.

**Education training and development**

4.22 Many PCG/Ts felt that they were lacking staff with appropriate skills in key areas including IT (information technology) skills to support PCG/T staff and practice based clinical systems, staff with information analysis skills, and trainers. As well as operational staff, some PCG/Ts felt there was a need for strategic level IM&T staff with project management, people-management and change-management skills.

4.23 In 2000 PCG/Ts were given a target of developing an education and training policy by April 2001 (Department of Health, 2001b). By early 2002, only a third (33%) had developed such a policy for IM&T and 5% planned to develop one before April 2002. Forty-three percent planned to develop one after 2002 and 16% had no plans to develop such a policy.

4.24 Involvement in the PRIMIS initiative launched in 2000 has increased significantly from 23% in last year's survey to 57%. However, only 5% of PCG/Ts had plans to become involved in the future. Forty-one percent already employed between one and four PRIMIS facilitators and a further 27% planned to employ one or more facilitators.

**Obstacles to progress**

4.25 The main obstacles to progress in PCG/T IM&T development were lack of staff (80%), lack of funding (75%) and too many priorities (71%). Unrealistic deadlines (46%) and lack of training (43%) were also felt to be barriers to progress. Other barriers identified were attitudes/culture, lack of enthusiastic individuals in the PCT, too large an agenda and lack of central guidance.

4.26 One IM&T lead highlighted the enormous task facing primary care: 'Too much to do by too few with too little resource'. Another IM&T Lead felt that financial pressures were a major problem. ‘Without protected funding for IM&T the money is siphoned into perceived high priorities’.

4.27 In GP IM&T development the main obstacles to development were seen as: lack of training (68%), lack of funding (61%), lack of staff (52%) and too many priorities (48%). Other barriers identified included the independent contractor status of GPs and that the fact that the benefits of IM&T development are not always clear to GPs.
Conclusions

4.28 PCG/Ts have a vital role to play in developing information systems in primary care. The new strategy, Delivering 21st Century IT Support for the NHS, (Department of Health, 2002) considers the role of PCTs and identifies specific targets for PCTs to achieve over the next eight-years.

4.29 This survey shows that lack of staff and inadequate funding continue to be major problems. Some PCG/Ts have substantial funding whereas others have very little and the differences in reimbursement policies for GP computing are problematic. IM&T leads indicated frustration with the pace of change and with funding problems, ‘IT progresses far too slowly, partly because the agencies involved including suppliers as well as practices, can’t keep up’, ‘Local implementation strategy funding has been massively cut to help affect overspending in other areas; this is placing delivery of major projects such as the electronic patient record in serious risk’, ‘Pressure on local implementation strategy funding from the SAFF (Service and financial framework) process will impact on ability to put in place essential building blocks which will underpin ability to meet long term targets’.

4.30 Despite resource issues, the survey shows that PCG/Ts are making progress:

- Many PCG/Ts are now collecting data on GP referrals, waiting times for GP appointments and out-of-hours calls.
- Data to support the requirements of the coronary heart disease National Service Framework are being collected routinely in the majority of PCG/Ts.
- There has been an improvement in the perceived quality of data from practice systems which may be due to PRIMIS or other local data quality initiatives.
- PCG/Ts recognise the importance of common standards. Over 60% of PCG/Ts have adopted standards for data entry and extraction and a half have adopted data coding standards. Almost three-quarters of PCG/Ts have limited the choice of clinical systems in general practice. Furthermore the use of MIQUEST has increased significantly.
- Access to NHS Net, email and Internet by PCG/T staff and practice-based staff has now been achieved.

4.31 There are, however, still some areas for concern:

- Data to support the National Service Frameworks for older people and mental health are not currently routinely collected.
• Although all practices now have access to NHS Net, the Internet and email services, PCG/Ts must now focus on training staff to ensure that the benefits of such links are maximised.
• Information to support key PCG/T functions continues to be inadequate.
• There are still considerable doubts about the ability to meet national targets.

4.32 Overall, the evidence from our third survey indicates significant progress in key areas such as data use of electronic links and the availability and quality of data from general practice. PCG/Ts have also recognised the importance of standards for information systems and information management. However, resource issues are an enormous problem, both in terms of funding and most importantly, skilled staff. The Wanless report (Wanless, 2002) indicated that IM&T was a key priority for investment and Delivering 21st Century IT Support to the NHS (Department of Health, 2002) also acknowledges the need for improved resources. If these funds are made available PCTs will be in a better position to forge ahead in developing information and IT. However, the general lack of people with the right skills will remain a problem, so a large investment will have to be committed to training and development.
5. **Primary Care Development**

Keri Smith and David Wilkin

*National Primary Care Research and Development Centre*

**Introduction**

5.1 Recent years have shown a consistent commitment by government to placing primary care at the heart of the NHS, increasing access to care and raising quality standards. The NHS Plan (Secretary of State for Health, 2000) identified primary care as the key to delivering the modernisation agenda for the NHS. Supported by a substantial investment programme, the Plan outlined targets for extending the range of services, increasing access to primary care services, and enhancing the capacity of the workforce. PCG/Ts are expected to play a central role in fostering innovation and delivering change across the NHS, but they are best placed to deliver improvements in primary and community services.

5.2 Our first survey, six months after PCGs were established, captured their attempts to assess needs and existing service provision, set out their plans for investment and primary care development and establish an infrastructure to support development of primary and community services. The second survey, twelve months later, showed that they were placing primary care development and the integration of primary and community services at the forefront of their agendas. It was evident that most PCG/Ts had begun the modernisation process, and had started to put initiatives in place to secure delivery of improved services and wider access.

5.3 In our third survey, we examined progress in key areas of service development:

- Appropriate infrastructure for primary care development:
  - existence of specific managerial team and / or working group.
  - criteria and processes for allocating resources.
  - incentives for promoting primary care development.

- Improvements in primary care provision:
  - initiatives to extend range of services.
  - initiatives to improve access.
• Integration of practice and community services:
  - initiatives to integrate practice and community nursing.

5.4 Evidence presented in this chapter is derived mainly from interviews with the chairs of PCG boards and PCT professional executive committees. Seventy (97%) of the 72 chairs were interviewed in 1999/2000 and 69 (97%) of the 71 in 2000/2001. A response rate of 90% (61 of the 68) was achieved in 2001/2002.

**Progress and Problems**

**Infrastructure**

5.5 The vast majority of PCG/Ts (90%) had established working groups/sub-committees to deal with primary care development, compared with 71% in 2000/01. Eighty-five per cent had also appointed at least one senior manager to take responsibility for primary care development, reflecting the high priority attached to their role in this area. Many larger PCG/Ts had established locality groups, although only a third (31%) of these had devolved the budget for primary care development to these groups (See Chapter 2: Organisational Development and Governance).

5.6 Appropriate, reliable and timely information is crucial to the development and delivery of primary care services. It is concerning to note that, over the three years of our survey, the quantity and quality of information available to support the core functions of PCG/Ts has remained a significant problem (See Chapter 4: Information Management and Technology). Only 15% of chief executives rated information currently available to monitor service provision as meeting their needs well or very well. Such information is crucial to identifying problems in primary care provision, developing initiatives to improve services and assessing their effectiveness.

5.7 The establishment of a systematic process for assessing investment in practice-based services is an important step towards a PCG/T wide development strategy for primary care. Box 5.1 shows that the proportions of PCG/Ts that had implemented guidelines and criteria for decision-making in relation to practice-based services had remained about the same. There remained a significant minority where investment in practice-based services was still dealt with on an ad hoc basis.
Incentives for practice based primary care development

5.8 Ninety-five percent of PCG/Ts had introduced some form of incentive for practices to promote improvements in primary care provision. Apart from prescribing incentive schemes, which were almost universal, most schemes were related to improvements in access to practice based services, investment in practice premises and equipment/facilities, and achievement of quality targets identified through clinical governance.

5.9 In order to encourage practice based service development, the Department of Health allocated £50m to PCG/Ts during 2001/02 with a further £50m to follow, with the explicit intention that these funds should be allocated to schemes to improve practice based services and that the second tranche of funding should be allocated to practices on the basis of their achievement of targets set for the first round. Three-quarters (75%) of PCG/Ts had shared the initial funding between all practices. Forty-three per cent said that the allocation to practices was for initiatives targeting PCG/T wide priorities, while 18% said that the priorities of individual practices were more influential. The remainder tried to achieve a balance between the priorities for the PCG/T as a whole and individual practice priorities. Most common uses for the extra funding were implementing National Service Frameworks (75%), improving access to primary care (69%), extending the range of practice based services (55%) and improving prescribing (46%). Half of the PCG/Ts (50%) were willing to allow practices to use the additional incentive funding for personal financial reward of practice staff, and most were willing to allow these ‘reward monies’ to be used for education and training (82%), improved support services for staff (68%) and improvements in the physical environment for practice staff (65%).
However, only 43% of PCG/T chairs felt that the scheme would be effective or very effective in incentivising practice staff, and only 39% felt it would be effective or very effective in improving services.

**Access to primary and community services**

5.10 Problems of access to primary and community services tend to be concentrated in particular areas and among particular groups in the population. Thus, even relatively affluent and well-served areas commonly have specific access problems, often confined to a particular locality or group in the population. We asked chairs of PCG/Ts to identify which groups in their populations had particular problems in accessing services and what initiatives the PCG/T was taking to address these problems. Box 5.2 shows the proportions reporting major problems of access for groups known to suffer problems.

**BOX 5.2: PERCENTAGE OF PCG/Ts REPORTING MAJOR PROBLEMS IN ACCESS FOR SPECIFIC UNDERSERVED GROUPS (2001/02)**

<table>
<thead>
<tr>
<th>Group</th>
<th>% of PCG/Ts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older People</td>
<td>52</td>
</tr>
<tr>
<td>Socio-economically deprived</td>
<td>50</td>
</tr>
<tr>
<td>Refugees/asylum seekers</td>
<td>27</td>
</tr>
<tr>
<td>Ethnic minorities</td>
<td>15</td>
</tr>
<tr>
<td>Homeless</td>
<td>13</td>
</tr>
<tr>
<td>Rural population</td>
<td>8</td>
</tr>
<tr>
<td>Disabled</td>
<td>5</td>
</tr>
</tbody>
</table>

5.11 Problems relating to older people concerned mainly the provision of community services to those suffering illness and infirmity, often associated with risk of admission to hospital, residential or nursing care and discharge back to their own homes. Many PCG/Ts were involved in initiatives to improve access to community services through rehabilitation, intermediate care provision, rapid response teams and additional community nursing services (see Chapter 9: Partnerships). Access problems for deprived groups, refugees, ethnic minority populations and homeless people were often closely interconnected. Initiatives to improve access commonly involved the use of the Personal Medical Services (PMS) scheme to employ GPs, nurses and other health professionals to work with particular groups or in under served areas.
Healthy living centres and other initiatives around disease prevention and health promotion were also common, as were the use of interpreting services in those areas with significant numbers of non-English speaking residents. PCG/Ts reporting major access problems for rural populations were working to develop improved transport. Initiatives to improve access for people with disabilities tended to focus on improvements in practice premises and equipment (e.g. installation of hearing loops in all practices).

5.12 We reported last year that many PCG/Ts had either already introduced initiatives to improve access to primary care services or were planning initiatives. Box 5.3 shows that the number of PCG/Ts that had initiatives up and running, and thus actually affecting services for patients, had increased, apart from out-of-hours initiatives. The apparent decline in initiatives around out-of-hours care probably reflects the fact that most of these (e.g. GP co-operatives, out-of-hours centres, telephone triage, etc.) were now well established and no longer seen as initiatives.

BOX 5.3: INITIATIVES TO IMPROVE ACCESS TO PRIMARY CARE

<table>
<thead>
<tr>
<th>Initiative</th>
<th>2000/01</th>
<th>2001/02</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Existing initiatives %</td>
<td>Initiated by PCG/T %</td>
</tr>
<tr>
<td>Nurse-led services</td>
<td>41</td>
<td>52</td>
</tr>
<tr>
<td>Reduced waiting times for</td>
<td>23</td>
<td>69</td>
</tr>
<tr>
<td>appointments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extended role for pharmacists</td>
<td>29</td>
<td>81</td>
</tr>
<tr>
<td>Extended surgery opening times</td>
<td>20</td>
<td>40</td>
</tr>
<tr>
<td>Out-of-hours provision</td>
<td>59</td>
<td>22</td>
</tr>
<tr>
<td>Increase number of nurses</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Telephone/internet access</td>
<td>28</td>
<td>25</td>
</tr>
<tr>
<td>Increase number of GPs</td>
<td>23</td>
<td>56</td>
</tr>
<tr>
<td>Minor injuries centre</td>
<td>23</td>
<td>19</td>
</tr>
<tr>
<td>Healthy living centre</td>
<td>10</td>
<td>29</td>
</tr>
<tr>
<td>Walk-in centre</td>
<td>9</td>
<td>50</td>
</tr>
</tbody>
</table>

Note: In 2000/01 PCG/Ts reported initiatives to ‘promote recruitment and retention of GPs’
5.13 As well as an increase in the number of initiatives to improve access, it is notable that more of the schemes now operating had been initiated by the PCG/Ts, rather than by practices or other organisations. Schemes to introduce or extend nurse led services were concentrated mainly around coronary heart disease, nurse triage and smoking cessation clinics. The considerable increase in the number of PCG/Ts promoting improvements in waiting times for appointments is largely in response to the target that all patients should be able to see a GP within 48 hours by 2004 contained in the NHS Plan (Secretary of State for Health, 2000). Many PCG/Ts were working with the primary care collaborative run by the national primary care development team and designed to facilitate improvements in access to care through a collaborative approach (National Primary Care Development Team, 2002). Specific initiatives included the use of telephone and nurse triage as well as incentive payments to reduce waiting times. Many of the schemes to extend surgery opening hours using early morning, evening and Saturday surgeries were also accompanied by incentive payments for practices, and were often associated with PMS schemes. Initiatives to increase the number of GPs also usually involved the employment of salaried GPs under the PMS scheme. Many of the initiatives to extend the role of pharmacists involved pharmacists working more closely with practices to review prescribing practice, but also included pharmacists dealing with minor illnesses, running smoking cessation clinics and increased involvement in repeat prescribing. Development of new facilities such as healthy living centres and walk-in centres was less common, but there was a substantial increase in the number of PCG/Ts providing such facilities.

5.14 While we have no direct measure of the impact which these initiatives to improve access were having on patients, our respondents were increasingly confident that they were beginning to have an impact (Box 5.4). Less than a quarter (24%) of PCG/T chairs felt that they had had little or no impact on access to general practice services and more than a third (37%) reported that had already brought about substantial improvements. Over the three years of the survey, chairs have become increasingly confident that their PCG/Ts are beginning to improve access to primary care. General improvements were commonly attributed to extended opening hours and shorter waiting times for appointments, often associated with a drive to meet the national targets for waiting times. More localised schemes, including nurse-led services and salaried GPs were felt to have been successful in targeting access problems experienced in particular areas or by particular groups of patients. Those who said there had been no or little improvement tended to attribute failure to the continuing shortage of GPs and other primary care professionals.
BOX 5.4: CHAIRS’ VIEWS OF THE IMPACT OF THE PCG/T ON ACCESS TO GENERAL PRACTICE (2001/02)

Note: Rated on a five point scale from 1 ‘no improvement’ to 5 ‘major improvement’

Extending the range of services available

5.15 PCG/Ts have the opportunity to develop a more collaborative approach to service provision by encouraging practices to pool and share resources. This sharing of expertise and resources can achieve both a wider range of services available in the primary care setting and a more efficient use of resources. Box 5.5 shows the percentages of PCG/Ts that had developed schemes to extend the range of services available, usually through sharing resources and services between practices. In some instances the services provided were previously available to individual practices and their patients, but the PCG/Ts have taken the opportunity to extend these to the patients of other practices.

BOX 5.5: INITIATIVES TO EXTEND THE RANGE OF SERVICES AVAILABLE IN PRIMARY CARE

<table>
<thead>
<tr>
<th>Initiative</th>
<th>2000/01</th>
<th>2001/02</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Existing initiatives</td>
<td>Initiated by PCG/T</td>
</tr>
<tr>
<td>Counselling</td>
<td>65 %</td>
<td>70 %</td>
</tr>
<tr>
<td>Minor surgery</td>
<td>25 %</td>
<td>72 %</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>64 %</td>
<td>69 %</td>
</tr>
<tr>
<td>Specialist nurses</td>
<td>43 %</td>
<td>42 %</td>
</tr>
<tr>
<td>Specialist GPs</td>
<td>20 %</td>
<td>73 %</td>
</tr>
<tr>
<td>Specialist outreach clinics</td>
<td>32 %</td>
<td>57 %</td>
</tr>
<tr>
<td>Community psychiatric nurses</td>
<td>51 %</td>
<td>28 %</td>
</tr>
<tr>
<td>Complementary therapy</td>
<td>13 %</td>
<td>78 %</td>
</tr>
</tbody>
</table>
5.16 There has been a substantial increase in the number of schemes now in operation to extend the range of services available. The biggest increases have been in the number of PCG/Ts offering practice based minor surgical procedures and developing the roles of specialist GPs. GP specialists included a wide range, perhaps reflecting to some degree the availability of GPs with specialist interests, but the commonest specialities were dermatology (39% of PCG/Ts had a GP specialising in dermatology) and orthopaedics and rheumatology. Both GP specialists and GPs offering minor surgical procedures provided alternatives to referral to hospital based specialists. Specialist nurses were employed mainly to develop services for chronic illness, most commonly coronary heart disease, diabetes and chronic respiratory illnesses. Counselling and physiotherapy services had previously existed in most areas, often in fundholding practices, but the PCG/Ts have extended provision to cover all practices. The fact that fewer initiatives to extend the provision of community psychiatric nurses were reported this year may reflect changes in the commissioning and provision of specialist mental health services.

PCG/T activity levels in improving access and range of services

5.17 All PCG/Ts had initiated developments to improve access to services and extend the range of services available in primary and community settings. However, it was evident that some had been considerably more active than others. We constructed a crude indicator of the levels of activity in each PCG/T based on the number of schemes to improve access and/or extend the range of services. Scores for each PCG/T were calculated by awarding one point for each scheme currently operating and a further point if the scheme was initiated by the PCG/T. The resulting score out of a possible 38 provides no more than a rudimentary measure of the number of initiatives currently in place. It makes no allowance for differences in the scale or quality of schemes. Box 5.6 shows the resulting scores grouped into three broad categories.

<table>
<thead>
<tr>
<th>Activity level</th>
<th>Range of scores</th>
<th>No. of PCG/Ts</th>
<th>% of PCG/Ts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>0-12</td>
<td>18</td>
<td>29%</td>
</tr>
<tr>
<td>Average</td>
<td>13-20</td>
<td>26</td>
<td>43%</td>
</tr>
<tr>
<td>High</td>
<td>21-38</td>
<td>17</td>
<td>28%</td>
</tr>
</tbody>
</table>
5.18 In the light of the trend towards larger PCG/Ts through mergers, we examined the relationship between size and our activity indicator. Half (50%) of PCG/Ts with fewer than 100,000 population were in the high activity category, compared with 32% of those with populations between 100,000 and 150,000, and 18% of those with populations in excess of 150,000. The process of merging itself involves substantial upheaval, and this may be reflected in the fact that only 14% of PCG/Ts which had been involved in mergers were in the high activity category, compared with 38% of those not involved in mergers.

5.19 The transition from PCG to PCT should provide increased opportunities to initiate changes in services as well as increased responsibilities. However, there was little difference in the level of activity between the early trusts and the PCGs. Indeed only 14% of the April 2001 trusts were in the high activity category. While the number of trusts is small (8 in 1999/2000 and 21 in 2001/2002) this finding is consistent with the finding that those involved in mergers had lower levels of activity. The organisational upheaval of a merger and moving to trust status (and in some instances both) may divert resources away from initiatives to improve service provision, at least in the short term. However, this was not supported by the perceptions of chairs on the effects of trust status on capacity to deliver primary care development. Many felt that they had more autonomy and control that would enable them to introduce initiatives to improve primary care which were not possible when they were PCGs.

5.20 This crude analysis of activity levels does not suggest that larger PCG/Ts or the early trusts were more active in introducing initiatives to improve access to services or extend the range of provision. Indeed small PCGs seemed to have been at least as active in bringing about change. This may of course simply reflect the fact that the larger organisations and the trusts have not yet had sufficient time to bring about change.

Integration of community and practice nursing

5.21 The opportunity to integrate practice and community nursing services has been one of the key reasons advanced by chief executives in our surveys for making the transition to PCT status. Eighty-six percent of PCGs gave integration of primary and community services as a reason for wanting to become a trust. However, Box 5.7 suggests that progress towards integrating practice and community nurses is rather slower than might have been anticipated. While joint meetings and joint training are fairly common, only a minority of PCG/Ts have begun to form integrated nursing teams or share nursing records, and very few are attempting to introduce integrated management or common employment contracts. The practical problems of bringing practice employed and community nurses under the same management and employ-
ment arrangements may be proving more difficult than some PCG/Ts had anticipated. While trusts were somewhat more likely than PCGs to have instituted joint meetings and training, the differences were small.

BOX 5.7: INITIATIVES TO INTEGRATE PRACTICE AND COMMUNITY NURSING.

<table>
<thead>
<tr>
<th>Initiative</th>
<th>2000/01 Existing initiatives%</th>
<th>2000/01 Initiated by PCG/T%</th>
<th>2001/02 Existing initiatives %</th>
<th>2001/02 Initiated by PCG/T%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint meetings</td>
<td>83</td>
<td>59</td>
<td>77</td>
<td>49</td>
</tr>
<tr>
<td>Staff training and development</td>
<td>58</td>
<td>65</td>
<td>66</td>
<td>60</td>
</tr>
<tr>
<td>Integrated nursing teams</td>
<td>30</td>
<td>62</td>
<td>36</td>
<td>59</td>
</tr>
<tr>
<td>Shared records</td>
<td>30</td>
<td>24</td>
<td>21</td>
<td>39</td>
</tr>
<tr>
<td>Common management</td>
<td>7</td>
<td>40</td>
<td>15</td>
<td>56</td>
</tr>
<tr>
<td>Common contracts</td>
<td>7</td>
<td>20</td>
<td>8</td>
<td>80</td>
</tr>
</tbody>
</table>

Personal Medical Services

5.22 The Personal Medical Services (PMS) contract provides an alternative to the traditional individual GP contract. It allows individual practices, groups of practices or other organisations (eg NHS trusts) to hold contracts for the provision of general practice based services. It provides increased flexibility and opportunities for reconfiguring local services, including the employment of salaried GPs, extended roles for nurses and provision of a wider range of community services. A small first wave of pilot PMS sites was established in 1998. By 2002 four waves of PMS schemes had been approved, including more than 1,300 schemes in England as a whole and covering 19% of registered patients. PMS contracts provide PCG/Ts with increased flexibility to tackle particular problems in service provision and to negotiate contracts that incorporate quality standards.

5.23 First and second wave PMS schemes were inherited by PCG/Ts when they were established in April 1999, but they have been much more closely involved in the negotiation of contracts for third and fourth wave sites. Thirty-eight per cent of PCG/Ts inherited first or second wave PMS sites, usually involving one or two practices. Seventy two per cent had third or fourth wave PMS sites. Overall, 82% of PCG/Ts had PMS schemes covering at least part of their patient populations. Twenty-eight per cent had between one and three PMS schemes and 35% had seven or more. While most PMS contracts were
for individual practices, a fifth (20%) of PCG/Ts had multi-practice schemes covering two or more practices, and one had transferred all of its practices to PMS contracts. Eighty-two per cent of PCG/Ts had PMS schemes employing salaried GPs and 52% had schemes offering nurse-led primary care services.

5.24 PCG/Ts did not have any opportunity to influence the contracts of first and second wave PMS schemes that were already in place. Influence over the contracts of third and fourth wave schemes depended on the extent to which responsibility for negotiating contracts was devolved to the PCG/Ts by health authorities. Sixty-two per cent said they had substantial influence over the contracts of third wave schemes and 75% had substantial influence over fourth wave schemes. Only a small minority, 14% and 8% respectively, felt they had little or no influence. Although most PCG/Ts were involved in negotiating PMS contracts, only a quarter (24%) had developed contracts that included financial incentives linked to improvements in services. These incentive schemes were mostly related to achievement of targets relating to access to care, and only two PCG/Ts reported financial incentives linked to quality standards. Half (51%) of the PCG/Ts in our sample were using or planning to use PMS flexibilities to tackle specific problems relating to access to services, most commonly to target services on under served areas or groups in the patient population. Five had used the scheme to establish services for refugees or asylum seekers and four to serve the needs of homeless people.

Conclusions

5.25 It is clear that primary care development remains at the forefront of the agenda for PCG/Ts. Most have established primary care development groups and criteria for investment and development decisions. However, access to appropriate, reliable and timely information to support decision-making remains a serious problem. Most PCG/Ts have introduced incentive schemes for practices to promote improvements in primary care provision.

5.26 PCG/Ts are targeting groups with problems of accessing primary and community services, particularly older people, deprived populations/areas, refugees, ethnic minorities and homeless people. They are using a wide variety of initiatives, often making use of the flexibilities allowed under the PMS contract for general practice provision. There has been an increase in the number of PCG/Ts promoting initiatives to improve access to services, including nurse-led services, reducing waiting times for appointments, extended surgery opening times and extended roles for pharmacists. PCG/T chairs are increasingly confident that they are beginning to see significant improvements in access to general practice.
5.27 As well as improvements in access to services, there is evidence of continued initiatives to extend the range of services available in primary care settings. Many PCG/Ts have extended the provision of counselling, minor surgery, physiotherapy and specialist nurses, making these services available through all of their practices. Almost two thirds have taken advantage of the opportunity to develop specialist roles for GPs with qualifications and interests in key specialties such as dermatology, rheumatology and orthopaedics.

5.28 While all PCG/Ts had been involved in some initiatives to improve access to services and/or extend the range of services available, there was substantial variation in the number and range of initiatives being developed. We had expected to find that the early trusts and larger PCG/Ts (with more resources) would be more active in introducing initiatives. However, there was no evidence that trusts or larger PCG/Ts were doing more than PCGs or smaller PCG/Ts.

5.29 Integration of primary and community health services has been one of the most common reasons given by PCGs for making the transition to PCT status. Integrating practice and community nursing services is a key component of this process. Although most PCG/Ts had introduced joint meetings and staff training only a minority had taken the next steps of creating integrated nursing teams, shared records and common management.

5.30 Most PCG/Ts were using the flexibilities offered by the PMS contract to develop primary care provision, often using the scheme to target groups with poor access to services.

5.31 The Tracker survey does not enable us to evaluate the impact on patients of PCG/T led initiatives to improve services. Nevertheless, the evidence from this latest survey shows that PCG/Ts are focusing their investment and development on improving access to services, extending the range and providing a more integrated service. They are addressing many of the key targets in the NHS Plan (Secretary of State for Health, 2000) in ways that should produce improvements in services. However, progress towards achieving some of the targets may be slower than required.
6. Clinical Governance
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National Primary Care Research and Development Centre

Introduction

6.1 Clinical governance is a whole system based strategy for improving quality in the NHS. It is defined as ‘a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish’ (Department of Health, 1998). PCG/Ts are responsible for implementing clinical governance in primary and community health care.

6.2 In our first survey (1999/2000), we showed that PCGs had embarked on a wide range of activities to implement clinical governance. Much effort had been devoted to assessing baseline capacity and setting up an infrastructure for clinical governance. Our second survey (2000/01) showed evidence that PCG/Ts had made considerable progress in implementing mechanisms for monitoring and improving quality standards, with particular emphasis on collaboration, education and shared learning. However, relatively few PCG/Ts had begun to grapple with the problems of quality assurance, including establishing methods of dealing with poor performance. While substantial progress had been made in the first two years, clinical governance leads highlighted problems of a lack of capacity and resources to support the process.

6.3 The third survey focused on markers of progress in the development of clinical governance in PCG/Ts, examining the infrastructure for clinical governance, engagement of health professionals, quality improvement activity, access to information and approaches to dealing with poor performance. Evidence presented in this chapter is derived from responses of clinical governance leads to a postal questionnaire. In year 1, 53 (74%) of the questionnaires were returned, in year 2, 58 (82%) and year 3, 49 (72%).
Supporting clinical governance

6.4 Clinical governance leads play a very important and demanding role in promoting quality improvement in PCG/Ts. Most (81%) were GPs and only nine PCG/Ts (18%) had a nurse acting as a joint clinical governance lead. Almost three quarters (71%) spent more than six hours per week on their clinical governance responsibilities and 19% spent more than 15 hours each week. 70% of respondents found it difficult to combine their clinical governance commitments with their other commitments. Perhaps not surprisingly, in view of the workload, there had been some turnover among clinical governance leads. A quarter (25%) of respondents had been in post for less than a year, although 40% had been doing the job for more than three years.

6.5 Clinical governance leads were supported by sub-committees or working groups which included a range of health professionals. Apart from GPs, who were represented on all working groups, 88% included a community nurse, 59% a pharmacist, 51% a practice manager and 63% a lay representative.

6.6 Funding to support clinical governance activity was highly variable. Despite the many sources of funding for quality improvement, 42% said that they did not have a dedicated PCG/T budget for clinical governance (41% in 2000/2001). Where budgets were available, they ranged from £13,000 to £400,000, but more than half (52%) had budgets of less than £50,000. However, for those PCG/Ts with a clinical governance budget the average had increased from £23,000 in 2000/01 to £97,000 in 2001/2002. Most PCG/Ts provided some administrative and professional support for clinical governance, but 26% said they had little or no administrative support and 31% little or no professional support.

Engaging health professionals: securing commitment to quality improvement

6.7 The involvement of primary care professions in clinical governance working groups is an important step towards engaging health professionals in the process. Most (92%) reported that all or most of their practices had identified individual practice clinical governance leads, a slight reduction on the previous survey, when all claimed to have clinical governance leads in all or most practices.
6.8 While only small numbers of primary care professionals will be engaged in the process of implementing clinical governance across the PCG/T, the support and engagement of a much wider group is essential for success. Box 6.1 shows that increasing proportions of clinical governance leads felt that GPs, nurses and managers were supportive of the process. The views of the different categories of staff did not appear to show much variation between organisational type (PCG / PCT) or by the size of the organisation.

**BOX 6.1 PERCEIVED SUPPORT FOR CLINICAL GOVERNANCE AMONG PRACTICE STAFF**

<table>
<thead>
<tr>
<th>Category</th>
<th>2000/01</th>
<th>2001/02</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice managers</td>
<td>41</td>
<td>59</td>
</tr>
<tr>
<td>Practice nurses</td>
<td>51</td>
<td>65</td>
</tr>
<tr>
<td>Community nurses</td>
<td>41</td>
<td>55</td>
</tr>
<tr>
<td>General practitioners</td>
<td>41</td>
<td>65</td>
</tr>
</tbody>
</table>

Note: Rated 4 or 5 on five point scale from 1 ‘no support’ to 5 ‘very supportive’

6.9 In the 2000/2001 survey, clinical governance leads were asked to rate practice and community nurses support together. Sixty-two percent rated them supportive or very supportive.

**Implementing clinical governance: priorities and activities**

6.10 Priority areas for clinical governance activity reflected the already published NSF, with 89% identifying coronary heart disease as a priority, 48% mental health, 48% diabetes and 39% care for older people. Both national and local concerns and initiatives helped shape priorities for clinical governance. Ninety-four per cent of respondents rated the NSF as a strong influence, although only 37% rated the NICE as a strong influence, compared with 56% last year. At the local level, 85% rated the clinical governance working group as a strong influence, 65% local prescribing priorities and 56% health improvement priorities.
Our second survey showed that PCG/Ts were adopting a broadly educational and supportive approach to clinical governance. Evidence from the latest survey shows that they have continued to develop these supportive approaches (Box 6.2). There were notable increases in the numbers of PCG/Ts using incentives, local guidelines and analysis of ‘significant events’.

**BOX 6.2: PERCENTAGE OF PCG/Ts USING APPROACHES TO CLINICAL GOVERNANCE AND QUALITY MANAGEMENT**

<table>
<thead>
<tr>
<th>Approach</th>
<th>2000/01</th>
<th>2001/02</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP personal learning plans</td>
<td>93</td>
<td>96</td>
</tr>
<tr>
<td>Practice development plans</td>
<td>-</td>
<td>96</td>
</tr>
<tr>
<td>PCG provided education/training</td>
<td>-</td>
<td>90</td>
</tr>
<tr>
<td>Significant event reporting</td>
<td>49</td>
<td>90</td>
</tr>
<tr>
<td>Risk management</td>
<td>76</td>
<td>82</td>
</tr>
<tr>
<td>Incentives</td>
<td>43</td>
<td>75</td>
</tr>
<tr>
<td>Feedback to practices of audit results</td>
<td>-</td>
<td>71</td>
</tr>
<tr>
<td>Half day training events for practice staff</td>
<td>57</td>
<td>69</td>
</tr>
<tr>
<td>Local guidelines</td>
<td>44</td>
<td>65</td>
</tr>
<tr>
<td>Promoting organisational audit</td>
<td>-</td>
<td>63</td>
</tr>
<tr>
<td>Patient surveys</td>
<td>48</td>
<td>61</td>
</tr>
<tr>
<td>Analysis of complaints</td>
<td>47</td>
<td>57</td>
</tr>
<tr>
<td>Cross practice clinical audit</td>
<td>43</td>
<td>43</td>
</tr>
<tr>
<td>National guidelines</td>
<td>-</td>
<td>41</td>
</tr>
</tbody>
</table>

More than two thirds (69%) of PCG/Ts had identified clinical guidelines that they were implementing in all practices, most commonly relating to coronary heart disease (49%), diabetes (22%) and mental health (10%).

Fifty-two per cent of PCG/Ts required practices to undertake clinical audit, 46% specifying the clinical areas in which audits were to be conducted. Most of the remainder encouraged practices to undertake clinical audits, with only two PCG/Ts (4%) leaving it to practices to decide whether to carry out audits.
6.14 Almost two thirds (65%) of PCG/Ts were using incentives to support quality improvement (other than prescribing incentive schemes), compared with 51% in 2000/01. Of those using or planning incentive schemes, 89% were using financial incentives. Box 6.3 shows the most common aspects of care targeted by incentive schemes. Thirty five per cent of those offering financial incentives to practices restricted these to less than £5,000, but 21% allowed incentive payments of over £10,000. Incentive payments were most commonly made for meeting targets, quality scores or participating in clinical governance activities.

**BOX 6.3: PERCENTAGE OF PCG/Ts USING INCENTIVE SCHEMES FOR SPECIFIC TARGETS (2001/02)**

<table>
<thead>
<tr>
<th>Initiative</th>
<th>% of PCG/Ts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementing CHD NSF</td>
<td>59</td>
</tr>
<tr>
<td>Participation in audit</td>
<td>47</td>
</tr>
<tr>
<td>Attendance at PCG/T training</td>
<td>37</td>
</tr>
<tr>
<td>Provision of quality of care information</td>
<td>35</td>
</tr>
<tr>
<td>Practice development plans</td>
<td>35</td>
</tr>
<tr>
<td>Initiatives to improve access to appointments</td>
<td>33</td>
</tr>
<tr>
<td>Implementing mental health NSF</td>
<td>31</td>
</tr>
<tr>
<td>Implementing NSF for older people</td>
<td>25</td>
</tr>
<tr>
<td>Initiatives to improve access to services</td>
<td>25</td>
</tr>
<tr>
<td>Significant event analysis</td>
<td>16</td>
</tr>
<tr>
<td>Adherence to guidelines</td>
<td>12</td>
</tr>
<tr>
<td>Patient surveys/evaluations</td>
<td>12</td>
</tr>
<tr>
<td>Longer booking intervals for appointments</td>
<td>4</td>
</tr>
</tbody>
</table>

6.15 In addition to initiatives focusing on the quality of clinical care, many PCG/Ts had set targets relating to access to general practice services. In preparation for meeting access targets set out in the NHS Plan (Secretary of State for Health, 2000), 61% had set targets for waiting times for GP appointments, 43% for waiting times to see other members of the primary care team, 31% for surgery opening hours and 18% for out of hours care.
6.16 Most PCG/Ts continue to use developmental, supportive and educational approaches when dealing with poor performance in practices (Box 6.4). While the emphasis remained strongly on these approaches, a fifth of PCG/Ts were now beginning to use more formal disciplinary procedures. With the abolition of health authorities from April 2002, PCG/Ts may find themselves more involved in formal processes where their supportive/developmental approaches do not work.

BOX 6.4 PERCENTAGE OF PCG/Ts USING APPROACHES IN DEALING WITH POOR PERFORMANCE

Information on quality of care

6.17 Information is the key to quality improvement and the implementation of clinical governance, both as a means of identifying problems and measuring change. Successful implementation of clinical governance requires a willingness to share information about the quality of care provided. In the past such information has rarely been available outside of the individual practice. Box 6.5 shows that while most PCG/Ts are now obtaining information from all or most of their practices related to coronary heart disease and diabetes, information about other key areas of clinical care is less commonly available. A third of PCG/Ts (35%) were offering financial incentives to practices to provide information on quality of care.
BOX 6.5: PERCENTAGE OF PCG/Ts WHERE ALL OR MOST PRACTICES WERE PROVIDING INFORMATION ON CARE PROVIDED

6.18 Box 6.6 shows that the numbers of PCG/Ts making information available to their boards/executives, practices and the general public have increased only slightly in the past year. There was virtually no change in the numbers making information available in a form which permitted identification of individual practices. It was however interesting to note that a greater proportion of PCGs (58%) than PCTs (18%) were making quality data available to the public. This may suggest that the greater involvement of lay members in the board structure of PCTs has not yet made them more likely to make data available to the public than PCGs.
6.19 The type of information available varied greatly. Information provided to boards/professional executive committees and to practices included comparative data on prescribing, referrals, achievement of preventive health care targets, patient survey data and the results of audits undertaken. Information available to the general public was usually anonymised and included results of patient satisfaction surveys, prescribing, referrals and various board/executive reports and papers. However, while some clinical governance leads said that information was available to the public on request, others reported a more proactive approach of making information available through regular newsletters.

Clinical governance related to National Service Frameworks

6.20 Ninety two per cent of PCG/Ts had identified individuals with lead responsibility for quality improvement in coronary heart disease, 86% for mental health, 82% for cancer, 69% for diabetes and 66% for care of older people. The priority being given to clinical care in these areas was reflected in the development of practice based registers. Ninety six per cent of PCG/Ts reported that all or most of their practices had registers for patients suffering from coronary heart disease, 90% for diabetes, 53% for cancer, 40% for older people and 29% for mental health. Most had also developed or were in the process of developing PCG/T wide strategies for implementation of the NSFs, including protocols, guidelines and service agreements (coronary heart disease, 96%; mental health, 81%; diabetes, 87%; older people, 89%).
6.21 Strategies for implementing the NSF for mental health addressed all of the seven standards recommended in the NSF. Of those PCG/Ts that had developed a strategy for implementing the mental health NSF, 77% were addressing mental health promotion (standard 1), 81% access to services (standards 2 and 3), 73% effective services for people with severe mental illness (standards 4 and 5), 58% caring about carers (standard 6) and 54% preventing suicide (standard 7).

6.22 Seventy-seven per cent of PCG/Ts reported that they had agreed a protocol for the systematic assessment, treatment and follow-up of people with coronary heart disease. However, only 39% had established with local hospitals a mechanism for agreeing an integrated system of quality assessment and quality improvement for coronary heart disease.

Achievements, obstacles and key tasks

6.23 We asked clinical governance leads to reflect on their achievements to date, the main obstacles or barriers to the successful implementation of clinical governance and the key tasks facing them in the coming year. They identified a wide range of achievements, focusing particularly on the processes of clinical governance. Education and learning initiatives figured prominently, for example: ‘developing relevant clinical and non-clinical educational programmes’, ‘defining and organising a range of education and training events, including the support of practice based multi-disciplinary events’ and ‘establishment of protected learning time half days’. Compared with previous years, clinical governance leads were more able to identify ways in which they had actually begun to implement quality improvement activities: ‘setting up, delivering and being in advance of most of our targets for clinical governance framework and accountability agreement’, ‘practices actively working to improve chosen targets and showing improvement when monitored’, ‘involving all practices in structured diabetic care’, ‘the adoption of a PMS contract based upon the principles of clinical governance by 23 out of 24 practices with the one remaining practice planning to move to PMS this year’. Others mentioned initiatives around the NSFs, particularly coronary heart disease which was mentioned by a fifth of respondents. Many clinical governance leads regarded the engagement of primary care professionals in the process of clinical governance and a sense of shared ownership as an important achievement in itself. This was summed up in two comments ‘getting ownership by practices’ and ‘GPs are no longer so afraid of it’.

6.24 We referred earlier to the problems experienced by clinical governance leads in balancing their practice commitments and their clinical governance work, and to the lack of staff and funds to support clinical governance. It was thus not surprising that four fifths of respondents mentioned shortage of resources
as the biggest obstacle to the successful implementation of clinical governance: ‘lack of resources, funds and human time’, ‘inadequate resources – lack of administrative and support staff’ or simply ‘time, money’. The perceived constraint on resources was compounded by the perception of an ever growing agenda: ‘number of must-do’s overwhelming practices’, ‘massive agenda – constantly struggling to prioritise’, ‘pace of change’. More specifically, around a fifth mentioned the process of organisational change associated with mergers and the transition to trust status as an obstacle to success: ‘last year PCG has been concerned with merger, so has withered – board members not replaced – others burdened with project work’, ‘constant structural change’, ‘move from PCG to PCT and disruption of merger and reorganisation’. However, it was notable that fewer clinical governance leads than in previous years mentioned mistrust by GPs and other practice staff as an obstacle. Only 14% mentioned this as a problem in 2001/2002, compared with 25% in 2000/2001.

6.25 Tasks for the year ahead reflected a desire to build on achievements to date with further work on the processes of clinical governance and quality improvement: ‘implementation of guidelines’, ‘develop the capacity in primary care to deliver the PCT’s clinical governance action plan and therefore promote continuous quality improvement’, ‘develop and agree a framework for supporting poor performers’. Most wanted to focus on quality improvement initiatives already underway and to see these having an effect. However, about a quarter mentioned dealing with the problems of organisational change associated with merger and the move to trust status as important tasks for the year ahead: ‘keeping momentum as we become a trust’, ‘to integrate three PCGs and a community trust with respect to clinical governance’, ‘maintaining ownership and involvement of practices during the change from PCG to PCT’.

Conclusions

6.26 Over the three years of the Tracker survey we have described the process of introducing clinical governance in primary care. In their first year, most PCGs concentrated their efforts on establishing a basic infrastructure for clinical governance and engaging sometimes apathetic or resistant health professionals. Our second survey provided evidence of significant progress in securing the engagement of health professionals, promoting a culture of quality improvement and developing an educational and supportive approach to clinical governance.
6.27 At the end of their first three years PCG/Ts have demonstrated substantial achievements in the field of clinical governance. They have largely secured the engagement of and ownership by the key health professions. They have developed and extended a wide range of approaches to supporting quality improvement and they are focusing attention on achieving the quality standards set out in the various NSFs. Most importantly, they have established a culture of quality improvement which is increasingly embedded in the organisations and underpinned by the collection and sharing of essential information on the quality of care provided.

6.28 The Tracker Survey is not designed to collect evidence on the impact of clinical governance activity on the quality of care actually provided or the health of patients using primary care. However, PCG/Ts are beginning to collect this information themselves and to monitor the effect of their initiatives on the care provided through routine data collection and audit.

6.29 The undoubted achievements of PCG/Ts in implementing strategies for quality improvement have been gained against a background of continuing organisational change and, in many cases, with very limited resources. The transition from PCG to PCT and the process of merging with neighbouring PCG/Ts have sometimes diverted attention from the main task of delivering improvements in quality. Clinical governance leads expressed almost universal concern about the lack of resources to support the process. Taken together with the continually expanding agenda created by NSFs, NICE guidance and an increasing number of performance targets, this gives cause for concern about their capacity to deliver continuing improvements in quality across all areas. Some clinical governance leads recognised a need to become more selective in identifying priority areas and concentrating their efforts in these areas.
7. Prescribing
Judy Cantrill
National Primary Care Research and Development Centre

Introduction

7.1 Since the establishment of PCGs in 1999, prescribing has continued to be a high profile activity, receiving much attention in both the professional press and media. Much of this is the result of the increasing output from the National Institute for Clinical Excellence (NICE), which has now published a total of 42 technology appraisals since 1999, the majority of which relate to the use of medicines. The first National Service Framework (NSF) for mental health was published in September 1999, followed by the guidance for coronary heart disease in March 2000 and that for older people in March 2001 (Department of Health 1999; 2000a; 2001c). Others are currently in preparation. The outputs from NICE, together with the NSFs, have significant implications for the way medicines are used in primary care. As PCG/Ts have developed, they have taken increasing responsibility for managing activities within the organisation. From 1st April 2002, all PCTs have taken on the responsibility for managing prescribing.

7.2 The overall aims of these two major initiatives (NICE and the NSFs) are to improve standards of care and reduce variation in clinical practice. However, the net outcome of the guidance is usually that prescribing needs to be increased in specific therapeutic areas. This clearly raises further the challenge already identified in the earlier rounds of the Tracker survey, namely the need to improve the quality of medicines usage but to keep within a restricted budget.

7.3 Results presented in this chapter are derived from postal questionnaires sent to PCG/T prescribing leads. Forty-eight (71%) responded to the questionnaire in this year (2001/2002), 57 (80%) in year two and 52 (72%) in the first year.

Progress and Problems

Supporting prescribing

7.4 In 2001/02, all but one of the 48 PCG/Ts responding had a prescribing subgroup. One had disbanded the group in favour of the pharmaceutical adviser
working with individual practices on specific initiatives. Only one prescribing
sub-group did not include a pharmaceutical adviser (vacant post) at the time
of the survey. The size and composition of the groups varied considerably with
three PCG/Ts including a GP representative from each practice. Other mem-
bers included the chief executive, clinical governance lead, a practice manag-
er, public health consultant, modernisation director and a community services
pharmacist. Some co-opted specialist advice when necessary, for example,
microbiologists, dieticians or specialist nurses.

7.5 All PCG/Ts had pharmaceutical posts dedicated to prescribing support. The
average number of hours of pharmacist advice available had increased from
37 hours in 2000/01 to 56 hours in 2001/02. There was great variability in the
level of support available, ranging from a low of 16 hours per week to 145
hours. A total of 15 PCG/Ts were employing pharmacy technicians; in eight of
these technicians were also represented on the prescribing sub-group. Over
half (58%) were continuing to fund prescribing support from the prescribing
budget (63% in 2000/01; 51% in 1999/2000). However, there has been a pro-
gressive increase in the use of funds from PCG/T management budgets (65%
in 2001/02; 44% in 2000/01; 24% in 1999/2000).

7.6 Two-thirds (67%) of PCG/Ts were using community pharmacists in specific
initiatives related to prescribing, other than providing prescribing advice. The
types of services being delivered by community pharmacists were diverse and
wide ranging. They included coronary heart disease initiatives; minor ailments
services; management of hypertension; medication reviews for the elderly;
provision of emergency contraception; and medication review for nursing and
residential home patients. There was also further evidence that community
pharmacists are becoming more involved in prescribing issues, as they were
represented on 76% of prescribing sub-groups. The use of nurses in specific
prescribing initiatives was less common (27%), but the survey may not have
identified initiatives being undertaken by nurses within individual practices if
these were not part of wider PCG/T initiatives.

Priorities, targets and incentives

7.7 All PCG/Ts had prescribing incentive schemes in place. The majority of these
(83%) were linked to both budgetary and quality targets. Sixty-three per cent
were allowing practices to retain savings from their prescribing budgets. This
figure is little changed from previous years. The amount that could be retained
by the practice varied from £4,000 to £35,000 (other responses to this ques-
tion are shown in Box 7.1. Reasons given for not allowing practices to retain
savings included: ‘forecast overspend throughout’, ‘savings used to balance
overspend’ and ‘low prescribing does not mean good prescribing’.
7.8 As in previous years, coronary heart disease, antibiotic prescribing, and proton pump inhibitors were common areas for PCG/T prescribing targets (Box 7.2). Of the 41 respondents who gave details of their incentive scheme, 76% had at least one prescribing target relating to specific (e.g. low dose aspirin, statins, beta-blockers) or general aspects of the NSF for coronary heart disease. However, there was a notable drop in the use of generic prescribing as part of the incentive scheme from 71% in the previous year to a current level of 33%.

7.9 Reduction of prescribing of antibiotics and proton pump inhibitors are both part of the NHS performance indicators set. However, reduction in the use of benzodiazepines (also part of this set and a recommendation in the NSF for mental health) was a target identified by only seven PCG/Ts. The decline in the use of generic prescribing as part of the incentive scheme probably reflects the fact that the rate in England is currently running at 71%, and there may be little more room for improvement in this area. Another notable finding is the drop in targets relating to the overall management of coronary heart disease. It is possible that some PCG/Ts feel that they have now made significant improvements in this area, and this is supported by some of the respons-
es to the question about significant achievements in the past year. However, other respondents to the questions about barriers and key tasks for the coming year made reference to the difficulties in achieving NSF targets. In contrast, it is interesting to note that the use of statin prescribing as a target had not decreased. An explanation may be that this is one of the standards within the NSF where most work needs to be done and that others e.g. usage of low dose aspirin have already been achieved.

**BOX 7.2: PERCENTAGE OF PCG/Ts USING PRESCRIBING TARGETS AND LINKS TO INCENTIVES, HEALTH IMPROVEMENT PROGRAMME AND CLINICAL GOVERNANCE.**

<table>
<thead>
<tr>
<th>TARGET</th>
<th>Total</th>
<th>Linked to Incentive Scheme</th>
<th>Linked to Health Improvement Programme</th>
<th>Linked to Clinical Governance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2000/01</td>
<td>2001/02</td>
<td>2000/01</td>
<td>2001/02</td>
</tr>
<tr>
<td>Reduced antibiotic prescribing</td>
<td>69</td>
<td>52</td>
<td>89</td>
<td>84</td>
</tr>
<tr>
<td>Reduced PPI prescribing</td>
<td>71</td>
<td>50</td>
<td>82</td>
<td>92</td>
</tr>
<tr>
<td>Increased generic prescribing</td>
<td>71</td>
<td>33</td>
<td>97</td>
<td>94</td>
</tr>
<tr>
<td>Improved CHD management</td>
<td>67</td>
<td>31</td>
<td>65</td>
<td>87</td>
</tr>
<tr>
<td>Increased statin prescribing</td>
<td>24</td>
<td>27</td>
<td>57</td>
<td>31</td>
</tr>
<tr>
<td>Reduced NSAID prescribing</td>
<td>14</td>
<td>23</td>
<td>100</td>
<td>73</td>
</tr>
</tbody>
</table>

7.10. In order to help achieve these targets, 75% of PCG/Ts were using prescribing guidelines (70% in 2000/01). Most of these guidelines related to the prescribing targets listed in Box 7.2. Forty-four per cent of PCG/Ts had developed and adopted prescribing formularies, of which almost half (48%) were comprehensive formularies. A further 23% were in the process of developing formularies.

7.11. The influence of the NSFs is continuing to grow with almost all PCG/Ts (96%) feeling that they had a strong influence on their prescribing targets and priorities (71% in 2000/01). There was little change since our last survey in the per-
ceived influence of NICE guidance, with 72% perceiving this to be a strong influence. Only a quarter (25%) of prescribing leads felt that the Commission for Health Improvement was influential in determining prescribing targets and priorities. PCG/Ts’ own clinical governance priorities appeared to be having an increasing influence on prescribing, with 77% rating them a strong influence this year, compared with 52% in 2000/01. Similarly, 56% of prescribing leads rated health improvement priorities as a strong influence on prescribing, compared with 31% in the previous survey.

Monitoring and improving prescribing

7.12 There was little change in the number of PCG/Ts using prescribing indicators based on prescribing and cost data (PACT): 87% in 2001/2002 compared with 96% in 2000/2001; or in the number using the electronic version of PACT: 87% in 2001/2002 compared with 83% in 2000/01. The use of the prescribing tool has risen steadily over the three years of the survey, from an initial 26% in 1999/2000 to 59% in 2001/2002. Only one PCG/T was not using PACT to identify poorly performing practices. The practice of sharing identifiable prescribing data with all practices has also increased over the three years of the survey from 58% in 1999/2000 to 74% in 2001/2002. However, more prescribing leads reported resistance from GPs to sharing identifiable prescribing data, 24% compared with 12% in 2000/2001.

7.13 Forty-four per cent of PCG/Ts were using a formulary, and half of these were described as ‘comprehensive’. A further 23% were in the process of developing a formulary. Reasons for not having or developing a formulary included: ‘not felt necessary’, ‘too much effort developing and maintaining something they [practices] may feel they do not own’ and ‘shortage of time and manpower’.

7.14 Three-quarters (75%) of PCG/Ts were using prescribing guidelines. Not surprisingly, the most common guidelines were closely mapped to the prescribing targets: antibiotics (44%), gastrointestinal disease (44%), cardiovascular disease (17%), and those specific for statins (25%).

Achievements, barriers, key tasks

7.15 Many prescribing leads judged their achievements in terms of meeting some of the specific prescribing targets set out in Box 7.2. These were most commonly the decreased use of proton pump inhibitors and antibiotics, but also success in being able to raise the level of statin prescribing. Some referred more generally to the issue of quality in relation to prescribing: ‘continually encouraging improvements in quality’, ‘more practices achieving quality markers’. Others felt that their achievements were reflected in the processes which
had been developed: well developed prescribing strategy group, ‘developing a strong area prescribing committee with representation from primary and secondary care’, ‘producing monthly newsletter which is distributed to GPs, pharmacists and Trusts in the PCT’. Some cited the greater engagement and utilisation of professional groups: ‘GPs eventually sharing non-anonymised PACT data’, and ‘continued development of patient group directives for community pharmacists and nurses’. A small number felt that their achievements related to budgetary control: ‘almost balancing our budget’, ‘persuading PCG board, with the help of clinical governance, to add money to prescribing budget for statins’.

7.16 The most commonly identified barrier to success in terms of prescribing was financial: ‘underfunding of our prescribing budget’, ‘failure to allocate a realistic budget due to lack of funding’. Respondents frequently mentioned the pressures posed on the prescribing budget by the NSFs and NICE: ‘the cost of NSF ideals and practical funding do not add up’, ‘tension between controlling costs and meeting NSF targets’, ‘goal posts constantly changing e.g. NICE guidelines’. In total, 70% of respondents made reference to the negative aspects of the NSFs, NICE or the ‘limited’ budget available for drugs. Others cited the lack of human resources: ‘inadequate clerical and professional staffing levels’, ‘lack of a prescribing adviser’.

7.17 The key tasks for the future frequently related to their desire to remove the barriers that had been identified in the previous section: ‘realistic budget setting with realistic growth’, ‘justify and try to secure a larger prescribing budget’. This was frequently linked to their desire to implement NICE guidance and the NSFs: ‘achieve realistic budgets that take the emerging NSFs into consideration’. The dual aims of controlling costs while continually trying to encourage improvements in quality were, as in previous years, a recurring feature. In order to help them achieve their aims a number of respondents recognised the need to increase the level of support provided to practices and to the wider groups of professionals who are becoming more involved in prescribing. Ways in which this support could be provided were identified as: ‘revamp prescribing adviser and support roles’, ‘support new prescribers (nurses and pharmacists)’, ‘to get in place community pharmacists to support primary care prescribing’. For other respondents the key task was to work more closely with secondary care providers: ‘improve continuity of care at the interface’, ‘develop the formulary in discussion with secondary care’.
7.18 Prescribing sub-groups have been a relatively strong feature of PCG/Ts since their inception. They have matured and developed over the lifetime of the survey and have taken on increasing responsibilities for managing prescribing.

7.19 The level of dedicated pharmaceutical resource available to support prescribing has continued to increase, but there is considerable variation between PCG/Ts.

7.20 The high level involvement of community pharmacists in both prescribing sub-groups and other PCG/T initiatives to improve prescribing is a notable feature in this year’s survey.

7.21 The financial rewards to practices as a result of savings on the prescribing budgets were highly variable. Although 16 PCG/Ts did not allow the practices to retain any savings another allowed up to £35,000.

7.22 Almost 75% of the prescribing leads feel that both the NSFs and NICE have a great influence on their prescribing targets and priorities. To a large extent this was reflected in their activities in relation to the components of the prescribing incentive schemes and to guideline development.

7.23 However, the negative effect of the implementation of this guidance was a recurring theme when asked about barriers to success in relation to prescribing. Although the role of the NSFs and NICE in pushing forward the quality agenda was clearly recognised, the resource implications were perceived as difficult to manage. As a consequence, the prescribing leads saw achieving ‘realistic’ prescribing budgets as a key task for the future. This is particularly relevant as, since 1 January 2002, PCG/Ts had a statutory obligation to fund treatments recommended in technology appraisal guidance from NICE.
8. Commissioning
Bernard Dowling, Anna Coleman, David Wilkin and Cathy Shipman

National Primary Care Research and Development Centre and
The King’s Fund

Introduction

8.1 The commissioning of community and hospital services for patients is one of the three core functions of PCG/Ts. Furthermore, commissioning can also be used as one mechanism, amongst others, to achieve aspects of their other core functions such as improving the health of the population and developing community services. In effect, commissioning can be defined as a means of procuring, and paying for, high quality community and hospital services primarily by way of partnership working between the commissioners and providers. However, other characteristics of the function may include negotiation, persuasion, target setting, contractual demands, providing incentives, and monitoring service delivery standards and patient outcomes. It should be a rolling procedure where the service level agreements and long-term service agreements (official terms for the contracts PCG/Ts hold with providers) arising from these processes are compared to service delivery performance on an ongoing basis, with the intention of ensuring the terms of the agreements are being met.

8.2 Our previous surveys showed that commissioning was not a major priority for PCGs in their first year, 1999/2000, but that it became a higher priority in their second year. Indicators of the progress PCG/Ts were making in commissioning for the second round of the Tracker survey were: establishing appropriate infrastructures by setting-up subgroups, taking increased responsibility for commissioning, implementing National Service Frameworks, changing contracts with providers, the extent of collaboration with outside bodies and consultation with stakeholders, and achieving commissioning objectives (Wilkin et al, 2001). This year, although some of these areas were covered, we tried to assess what PCG/Ts are actually achieving in terms of commissioning. We also examined:

- Reported progress towards changing patterns of patient care.
- The degree of leverage that commissioning leads perceived their PCG/Ts held over providers. This is a crucial question in that an essential part of the commissioning function is to make providers shape their services to reflect the wishes of PCG/Ts, which should in turn reflect the needs of patients.
PCG/Ts’ performance as commissioners, using simple indicators based on whether they had used long-term service agreements, developed integrated care pathways, set and achieved targets, introduced quality standards in contracts for older people and for diabetic services, and operated financial incentives for providers.

8.3 This chapter primarily draws on information from postal questionnaires sent to PCG/T commissioning leads. Commissioning leads from forty-six (68%) PCG/Ts responded, representing twenty-five PCTs and twenty-one PCGs, compared to fifty-one PCG/Ts (72%) last year.

**Progress and Problems**

**Commissioning infrastructure**

8.4 Creating an infrastructure to support commissioning is essential. Most PCG/Ts (83%) had employed directors or senior managers with specific responsibility for commissioning. Eighty-three per cent had established subgroups to take forward the commissioning agenda, an increase from 62% last year, though only 14% of those with a subgroup allocated an administrative or operating budget to it. Of the PCG/Ts with a subgroup, 45% operated joint subgroups with other PCG/Ts.

8.5 Virtually all subgroups (95%) had GP members, a far greater percentage than for other stakeholders. For example, only 21% included practice managers, 26% community nurses, 29% practice nurses, 42% health authority representatives, 45% social services representatives, and 47% public health specialists. Only 18% had lay members. Considering the importance of commissioners and providers working together, it is perhaps surprising that only 20% of subgroups included acute trust managers and 11% acute trust clinicians, while just 15% included community trust managers and 11% community trust clinicians.

8.6 However, despite the low levels of provider membership in commissioning subgroups, almost half (47%) of the commissioning leads saw hospital clinicians as having a strong influence on commissioning decisions (Box 8.1). The only other stakeholders perceived as having more influence were GPs and other PCG/Ts. The impact of users, patient representatives (Community Health Councils) and carers on commissioning decisions was perceived as minimal. Considering that PCG/Ts are expected to work in partnership with social services departments to deliver improved services, it is perhaps surprising that only one-fifth (21%) of commissioning leads rated social services as being influential in commissioning decisions.
Factors influencing commissioning priorities

8.7 Respondents were asked to rate the importance of a range of possible influences on the commissioning priorities of PCG/Ts (Box 8.2). It is clear that maintaining financial balance, improving access to services, achieving national policy targets and implementing the National Service Frameworks are key factors shaping the commissioning priorities of PCG/Ts.
**Taking responsibility for commissioning**

8.8 Over the three years of the survey, PCG/Ts have increased their involvement in commissioning hospital services, taking responsibility from health authorities. From April 2002, with the old health authorities being replaced by strategic health authorities, PCTs will take full responsibility for commissioning. For the year 2001/02, 94% were involved in commissioning acute services, a marginal increase on the 90% involved in the previous year. Sixty-one per cent were involved in commissioning mental health services, again a slight increase on the 54% in the previous year, and 76% were involved in commissioning accident and emergency services, compared with 67% in 2000/01.
8.9 Box 8.3 provides a summary of who commissioned services for the main specialties for the financial year 2001/02. It should be noted that most of this commissioning work should have been completed prior to April 2001 in order that agreements were in place for the beginning of the financial year. Thus a year before the replacement of the old health authorities by the new strategic health authorities, most PCG/Ts had some involvement in commissioning most specialist services. Apart from mental health, oncology and accident and emergency services, only about a third of PCGs were relying on health authority input to commissioning, usually working in partnership with the health authority. Most commissioning leads expressed confidence about the reduction in number and change in role of health authorities from April 2002. Nearly two-thirds (63%) felt that the change would have a positive effect on their performance in commissioning (4/5 on a five-point scale from 1 representing ‘very negative’ to 5 representing ‘very positive’).

**BOX 8.3: COMMISSIONING RESPONSIBILITIES OF PCG/Ts**

8.10 However, it is noteworthy that 6% of PCG/Ts still had no direct responsibilities for commissioning acute services by April 2001, with 2% relying totally on the health authority to perform this function for them and 4% on other PCG/Ts. One PCG reported having no involvement in commissioning any form of care, all commissioning being undertaken by the health authority.
Collaboration in commissioning

8.11 Collaboration between PCG/Ts in commissioning remains common. Box 8.3 shows that only about a quarter of PCG/Ts were commissioning specialist services independently. Forty-three per cent of commissioning subgroups included representatives from other PCG/Ts and 37% had operated joint commissioning groups with other PCG/Ts. Whether or not PCG/Ts commissioned services alone or shared with other PCG/Ts was only loosely related to size. The average population of those commissioning general surgery alone was 157,638 compared with 148,112 for those that shared responsibility for commissioning with other PCG/Ts. Figures for other acute specialties were similar. For accident and emergency services the corresponding averages were 178,932 and 133,720, and for mental health services 177,030 and 133,430. PCTs were somewhat more likely than PCGs to be commissioning services alone, but many PCTs continued to commission in collaboration with neighbouring PCG/Ts. Thus, for example, 33% of PCTs commissioned general surgical services independently, compared with 10% of PCGs and 46% of PCTs shared with other PCG/Ts compared with 48% of PCGs.

8.12 Perhaps unsurprisingly, in the light of perceived shortages of managerial capacity (See Chapter 11: Achievements, Obstacles and Key Tasks), achieving economies of scale and fostering expertise were seen by most commissioning leads as advantages of collaboration (Box 8.4). Almost as important was the perceived increase in leverage with providers that was obtained by working together. Losing touch with local issues was the most commonly identified disadvantage (Box 8.5).

**BOX 8.4: PERCEIVED ADVANTAGES OF COLLABORATION IN COMMISSIONING (2001/02)**

<table>
<thead>
<tr>
<th>Advantage</th>
<th>% of PCG/Ts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economies of scale</td>
<td>87</td>
</tr>
<tr>
<td>Foster commissioning expertise</td>
<td>76</td>
</tr>
<tr>
<td>Increased leverage</td>
<td>74</td>
</tr>
<tr>
<td>Improved decision-making</td>
<td>48</td>
</tr>
<tr>
<td>Better relationships with providers</td>
<td>41</td>
</tr>
<tr>
<td>Other</td>
<td>15</td>
</tr>
</tbody>
</table>

% of PCG/Ts
Commissioning non-NHS services

8.13 Four-fifths (81%) of PCG/Ts commissioned services from non-NHS providers, a small increase on the 74% that did so the previous year. A wide range of services was commissioned, though the most common were termination of pregnancy and palliative care services. The number and approximate value of contracts with non-NHS providers is in shown in Box 8.6.

**Box 8.5: Perceived Disadvantages of Collaboration in Commissioning (2001/02)**

<table>
<thead>
<tr>
<th>Perceived Disadvantage</th>
<th>% of PCG/Ts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Losing touch with local issues</td>
<td>54</td>
</tr>
<tr>
<td>Diluting decision-making</td>
<td>30</td>
</tr>
<tr>
<td>Diluting responsibility</td>
<td>28</td>
</tr>
<tr>
<td>Worsening relationships</td>
<td>7</td>
</tr>
<tr>
<td>Diluting commissioning expertise</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>15</td>
</tr>
</tbody>
</table>

**Box 8.6: Number and Value of Non-NHS Contracts (2001/02)**

<table>
<thead>
<tr>
<th>Value Range</th>
<th>Number of Contracts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than £10,000</td>
<td>7</td>
</tr>
<tr>
<td>£10,000-£49,999</td>
<td>13</td>
</tr>
<tr>
<td>£50,000-£99,999</td>
<td>16</td>
</tr>
<tr>
<td>£100,000-£499,999</td>
<td>27</td>
</tr>
<tr>
<td>£500,000 or more</td>
<td>7</td>
</tr>
</tbody>
</table>
8.14 The average value of non-NHS contracts in the forty-three PCG/Ts that answered the question (based on the mid-point of the four lowest ranges and £500,000 for the highest range) was £308,000. Commissioning from non-NHS providers thus represents only a very small proportion of total spending.

Targets in commissioning

8.15 Eighty-nine per cent of commissioning leads reported that their PCG/Ts had set targets for providers to reduce waiting times for outpatient appointments, and 26% of those said the targets had been fully achieved, 68% partially achieved, and 6% not achieved. Four-fifths (79%) reported setting targets to reduce waiting times for elective surgery, and 29% said the targets had been fully achieved, 61% partially achieved, and 11% not achieved. Less success was reported by the 65% of PCG/Ts that had set targets to improve discharge arrangements, with only 5% saying that the targets had been fully achieved, though 81% reported partial success, and 14% said they had not been achieved. The level of success in getting providers to meet targets suggests that some benefits in patient care are accruing as a result of PCG/Ts’ role in commissioning.

Influencing providers through the commissioning process

8.16 Service level agreements and long-term service agreements are mechanisms by which PCG/Ts and hospital and community providers agree levels of service provision, quality standards and payments. Service level agreements last one-year, though they tend to be routinely renewed, while long-term service agreements run for a longer period, usually three-years. Only 17% of PCG/Ts held long-term service agreements with any providers (16% in 2000/01). Commissioning leads did however recognise some advantages in long-term service agreements. For example, 78% believed they assisted long-term planning, 50% felt they brought greater stability in relationships between PCG/Ts and providers, 46% thought they increased stability in service provision, and 33% considered that they gave more stability in price changes. But such advantages are clearly not sufficient to motivate many PCG/Ts to negotiate long-term service agreements. On the other side of the equation, 48% of commissioning leads felt that long-term service agreements made it harder to create change, 46% felt they could result in a loss of flexibility, 35% thought they would make it harder to rectify inadequacies, and 13% believed they might make relationships go stale.
8.17 While changing providers is not encouraged, because of its potential to destabi-
libise services, it remains one of the options for improving services where
existing providers have proved unsatisfactory. However, there was little evi-
dence of PCG/Ts trying to improve services through this mechanism. Only
10% said they had changed providers for community health services over the
last year, and even fewer (7%) reported changing providers for mental health
services. None of the PCG/Ts in our sample had changed providers for gen-
eral surgery, gynaecology or obstetrics, general medicine, ear nose and
throat, paediatrics, oncology, or accident and emergency, and just one had
changed provider for orthopaedics. Changing providers is clearly not a strat-
ey that PCG/Ts have adopted. Lack of choice between different providers
does not appear to explain this apparent unwillingness to change provider.
Most PCG/Ts had a choice of providers for the major acute specialties.

8.18 Another instrument that can be used to enhance services through the con-
tracting process is to include financial incentives for providers into service
level agreements and long-term service agreements. However, only 12% of
PCG/Ts had done this, which is even fewer than the previous year when 17%
had done so. The majority of the incentives identified were non-recurring
bonuses to reward adherence to waiting time targets.

8.19 One option for using the commissioning process to enhance the quality of
providers’ services is to incorporate quality standards into service level agree-
ments or long-term service agreements. Almost a third (32%) of PCG/Ts had
used quality standards for acute medical care for older people. Examples
included measures to ensure the acute sector supplied twenty-eight days of
any drugs required by patients, access times, improvements in discharge
planning and, most commonly, elements of the National Service Frameworks.
National Service Frameworks were also mentioned more commonly than any-
thing else by the 24% of PCG/Ts that had incorporated quality standards into
service level agreements and long-term service agreements for the care of
diabetic patients.

8.20 Another important mechanism for improving services is the development of
agreed integrated care pathways, as a way of ensuring an integrated and
‘seamless’ service. The 2000/01 Tracker survey reported some progress had
been made in developing integrated care pathways. Although only a minority
of PCG/Ts had integrated care pathways in place for each specialty, virtually
all were in the process of developing them (Box 8.7).
8.21 In order to obtain an assessment of the relationship between PCG/Ts as commissioners and the providers, we asked commissioning leads how much leverage they held over NHS providers of hospital services (Box 8.8). Less than a quarter (24%) felt that they had substantial leverage, while 44% felt that they had little leverage. That nearly half of commissioning leads felt hospital clinicians were influential in commissioning decisions (see Box 8.1) could be relevant to these statistics. Interestingly, 29% of the PCG commissioning leads felt they had strong leverage over providers while only 20% of PCTs did. Yet a higher percentage of PCGs (53%) also perceived themselves to have weak leverage.
leverage over providers than the PCTs that did so (36%). As such, there is no clear consistency between PCGs and PCTs in the relationship between trust status and high or low leverage. However, the larger PCG/Ts (with populations over 200,000) tended to feel they had more leverage over hospital providers than the smaller PCG/Ts.

BOX 8.8: COMMISSIONING LEADS’ PERCEPTION OF DEGREE OF LEVERAGE OVER HOSPITAL PROVIDERS (2001/02)

Activities in commissioning

8.22 In an attempt to obtain an overview of the performance of PCG/Ts as commissioners, we used the responses of commissioning leads to construct a simple indicator of activity. We concentrated on questions that discriminated between PCG/Ts. Thus, for example, we have not included whether or not they had established commissioning groups, since virtually all had done so. Although the resulting indicator is inevitably crude and restricted by the data available, it provides a useful starting point for comparing the activity of different PCG/Ts. The variables included and scoring system were:

- Use of long-term service agreements. This factor is used to reflect the policy expectation that the scrapping of short-term contracts should cut transaction costs, improve stability and generate a better environment for improving services (Secretary of State for Health, 1997). Four points were awarded for PCG/Ts that used long-term service agreements.

- Use of integrated care pathways. Just planning to introduce them is not a criterion for achievement in this case, and the rationale for using this factor is linked to the establishment of a ‘seamless’ service. One point was awarded for each integrated care pathway in place up to a maximum score of five.

- Use of quality standards for acute medical care for older people, and diabetes services. Two points are awarded if quality standards are in place for either service, meaning that a maximum of four points was awarded if a PCG/T had introduced them for both areas of care.
• Use of targets to reduce outpatient waiting times, reduce waiting times for surgery, and improve discharge arrangements. One point was awarded for each area of care where targets had been set and a further point for each target that had been fully achieved, making a total six points available for this factor. The rationale for this measure is that targets set in these areas imply that PCG/Ts are at least attempting to improve services, and if the targets were met then the improvements have been realised.

• Use of financial incentives for providers. This measure is used because it implies that those that have done so will be in a better position to shape the standard of care a provider will supply. Those PCG/Ts that were using financial incentives were awarded two points. A lesser weighting has been attributed to this factor because it is uncertain what the impact of such incentives might be.

8.23 PCG/Ts could score from zero to twenty-one points on this crude indicator of commissioning activity. The highest score attained was fourteen and the lowest was one. Scores were grouped into three categories, best performers (scores of eight or more), average performers (scores between three and seven) and worst performers (scores of one or two). Twenty per cent of the PCG/Ts in our sample were ‘best performers’, 65% ‘average performers’ and 15% ‘worst performers’. There were no differences in the commissioning activity of PCGs and PCTs (Box 8.9). Considering that PCTs hold more responsibility for commissioning and have greater managerial capacity, they might have been expected to be performing better than PCGs in commissioning hospital services.

**BOX 8.9:** PERCENTAGES OF PCGs AND PCTs IN THREE BANDS OF SCORES ON INDICATOR OF COMMISSIONING ACTIVITY (2001/02)
8.24 However, there was an apparent relationship between commissioning activity and perceptions of the degree of leverage over hospital providers. The mean leverage rating (from a five-point scale running from 1 representing ‘very little’ leverage to 5 representing a ‘great deal’ of leverage) of the ‘best performers’ in commissioning was 3.1. The mean for ‘average performers’ was 2.7, and the mean for the ‘worst performers’ was 2.4. In other words, greater perceived leverage over providers seems to be associated with higher activity in terms of the factors included in our indicator.

8.25 While our sample size is insufficient to demonstrate statistical significance, this trend seems to suggest that the degree of leverage over providers could be a key to better commissioning activity. Without sufficient leverage, providers may ignore the wishes of commissioners. The fact that less than a quarter of respondents considered they had substantial leverage (Box 8.8), suggests a need to seek ways of increasing the leverage that PCG/Ts can bring to bear on providers. It is worth noting that when PCG/T commissioning leads were asked what the main obstacles or barriers were to success in commissioning, 50% mentioned lack of influence over providers. Other obstacles to success included too many competing priorities (72%), lack of funds (61%), shortage of staff (59%) and lack of expertise (20%).

Achievements, failures and key tasks

8.26 Commissioning leads were asked what had been the most significant achievements in commissioning over the last year. Twenty eight per cent mentioned establishing new services and 28% mentioned developments in existing services, suggesting that many PCG/Ts are using commissioning to bring about improvements in at least some services. Other achievements included maintaining financial balance, improvement in relationships, enhancing information flows and meeting waiting time targets.

8.27 A very wide range of failures was mentioned, including failure to achieve financial balance, to meet waiting time targets, and not succeeding in establishing new services. Overall a lack of resources was blamed for 50% of the failures mentioned. Some commissioning leads said that PCG/Ts were overburdened with targets and organisational upheaval and that these constituted further reasons for their failure to make an impact as commissioners. Examples of such opinions were, ‘hampered by major organisational change (trust merger)’ and ‘efforts diluted by too many targets’.
In identifying key tasks for the forthcoming year, commissioning leads mentioned a wide range of intentions although common reference was made to the development of new services and meeting targets. Linked to the perceived reasons for failures discussed above, another task that was mentioned related to resource issues like finding the assets to perform the commissioning function effectively, and this was reinforced by perceptions of growing lists of priorities and targets. This concern over a perceived gap between the expectations placed on PCG/Ts and the resources available to meet them reflected comments made by other survey respondents, including chief executives (See Chapter 11: Achievements, Obstacles and Key Tasks).

Conclusions

In most cases PCG/Ts have extended their responsibilities for commissioning by taking more responsibility for tasks previously undertaken by health authorities. The infrastructures needed for commissioning function, such as the establishment of subgroups and working in collaboration with other bodies, were largely in place. While general practitioners seem to have more influence over the commissioning agenda than other stakeholders, it is national priorities that have most weight in determining commissioning priorities.

Most PCG/Ts commission some services from non-NHS providers, though the financial impact of this in terms of the money lost to NHS providers is marginal. It is also rare for PCG/Ts to use a change of service provider as a means of obtaining improved services. Long-term service agreements are still rare, with PCG/Ts largely holding one-year service level agreements with providers. Quality standards are being introduced into service agreements, which is an encouraging development in attempts to improve care.

Another example of commissioning improving the provision of care is that steps are being taken to develop integrated care pathways across a wide range of services. Although there are more plans to do so than the number of systems of care already in place, there is still quite a number of integrated care pathways reported as already established.

The degree of leverage held by PCG/Ts over NHS providers is perceived as being low. This is worrying because PCG/T activity in the commissioning function appears to be related to the degree of leverage they perceive themselves as holding. A higher perception of leverage was linked to more activity in commissioning. Conversely, PCG/Ts performing less actively as commissioners perceived themselves as having less leverage over providers.
Overall, some progress has been made in the commissioning function. But as with other key PCG/T personnel, commissioning leads perceive a lack of resources as an important obstacle to the successful execution of the commissioning function. The apparently widening gap between the expectations on PCG/Ts and their capacity to meet them means that the signs of progress in the commissioning function must be tempered by caution as far as longer-term prospects are concerned.
9. Partnerships
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National Primary Care Research and Development Centre

Introduction

9.1 Current policy emphasises the role of local government in tackling problems of poor health. Local authorities have a statutory duty to promote the health and well-being of their residents (Department of Environment, Transport and the Regions, 1998) and the leadership role of local authorities has been enhanced through their new powers to scrutinise local NHS strategic plans (Department of Health, 2001d). Effective partnerships between local authority and NHS services, in order to improve the overall integration of services, is also a high priority (Secretary of State for Health, 2000), especially in relation to older people’s services. The Tracker survey therefore has a particular focus on partnerships and their outcomes in relation to new services, or more effective arrangements, for older people.

9.2 Since 1997, many new measures have been introduced to facilitate inter-agency partnerships. These include targeted funding; the flexibilities in section 31 of the Health Act 1999 (pooled budgets, delegated commissioning to a single ‘lead’ organisation and integrated provider organisations); and Care Trusts. However, closer collaboration is also likely to require changes at other levels within and between organisations, such as the realignment of boundaries so that services cover coterminous areas, joint staff appointments and other human resource changes that allow front-line staff to work more closely together. Increased evidence of such initiatives over the three rounds of the survey would therefore be expected, indicating closer inter-agency partnerships.

9.3 In addition to NHS-local authority partnerships, statutory organisations are also encouraged to collaborate with voluntary sector organisations (Home Office, 1998) and with private sector providers (Department of Health, 2000b). The survey therefore also sought evidence of these wider partnership networks among PCG/Ts.

9.4 It may, however, be difficult to sustain collaborative relationships between organisations and their staff during periods of major organisational change. The transition from PCG to PCT and the associated mergers between
PCG/Ts may threaten the continuity of relationships, at least temporarily, particularly if key individuals (such as the social services representatives on PCG boards / PCT executive committees) change.

9.5 Most of the data reported in this chapter is derived from the postal questionnaires received from social services representatives on the PCG board/PCT executive (54, 79%, responding in 2001/2002) or from interviews with PCG/T chief executives (66, 97% responding in 2001/2002).

Progress and Problems

The role of the social services representative

9.6 The requirement for PCG boards / PCT executive committees to include a representative from the local social services department signalled a clear aim of broadening the governance of these new NHS organisations, and of cementing key local collaborative relationships at the highest levels. However, as PCG/Ts have developed, it is not clear that these intentions have been fulfilled.

9.7 There has been a high turnover among social services representatives on the board/professional executive committee since April 1999. Less than a third (30%) of current representatives have held this position continuously since the PCG was established three years ago. Indeed, 32% had been appointed since March 2001, less than a year before the most recent survey. Moreover, it was not clear that these changes were necessarily caused by the move from PCG to trust status or by mergers between PCG/Ts. Thirty nine per cent of PCG/Ts that had not merged and had no plans to merge had social services representatives who had come into post after March 2001.

9.8 Most social services representatives had at least some senior management responsibilities. In addition, half (48%) said their job included both strategic and operational responsibilities and only 4 (7%) said their roles were mostly operational. The seniority of most social services representatives may have contributed to the difficulties reported by a third of them (33%) in combining their responsibilities in the PCG board / PCT executive committee with their other commitments. This may in turn have contributed to their high turnover.
9.9 It had appeared in the first round of the Tracker survey (Wilkin et al, 2000, Glendinning et al, 2001) that social services representatives were using their positions on the PCG board to develop channels of communication with the wider local authority. However, these do not appear to have been sustained. By year 3, one in seven (15%) social services representatives said there was no routine liaison with their social services department or the wider local authority about matters relating to the PCG/T.

9.10 Furthermore, in the latest survey, only a small minority (11%) of social services representatives held office on the PCG board/PCT executive committee and only 4 were chairs of sub-committees, a fall from 9 the previous year. There was also a decline in the proportion of social services representatives who were members of PCG/T sub-committees and working parties (69%), compared with four-fifths in previous years. No social services representative was chair of the board/executive committee in this survey.

9.11 The slow development of the social services representative’s role as a strategic link between the PCG/T and local authority may reflect the turnover among these representatives. However, another major barrier which continues to impede the usefulness of the social services representative in building strategic links between the PCG/T and local authority, is that of discrepancies in geographic boundaries between organisations in the two sectors. Differences in boundaries continued to prove problematic for PCG/Ts and their associated local authorities. Despite the opportunities for closer alignment that have been created by PCGs’ transition to trust status and by mergers between neighbouring PCG/Ts, two fifths (40%) had made no changes to their external boundaries or internal divisions within the last 2 years. Consequently, a quarter (24%) of PCG/Ts still covered patients in local authorities that were not represented on the board/executive. Between two thirds and half of the PCG/Ts shared the same boundaries as their local social services department(s) for older people’s services (64%), mental health services (61%) or children’s services (56%).

9.12 In view of these discrepancies, it is not surprising that half (49%) of social services representatives thought boundary differences were continuing to create barriers to closer collaboration. Almost half (47%) of PCG/T chief executives concurred with this view. The situation was even more complicated for the 42% of PCG/Ts in two-tier local authority areas. This was due to the local district councils, which could number between one and six within the area covered by the PCG/T, having no statutory right of representation on the PCG board/PCT executive. However, despite this, a majority of PCG/Ts reported that additional local authority representatives, over and above the social services representative, sat on a wide range of PCG/T committees, working parties and subgroups (Box 9.1).
9.13 This evidence suggests that, although social services representatives may not play an important role in the governance of PCG/Ts, their involvement is far from the only indicator of developing partnerships. Indeed, considerable progress is evident in other types of collaboration between PCG/Ts, their social services counterparts and wider local authority and community networks, as the following sections reveal.

**Strategic inter-agency partnerships**

9.14 A number of measures can facilitate the development of strategic inter-agency partnerships between PCG/Ts and local authorities. These include the flexibilities in section 31 of the 1999 Health Act; the creation of Care Trusts; joint senior appointments to plan services across agency boundaries and new resources intended to support joint service investment.

9.15 The 1999 Health Act flexibilities went ‘live’ in April 2000. By the third round of the survey, nearly two years later, over half of PCG/Ts (55%) were reported to be involved in local initiatives using the flexibilities.

9.16 Given the status of PCGs, it is not likely that they would have been involved as statutory partners. However, as PCGs’ responsibilities for budgets and service commissioning have increased, their participation in such initiatives will inevitably also have grown. In both years, local Health Act flexibility partnerships most commonly covered older people’s services, learning disabled people’s services and adult mental health services. This is consistent with the national pattern (Hudson et al, 2002).
9.17 In contrast, only 4 PCG/Ts (7%) had plans to become part of a Care Trust within the near future. Following the fieldwork, two of these PCG/Ts did become part of the same Care Trust in April 2002.

9.18 An important starting point for joint service planning across agency boundaries is to pool the information held by different organisations about service needs and existing patterns of provision. This is a particular priority in relation to older people’s services, where there is greatest pressure to improve collaboration and develop new services to fill local gaps. However, only a minority of PCG/Ts had completed mapping of local health and social services for older people or assessed the likely demand for such services in their areas. In most PCG/Ts, this was still in progress (Box 9.2).

**BOX 9.2: PERCENTAGE OF PCG/Ts HAVING CARRIED OUT ASSESSMENT OF NEED/MAPPING OF SERVICES FOR OLDER PEOPLE (2001/02)**

9.19 The creation of joint posts between PCG/Ts and local authorities is a further indicator of strategic collaboration. Over half (58%) of PCG/T chief executives reported the joint appointment of a co-ordinator to develop intermediate care services (as recommended in the National Service Framework for older people, Department of Health 2001c). Of these, half (53%) were employed by the PCG/T and a quarter (26%) by the social services department. In addition, over two thirds (70%) of chief executives reported the appointment of staff to develop partnerships with the local authority. Funding for these posts was usually split with the local authority (and sometimes other PCG/Ts), with line management provided by the PCG/T or jointly.

9.20 In addition, the number of PCG/Ts involved in investing ‘badged’ social services Modernisation Grants in joint service developments with their local social services department has increased steadily since 1999/2000 (Box 9.3).
Note: By 2001/02, the partnership and prevention grants had been replaced by a single ‘promoting independence’ grant

**Operational level partnerships**

9.21 If users are to experience changes in services, collaboration between local authorities and PCG/Ts at senior, strategic levels will need to be accompanied by changes at other levels within the organisations. These changes may include the relocation of staff so they can work more closely with each other, joint training and the introduction of common procedures across organisational and professional boundaries.

9.22 Joint training between groups of NHS and local authority staff had taken place in over four fifths (89%) of PCG/Ts in the year preceding the third survey, an increase from 66% in year 2. Of those PCG/Ts reporting joint staff training, this included general away days (62%) and training about the single assessment process (55%).

9.23 In most (89%) PCG/Ts, at least some changes in the organisation of front-line health and social care staff had taken place in the preceding year. These changes included the reorganisation or relocation of staff; changes in the roles and responsibilities of staff; secondments and transfers of staff; and changes in staff terms and conditions of employment. Box 9.4 shows the increases in the numbers of PCG/Ts reporting each of these changes since the second survey. The exception was changes to terms and conditions of employment, arguably the most difficult to negotiate with staff and their representative organisations.
9.24 Two fifths (42%) of social services representatives said the PCG/T and social services department currently had GP attached social workers/GP link/liaison workers in part of the area.

9.25 However, despite these changes, almost half (48%) of the social services representatives reported encountering at least some problems in trying to improve collaboration between PCG/T and local authority staff. Commonly cited problems included ‘culture differences’, ‘different terms / conditions’, ‘capacity of the PCG/T and SSD to make the changes at a time of huge change’ and ‘accommodation difficulties’. Moreover, there was little change, compared with the previous year, in the proportions of PCG/Ts in which relationships between social services, community health and general practice staff were reported to have improved. The proportions of social services representatives reporting improvements were virtually the same as in 2000/01. Indeed, in one instance, relationships between social services and community health staff were reported actually to have deteriorated.

9.26 Because of the high policy priority given to partnerships in relation to older people’s services (Secretary of State, 2000), questions in the Tracker survey on specific joint developments focused on services for this group. Indeed, by far the most common services currently provided in partnership between PCG/Ts and social service departments were for older people. In contrast, only about a third reported joint provision of adult mental health services (36%) or services for adults with learning disabilities (33%).
Joint provision and commissioning

9.27 The services provided jointly for older people focussed largely on intermediate care. Over three quarters (79%) of PCG/Ts and social services were jointly providing community-based rehabilitation services for older people. In two thirds (67%) of PCG/Ts, intermediate care facilities using GP beds or private nursing homes were provided jointly with social services. Just over half (55%) reported joint provision of integrated home care/nursing services.

9.28 With regard to commissioning in partnership with social services or other local authority departments, 78% of PCG/Ts had commissioned services for older people, 63% had commissioned learning disability services, 57% had commissioned mental health services, and 37% had commissioned children’s services. In relation to older peoples service, 68% of PCG/Ts commissioned community based rehabilitation schemes jointly with social services, as did 64% for joint assessments, 63% for rapid response home care schemes, 62% for integrated care management, and 57% for joint equipment services. Although there were fewer PCG/Ts commissioning GP attached social, link and liaison workers (30%), intermediate care beds in private nursing homes (28%), intermediate care beds in hospital GP units (28%), and integrated incontinence services (6%) with social services, the level of collaboration between these bodies still looks impressive.

9.29 Progress on the implementation of specific targets set out in the National Service Framework for older people (Department of Health, 2001c) appeared slow. Social services representatives were asked about implementation of the single assessment process, which is intended to simplify access to health and social care services – in particular, whether assessments could be carried out by any appropriately trained health or social services professional, and could use a single form for both health and social care. Box 9.5 shows that a surprisingly high proportion of social services representatives did not know whether these specific targets would be met.

BOX 9.5: PERCENTAGE OF SOCIAL SERVICES REPRESENTATIVES STATING THAT THE SINGLE ASSESSMENT PROCESS COULD ...

(2001/02)

<table>
<thead>
<tr>
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<th>Yes</th>
<th>No</th>
<th>Don’t Know</th>
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<tr>
<td>...be used by any health/social services professional</td>
<td>53</td>
<td>6</td>
<td>41</td>
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<tr>
<td>...use a single form for health and social care</td>
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9.30 Following the assessment process, a further step in integrating services involves developing a single system of care management to monitor and respond to on-going service needs. In three fifths (61%) of PCG/Ts, integrated care management had yet to be developed. However, more than a quarter (29%) did have this in part of the area and one in ten (10%) across the whole area.

9.31 Despite these developments, delays in discharging older people from hospital continued to be common. Nearly two thirds (62%) of social services representatives reported discharge delays caused by a shortage of community-based and domiciliary services and a similar proportion (60%) attributed delays to a shortage of nursing home beds locally. These problems are likely to constitute urgent priorities for PCG/T and local authority partnerships, in view of the proposed introduction of cross-charging in response to delayed and premature hospital discharge (Secretary of State for Health, 2002).

Wider partnership networks/relationships

9.32 It appears that PCG/Ts are becoming more embedded in local networks, with the majority (90%) of chief executives reporting that they or another PCG/T senior officer regularly meet with local authority officers in wider inter-agency fora. Four fifths (79%) of chief executives, said that these meetings addressed community development and/or regeneration programmes, and in three quarters (74%) that they dealt with health improvement priorities.

9.33 The proportions of PCG/Ts reporting joint activities with local authority departments other than social services had continued to increase. In year 2, 12% of PCG/Ts had reported no local authority collaboration (apart from social services). However, by year 3 all the PCG/Ts in the sample were working with one or more other local authority department. In two-tier local authorities, some of these departments will have been located at district council level. Apart from welfare rights services, the percentages of PCG/Ts working with each of a number of specified departments had increased between 2000/01 and 2001/02 (Box 9.6).
In addition, by the third round of the Tracker survey, all chief executives reported that their PCG/T was involved in at least one wider multi-agency, locally based initiative. The range of these multi-agency initiatives, and the increase in PCG/T involvement in each of them over the past year, is shown in Box 9.7.

BOX 9.7: PERCENTAGE OF PCG/Ts INVOLVED IN WIDER MULTI-AGENCY INITIATIVES
9.35 The flexible, integrated funding streams now held by PCG/Ts offer new opportunities for shifting expenditure into non-traditional areas. Many of the PCG/Ts (85%) reported allocating some of their resources to at least one non-NHS initiative aimed at improving health or quality of life, and two thirds (67%) were contributing to at least 3 such initiatives. The most common non-NHS initiatives to which PCG/Ts were contributing funding were community development (76%), services to supporting family carers (72%) and accident prevention (64%).

9.36 These wider PCG/T-local authority networks will provide a valuable basis for the new role of local authorities in scrutinising the plans of PCTs. All but one (97%) of the 29 chairs of PCT boards, who took part in the third survey, said that their PCT had held discussions with their local authority about this new function. When asked how the proposed scrutiny could complement the work of the PCT board, the vast majority responded positively. However, they also stressed the need for the process to be positive and non-confrontational.

9.37 Evidence on the development of partnerships between PCG/Ts and private sector organisations was equivocal. There was a slight increase since the last round of interviews in the proportion of PCG/Ts reporting having some form of private sector partnership in place, but the proportion reporting no such partnership had also increased (Box 9.8). Among the PCG/Ts which did report partnerships with private sector organisations, the most common were PFI capital developments, professional training and education, and intermediate care.

**BOX 9.8: INITIATIVES WITH THE PRIVATE SECTOR**
Activities in partnership working

9.38 Good strategic-level partnerships between senior officers may not be replicated in good operational relationships between front-line staff. Similarly, PCG/Ts which are working hard to develop new joint services with local authority partners may be temporarily unable to devote the same amount of attention to wider inter-agency and health improvement partnerships. Using data from our third survey, we have therefore constructed three indicators of partnership working:

- **Strategic planning.** Indicators: use of modernisation fund grants; involvement in Health Act flexibilities partnerships; joint appointments to develop intermediate care services and wider partnership activities (maximum score 5).

- **Operational level.** Indicators: changes in health and social services workforce; joint training activities; perceived quality of relationships between social services, general practice and community health staff; progress in implementing the single assessment process and integrated care management (maximum score 8).

- **Wider partnership networks.** Indicators: PCG/T membership of local inter-agency strategy group; meetings with senior local authority colleagues; involvement in initiatives with wider local authority services; the allocation of resources to non-NHS initiatives (e.g. community development); partnerships with private sector organisations (maximum score 6).

The ultimate objective of partnership working should, however, be improvements in services and in users’ experiences. However, given the breadth of the Tracker Survey, it was not possible to collect detailed data on these topics.

9.39 Using these scores, PCG/Ts’ level of activity on these three dimensions of partnership working was compared. There appeared to be little relationship between their scores on each dimension. Thus 55% of PCG/Ts performing well (scoring 4 or 5) on strategic level partnerships scored in the lower range (1-5) on operational level partnerships. Conversely, 52% of those performing less well in strategic-level partnerships scored in the higher range in operational partnership working. However, PCG/Ts performing well on strategic partnerships were slightly more likely also to achieve the maximum score in wider partnership working, 36% compared with 22% for those with lower scores on strategic planning.

9.40 We attempted to explain differences in the performance of PCG/Ts on these three dimensions of partnerships in relation to the following variables. PCGs were compared with PCTs to establish whether the early PCTs, with their increased control over decision-making and budgets were making more progress in partnership working than those making slower progress to trust status. The size of population covered by PCG/Ts was compared to see
whether larger PCG/Ts appeared to perform well in relation to strategic and wider partnerships, whereas smaller organisations might perform better in developing operational level partnerships. The type of local government structure (unitary or two tier) in the PCG/T area was examined, to assess the impact of organisational complexity on partnerships. Finally, the appointment of senior staff with experience of working in local authorities, voluntary organisations or the private sector was examined for evidence that the presence of senior managers with non-NHS backgrounds might have helped to bridge the information and cultural divides between the NHS and partner organisations.

9.41 PCTs appeared to perform better in relation to strategic partnerships than PCGs, almost three quarters (72%) scoring four or five compared with only 41% of PCGs. However, there was no difference between the performance of PCGs and PCTs in relation to operational level partnerships; 17% of PCGs scored seven or eight points on operational partnerships compared with only five per cent of PCTs, but 25% of PCGs scored three or lower compared with 16% of PCTs. Most PCGs and trusts scored relatively highly on wider partnership working, but 33% of PCGs scored the maximum 6 points compared with 24% of PCTs. It therefore seems that, while PCTs may have been gaining some advantage in developing partnerships in strategic planning, they had not yet demonstrated better performance in operational level partnerships or in developing wider partnership networks. In respect of both dimensions of partnership, the organisational upheaval involved in becoming a trust may have been a temporary barrier.

9.42 The size of PCG/T was not strongly related to performance on any of the dimensions of partnership. Small populations did not appear to constitute a barrier to developing partnerships in strategic planning, with 69% of PCG/Ts with less than 100,000 population scoring the maximum 6 points, compared with only 23% of those with more than 200,000. Neither was a large population a barrier to partnership working at the operational level, with 70% of PCG/Ts with over 200,000 patients scoring six or higher, compared with 50% of those with less than 100,000. Larger PCG/Ts were slightly more likely to score highly on wider partnership networks; 46% of those with more than 200,000 patients scored the maximum six points, compared with 31% of those with less than 100,000 patients.

9.43 Those PCG/Ts which were rated as performing better in relation to both strategic level and wider partnership networks were more likely to be working with unitary local authorities. However, perhaps surprisingly, this was not the case in relation to operational level partnership working, where three fifths (60%) of the best performing PCG/Ts were working with two tier authorities. Whether or not PCG/Ts employed senior managers who had previously
worked for local authorities, voluntary organisations or the private sector appeared unrelated to performance in partnership working.

**Achievements and Obstacles**

**Significant achievements**

9.44 In the previous round of the Tracker survey, significant achievements noted by the social services representatives had most commonly concerned the processes of working together (better understanding, improved trust, 39%); and joint activities which were mandatory or a very high policy priority (dealing with winter hospital pressures, developing intermediate care services, 22%).

9.45 In the current survey, three years after PCG/Ts first went ‘live’, these two areas of achievement were still noted. A quarter (27%) of social services representatives highlighted the process of joint working and new intermediate care. However, these achievements had been supplemented by a number of additional practical, concrete developments. These new achievements included strategic-level activities (contributing to the establishment of Local Strategic Partnerships, participating in Best Value reviews, working together on consultation and implementation of PCT and Health and Social Care Trust status and changes in boundaries (24%); the creation of new joint posts between the PCG/T and local authority (including managers and GP-attached social workers 20%); and joint commissioning (18%).

**Obstacles**

9.46 The main obstacles to partnership working, as perceived by the social services representatives, also appear to have shifted. In the second round of the Tracker survey, social services representatives reported PCG/T preoccupation with clinical matters (38%), lack of time and pace of change (32%) and differences in funding/budget streams (18%) as being the main obstacles.

9.47 In the latest round of the survey, similar proportions of social services representatives (35%) were still concerned about the pace of change and lack of time. However, additional, newly identified obstacles included resource constraints (24%), differences in boundaries between PCG/Ts and both unitary and two-tier authorities (20%), and a lack of individual and organisational capacity for inter-agency collaboration (15%).
9.48 Since the first Tracker survey in 1999/2000, progress has been made in the development of partnerships by PCG/Ts. The process of working across agency and professional boundaries is widely regarded as a success. There is widespread collaboration on the development of high priority services such as intermediate care. Joint appointments aimed at developing closer strategic and operational collaboration are common. PCG/Ts have also made remarkable progress in engaging with community and multi-agency networks, despite the problems created by complex geographical boundaries. However, the role of social services representatives on the PCG board and PCT executive committee may be correspondingly less important, as other channels of communication and fora for collaborative activity have developed.

9.49 However, many areas of partnership activity still appear to be determined primarily by national policy priorities such as the National Service Framework for older people (Department of Health, 2001c) and the NHS Plan (Secretary of State for Health, 2000), rather than by locally determined priorities. Boundary differences continue to make the development of partnerships more difficult, despite opportunities for closer realignment as PCGs have merged and/or become trusts. There remains very considerable potential for facilitating closer collaboration between front-line professionals, with indications that the integration of front-line services may not be proceeding as fast as strategic-level partnerships. Moreover, these weaknesses may continue, given other priorities facing PCG/Ts. Indeed, only 14% of chief executives identified partnerships as a key task for the next 12 months (See Chapter 11: Achievements, Obstacles and Key Tasks).
10. Health Improvement

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Introduction

10.1 Improving the health of the population and redressing inequalities is a core function of PCG/Ts. Consistently highlighted by government as central to the arena of primary health care, health improvement, health promotion and determinants of health continue to be key policy foci. In the time that has elapsed from the last Tracker survey Shifting the Balance of Power declared that ‘PCTs will become the lead organisations in assessing need, planning, and securing health services and improving health’ (Department of Health, 2001a). Tackling Inequalities (Department of Health, 2001e) underlined the key role of primary care organisations, for example, via Personal Medical Services (PMS) flexibilities. Local Strategic Partnerships outlined in the Neighbourhood Renewal Strategy have begun to take shape in many areas (Social Exclusion Unit, 2001). Crucially, the abolition and restructuring of health authorities in April 2002 has meant that the responsibility for public health and health promotion has shifted to the PCG/T.

10.2 Case study research linked to the Tracker survey has identified several factors that appear to be associated with greater progress in health improvement (Abbott and Gillam, 2001). These include corporate, board-level commitment to addressing inequalities, quality of leadership, availability of specialist public health support, development money and the strength of local partnerships.

10.3 The last survey demonstrated that PCG/Ts were still defining their role in improving population health. Many lacked the information and public health expertise to support this area of their work. Partnerships within and beyond the local authority were developing slowly but there were nevertheless visible signs of progress. In particular, many PCG/Ts had begun to support specific initiatives beyond the health sector.

10.4 Ultimately, the success of the efforts of PCTs in this area must be judged in terms of their impact on the health of the populations they serve, but this cannot be assessed after only three years. We therefore continued to measure progress in term of the processes and mechanisms for health improvement.
that PCG/Ts had instituted. They included evidence that:

- There was leadership for health improvement at senior levels of the organisation, as indicated by clear responsibility for health improvement and senior managers’ involvement on the relevant committees.
- The public health workforce had been assessed and that expertise was being augmented, for example via public health networks.
- PCG/Ts’ strategic planning capacity was being strengthened, as indicated by the development of health needs assessment and local health improvement programmes.
- Strategies establish targets for health improvement as well as mechanisms for monitoring impact.
- PCG/Ts are addressing health inequalities, as indicated by clear evidence of support for initiatives addressing determinants of health.

10.5 The data were collected in the three months preceding the abolition of health authorities, providing an assessment of the capacity of PCG/Ts to assume public health responsibilities. Unless otherwise stated, data reported in this chapter are drawn from interviews with PCG board and PCT executive committee chairs, 70 (97%) interviews were completed in 1999/2000, 69 (97%) in 2000/01, and 66 (90%) in 2001/2002.

**Progress and Problems**

**Leadership for health improvement**

10.6 Almost two thirds (63%) of PCG/Ts had a health improvement sub-group, relatively unchanged from the previous survey (67%). The chair or chief executive was a member in 51% of PCG/Ts where both responded, a mark of high-level commitment to health improvement. When a comparison was made between PCGs and PCTs for this, there was no discernable difference. The vast majority of PCG/Ts (92%) had a designated health improvement lead (83% in 2000/01). It was evident that there was a clear trend towards appointing public health specialists to this role, possibly with an appreciation of the specialist knowledge required (Box 10.1). Interestingly, of those who had health improvement leads, one in five (20%) were nurses. Only 3 (5%) PCG/Ts were reported to have neither lead nor sub-group.
10.7 Eighty-two per cent of PCG/Ts had a local health improvement programme (73% in 2000/01), although only six PCG/Ts (12%) had established dedicated health improvement budgets. Two thirds of PCG/Ts (66%) had access to 0.5 whole time equivalents or less of public health support. Unsurprisingly, additional public health input was rated as a high staffing priority by more than half the chief executives (55%). Almost three quarters (72%) of PCG/Ts had undertaken an assessment of locally available public health skills, and a further 20% were planning to. Over two thirds (71%) were linked to an identifiable managed public health network.

10.8 Chief executives were asked to assess the health authorities’ support to PCG/Ts with regard to a range of functions including health needs assessment, health promotion and public health (Box 10.2). While public health support had increased over the last year, chief executives were continuing to say that they had little support for needs assessment.
Strengthening of PCG/Ts’ planning capacity

10.9 In order to plan service developments to achieve health improvements PCG/Ts need to collect information on the populations they serve and on their health needs. The last survey showed that there had been a striking increase in health needs assessment carried out by PCG/Ts compared with the previous year. However, this increase was not sustained last year (Box 10.3). Overall there was little change in needs assessment activity relating to the main priority areas identified in the national health strategy. This may indirectly reflect the turbulence affecting public health support associated with moves to PCT status, especially in terms of the employment of public health specialists moving from the health authority to the PCT.

Box 10.3: Health Needs Assessment Undertaken by PCG/Ts

10.10 Importantly, one in five (20%) chief executives reported that the information they received to support needs assessment was not actually meeting these needs at all, an increase on previous years (7% in both 1999/2000 and 2000/01).

10.11 The Acheson Report (Secretary of State for Social Services, 1988) emphasized the importance of health impact assessment. There is limited experience of this and assessment tools are at an early stage of development. It is therefore unsurprising that less than a third (30%) of chairs claimed to have mechanisms in place for assessing policies for their health impact.
Partnerships for health improvement

10.12 The majority of PCG/Ts were working in partnership with local authorities to fund and develop both NHS and non-NHS initiatives. Eighty-five percent were involved with at least one such initiative, and two thirds (67%) with three or more. In the last survey, 97% of chief executives reported involvement in local initiatives with a wide range of agencies. By 2002, all PCG/Ts had such schemes. Eighty-five percent were running Sure Start schemes (62% in 2000/01), 73% had leisure initiatives (51% in 2001/02) and 38% had introduced initiatives relating to local housing (20% in 2000/01). This represented a steady extension of the levels of commitment evident a year ago (see Chapter 9: Partnerships).

10.13 As last year, 94% chief executives of the 16 PCG/Ts situated in Health Action Zones (HAZs) reported involvement in specific HAZ initiatives. HAZs have been key partners in a range of initiatives but they are being supplanted by new Local Strategic Partnerships. These were active on 89% of sites. However, the presence of an active partnership strategy group was not associated with other measures of the maturity of the PCG/Ts’ support for health improvement.

PCG/T health improvement strategies and targets

10.14 Two thirds of PCG/Ts (67%) had set health improvement targets, little change on the last survey (62%). Chairs were asked about progress in setting targets in the areas identified as national priorities: reducing smoking rates, reducing teenage conception rates, and reducing differences in life expectancy.

10.15 Half of the PCG/Ts (52%) had established targets to reduce smoking. Of these, almost a third (10, 31%) had targets that were fairly general and just entailed lowering current numbers, for example ‘reduce the absolute numbers over the next ten years’. Nineteen per cent detailed specific programmes designed to reduce smoking, such as ‘smoking advisory service – targets 500 per annum who give up for a minimum of four weeks’. Some respondents reported targets in line with national guidelines (6, 19%), and almost a third of chairs (10, 31%) did not know what the targets were.

10.16 Forty-three per cent of PCG/Ts had set targets to reduce teenage conception rates. These included general reductions (18%), targets in line with national guidelines (18%), and specific programmes or initiatives to deal with the problems (14%), such as ‘open access advice to schools, PCT sponsored condom supply’, and ‘shop front for contraception and sexually transmitted diseases’. Over a third (36%) of chairs could not give examples of the targets.
10.17 A third (32%) of PCG/Ts had set targets to reduce differences in life expectancy. Thirty-five percent (7) of these had initiated schemes around specific areas of chronic disease, such as coronary heart disease and diabetes. A fifth (20%) had set targets in line with national guidelines, and a quarter (25%) could not give details of the targets.

10.18 Almost a third (31%) of PCG/Ts mentioned other health improvement targets, 40% of these having set targets around coronary heart disease, and 20% addressing mental health.

Evidence of implementation

10.19 Ninety-eight per cent of PCG/Ts had implemented local health promotion programmes relating to smoking; 61% for promoting healthy eating; and 49% for weight reduction. These represented continuing progress on the previous year (Box 10.4). There had been a decline to 69% of those with local programmes for increasing physical activity in place but all PCG/Ts had implemented one or more of these types of programme.

BOX 10.4: LOCAL HEALTH PROMOTION PROGRAMMES IMPLEMENTED BY PCG/Ts

10.20 All but one chief executive reported that the PCG/T had allocated some of its budget to one or more of a range of health improving initiatives involving agencies beyond the NHS. In all areas, there were significant extensions of activity by comparison with the previous year. Almost three quarters (72%) were allocating some funding to leisure and recreation projects (a significant increase on 46% in 2000/01), and 63% were giving some money to initiatives to prevent accidents (28% in 2000/01). There was wide variation in the extensiveness of PCG/Ts’ financial contributions to such initiatives; one PCG was funding 7 non-NHS initiatives. The total sums involved varied widely but seldom exceeded £50k for any individual project.
10.21 PCG/T chairs were asked about the impact so far of the PCG/T on the health of local people. Only 16% of chairs believed that there had been any improvement in the health of local people as a result of PCG/T activity or policy. Most pointed to the difficulty in measuring short-term impact on health, for example ‘like any health outcome – it takes time’, ‘too soon to answer, but the initiatives are in place’, and ‘too early to prove – a lot of money and time needed’. However, others highlighted initiatives addressing the health needs of specific groups which they believed had made a difference to the health of the local population, such as ‘focused care on special groups, i.e. elderly, mental health, and the homeless’, and ‘ring-fenced money is targeted to limited areas for high emotive projects which benefit the health of minorities only’.

10.22 However, when asked to rate their anticipated long-term impact on the health of local people, 56% expected there to be a significant improvement. This is a slight decrease on the previous survey, where 61% of chairs believed the PCG/T would have a significant impact in the longer-term. That only just over half of chairs expected the PCG/T to significantly improve the health of local people is some cause for concern. However, it is possible that this may indicate that chairs perceive their roles to be limited.

Conclusions

10.23 The three Tracker surveys have charted significant progress as PCG/Ts establish an infrastructure for health improvement. PCG/Ts are using data for health needs assessment, addressing national population health priorities, and implementing local health improvement programmes. They are working with local authorities beyond social services departments and beginning to participate in local strategic partnerships. Furthermore, PCG/Ts have invested in a range of health promotion schemes.

10.24 Many PCG/Ts had implemented health improvement initiatives in line with national targets. Continued progress in implementing these initiatives around, for example, coronary heart disease, should in time yield significant health gains but PCG/Ts could be at the limits of their strategic planning capacity given the volume of existing central guidance. This may be reflected in the fact that many chairs expect to have little, if any, long-term impact on the health of their local populations.

10.25 PCG/Ts continue to report the need for more help with public health activities than they currently receive. The abolition of health authorities has reduced available support for PCTs in the short term.
While public health specialists have made great strides in establishing managed networks, strategic health authorities themselves are in flux. They appear unlikely to be able to offer much developmental support to new PCTs. Without continuing development of the public health workforce, PCTs may be unable to sustain and develop the health improvement activity which they have already initiated.

10.26 As they develop their performance management role, strategic health authorities will need to give due weight to achievement in this area of the PCTs’ brief. In particular, PCTs will need clear incentives to take an active role in furthering local strategic partnerships.
Introduction

11.1 At the end of the interviews with the chief executives, they were asked to identify achievements to date, obstacles to progress and key tasks for the following 12 months for their organisations. Whilst recognising that responses to these open ended questions are subjective and wide ranging, they help to identify key themes in the thinking of these influential individuals within PCG/Ts.

11.2 In 1999/2000 the main achievements cited by chief executives and chairs related to getting PCGs up and running (eg. building relationships with health professionals, organisational development and board working). While these sorts of achievements were still prominent in the second year, they were accompanied by many more references to improvements in the provision and quality of services, and improvements in access to care and reducing inequities. The main obstacles to success identified in both previous surveys were inadequate infrastructure (staff, premises, etc.) and resource constraints, although these had become more pronounced by the time of the second survey. Key tasks identified in 1999/2000 included primary care development, commissioning and clinical governance. While primary care development remained a priority in 2000/01, the most commonly identified tasks for the year ahead were concerned with impending mergers and making the transition from PCG to PCT.

11.3 Responses to the open ended questions have been classified using the categories from previous years as a starting point. However, additional categories were devised to reflect newly emerging themes in the responses. For this reason some categories do not include data for previous years when these categories were not appropriate. Responses were obtained from 66 chief executives (97%) in 2001/02, compared to 69 (97%) in 2000/01, and 72 (100%) in 1999/2000.
11.4 The shift in emphasis from achievements concerned with the establishment and operation of the organisation to actual improvements in services noted in the second survey had continued. Three out of the four most commonly mentioned categories of achievement were concerned with improvements in services, including improving quality through clinical governance (Box 11.1). Organisational development, relationships with primary care professionals and the internal working of the board or professional executive committee were no longer regarded as major achievements by chief executives, who seemed to be much more focused on delivering better services. The change over the three years of the survey suggests that PCG/Ts have reached a level of organisational maturity that allows them to concentrate on their main functions, rather than the establishment and operation of the organisation and its governance arrangements.

**BOX 11.1: ACHIEVEMENTS REPORTED BY CHIEF EXECUTIVES**

Note: Additional categories were devised for 2000/01 and 2001/02 data to reflect new common responses. These categories were not used previous years because of the small numbers of respondents within them.
11.5 Specific service developments, identified by 39% of chief executives, included many instances of new services operating, development of existing services or the widening of access to specific services. These included initiatives in intermediate care, out of hours co-operatives, GP specialists and services for specific groups including drug users, teenagers, diabetics and renal patients. Many respondents also referred more generally to achievements in primary care development without mentioning specific services. While fewer chief executives than last year mentioned achievements related to working with non-primary care agencies, these included more references to working with the voluntary sector and the wider local authority (beyond social services departments).

11.6 Achievements relating to prescribing and commissioning were uncommon in last year’s survey, but both were even more rare this year. It should be noted that some of the specific service developments, particularly around intermediate care provision, had occurred through the commissioning process. Nevertheless, the absence of achievements relating more generally to the commissioning role of PCG/Ts does suggest that they are concentrating their efforts in primary and community services.

Obstacles to Success

11.7 In each of the three years of the survey, inadequate infrastructure, particularly shortages of staff, have topped the list of obstacles or barriers to success. However, the numbers of chief executives mentioning these has increased from 40% in the first year to 61% this year (Box 11.2). Although problems with premises and other facilities had mostly been overcome by autumn 2000, staff shortages appeared to have become an even bigger problem. Inadequate management capacity was again the most commonly mentioned problem, but increasingly chief executives were adding a shortage of GPs, nurses and specialist staff (e.g. within IT) to the list. Similarly, resource constraints were identified by 21% in the first year and 49% this year. Taken together with references to time constraints and the pace of change, commonly associated with inadequate resources, virtually all chief executives mentioned one or more of these three categories of barrier to success.
11.8 The amount and complexity of organisational change, often associated with mergers and making the transition to trust status, and the perceived domination of central policy over local needs were new categories evident in responses to this year’s survey. However, these and the other categories used in previous surveys were far outweighed by the perception that inadequate infrastructure and lack of resources were the most important barriers to success.

### Key Tasks

11.9 Work related to making the transition to trust status and/or merging with other PCG/Ts, was again the most frequently mentioned key task for the year ahead (Box 11.3). However, only a third of chief executives mentioned tasks in this category, compared with an overwhelming 70% in our last survey, suggesting that many organisations are now able to move on from managing the process of organisational development. Many of those mentioning tasks related to becoming a trust or merging simply said that the task was to become and
develop as a PCT, but some mentioned more specific tasks such as supporting and integrating staff, especially where a merger was involved. A third of respondents also mentioned tasks related to organisational development or the working of the boards and professional executive committees of PCTs.

**BOX 11.3: KEY TASKS FOR THE FUTURE**

Almost a third of chief executives spoke about the importance of achieving financial balance. Most raised this in general terms, but where it was more specific the importance of prescribing costs was commonly mentioned. The concern with achieving financial balance reflects the prominence given to resource constraints as a barrier to success.

Meeting modernisation/national targets was another newly emerging theme in responses and was identified by over a quarter of respondents. Specified targets commonly included targets from the NHS Plan (Secretary of State for Health, 2000) and the various NSFs.
11.12 Primary care development remains a key task for about a quarter of PCG/Ts, building on achievements to date, but was mentioned by fewer chief executives than in previous years. Areas of development for the forthcoming year included bids for practice developments through the local investment finance trust, developing specialist GPs and integrating primary and community services.

11.13 While the number of chief executives who identified the development of commissioning as a key task for the year ahead had increased, it was still less than a fifth of respondents. Prescribing issues were identified as a key task by only two chief executives, and none mentioned clinical governance. The fact that relatively few chief executives identified these areas as key tasks should not be taken to imply that they are unimportant. However, they were not seen as major priorities for the year ahead, perhaps reflecting a view that these areas were already being adequately tackled.

Conclusions

11.14 As in the second year, chief executives were able to identify achievements where the organisation was having an impact on service provision. They felt that introducing specific new or extended services in primary care settings, implementing clinical governance and improving quality were important achievements. Developing relationships with non-primary care organisations was still seen as an achievement but no longer were relationships with primary care professionals perceived as such an important achievement.

11.15 This year’s survey reinforces and strengthens the findings of the previous two surveys in terms of the main obstacles to progress. Inadequate infrastructure and lack of resources are now identified as major obstacles to change by most chief executives. Lack of management capacity and resource constraints may have a direct effect on the attempts of the organisations to meet the growing list of targets and priorities.

11.16 While tasks addressing the obstacles associated with such organisational change as making the transition to trust status and managing the consequences of mergers with neighbouring PCG/Ts remain high priorities for a substantial proportion of chief executives, it seems that many are now concentrating efforts on improving services. Achieving financial balance and meeting national targets are priorities for an increasing proportion of chief executives.
12. Progress and Challenges
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Introduction

12.1 The first two reports of the Tracker Survey documented the rapid and far-reaching changes that have occurred in the NHS since 1999. There has been no sign in the third year of the ‘new’ NHS of that process of change slowing. By April 2002 all PCGs had become PCTs and 28 strategic health authorities had replaced the 95 health authorities in England. These changes will have major consequences for the workload of PCTs as they take direct responsibility for a range of functions previously undertaken by health authorities. Organisational change and development will remain an important concern for PCTs for at least the next year or so. At the same time as managing this process of organisational change, PCTs have major responsibilities in modernising the NHS, delivering improvements in the quality of care and managing three quarters of the total NHS budget.

12.2 Evidence from our third Tracker Survey of PCG/Ts has been set out in the main body of this report. We have assessed progress and problems in key areas of organisational development and service provision. Conclusions are drawn in each chapter, and there is an executive summary of the main findings. Although there will inevitably be some overlap with the main chapters and executive summary, in this chapter we outline the progress made in key areas of PCG/Ts’ responsibilities and the challenges facing them.

Primary Care Development

12.3 The government sees primary care as playing a central role in the achievement of its modernisation programme for the NHS (Secretary of State for Health, 2000). Its progression as an effective contributor to the planning, development and provision of health care to patients is therefore a critical aspect of the ‘new’ NHS. The first Tracker Survey, conducted in 1999/2000, described progress in assessing needs and existing service provision, making plans for investment and development, and establishing an infrastructure to support primary care and community services. The second survey in 2000/01 showed that PCGs and the first PCTs were giving high priority to the development of primary care. Common themes were initiatives to improve access
to services, managing the demand for primary care, and extending the range of services available in primary care settings. In this third Tracker Survey we examined progress in 2001/02 in three key areas: whether infrastructures for primary care development had been established, the improvements made in the provision of primary care, and the progress made in integrating practice based and community services.

12.4 With regard to infrastructures it is clear that most PCG/Ts had established working groups for primary care development and developed criteria for funding investments. They were using a wide range of initiatives to improve access to primary and community care, often linked to the flexibilities offered by PMS contracts to target groups with problems. There was also evidence of a wide range of initiatives to extend the range of services available in primary care, including counselling, minor surgery, physiotherapy, plus GP and nurse specialists. However, there was substantial variation between PCG/Ts in the number and range of initiatives being developed, though there was no evidence that PCG/Ts of different sizes were performing differently in this respect. Nor is there yet any evidence that PCTs were doing more than PCGs. Concerning the integration of services, most PCG/Ts had introduced joint meetings and training programmes for practice and community nurses, but only a minority had created integrated nursing teams, shared records, and common management arrangements.

12.5 Although we have no firm evidence concerning the impact on patients of the initiatives being introduced to develop primary care, PCG/Ts have been focussing on improving access to care, extending the range of services, and addressing many of the key targets in the NHS Plan (Secretary of State for Health, 2000). Nevertheless, progress is variable and hindered by major problems in getting access to the reliable and timely information that is necessary for good decision-making.

Improving Quality

12.6 Improving the quality of the health care received by patients is a central theme in the modernisation programme of the NHS. The changes being made to the service are intended to make high quality services available to all patients, irrespective of where they live, in order to enhance the overall health of the population and tackle inequalities in both health and access to care (Department of Health, 1998). The implementation of systems of clinical governance is the principle mechanism through which PCG/Ts are addressing quality improvement in primary care. Over three years the Tracker Survey has shown that significant progress has been made in implementing clinical governance.
In 1999/2000 PCGs had embarked on a wide range of activities to implement clinical governance, including the creation of basic infrastructures to support the process. In 2000/01 the implementation process had progressed with mechanisms in place to monitor and improve quality standards, particularly through collaboration, education and shared learning. However, our second report noted that less attention had been devoted to addressing issues of quality assurance, including methods of dealing with poor performance. By 2001/02, PCG/Ts had secured the engagement of a majority of health professionals in clinical governance, had developed and extended a wide range of approaches in support of quality improvement, and were focussing on meeting the quality standards set out in the various NSFs. It appeared that PCG/Ts had also established a culture of quality improvement that was increasingly embedded in the organisation’s ethos and was underpinned by the collection and sharing of information on the quality of the services provided.

Such achievements have been realised within an environment of continuing organisational change and often a reported shortage of resources. This raises several challenges. Because the quality improvement agenda is continually expanding with the issue of new NSFs, NICE guidelines and an increasing number of performance targets, there must be doubts about the ability of PCG/Ts to sustain quality improvement activity across all areas of care. It seems likely that PCTs will need to identify areas of priority and concentrate their efforts in these, rather than trying to address all areas.

The Tracker Survey has investigated whether the systems, processes and actions that are required for the implementation of clinical governance are being introduced. It has not collected evidence on the impact of clinical governance on the quality of care that patients receive. However, PCG/Ts are now taking steps to collect information that will inform them of the effects of initiatives to improve quality. Such outcomes are an obvious area on which future research into clinical governance should be focussed.

Sharing, Collaboration and Partnerships

Working across agency and professional boundaries is becoming more common. As organisations become more established there is evidence of increased collaboration within the PCG/T, between neighbouring PCG/Ts, and between PCG/Ts and other organisations (local authorities, the private sector, and multi-agency partnerships).
12.11 There is evidence from our surveys that PCG/Ts were fostering a more collaborative approach to primary care. They were sharing staff, training, information and resources with other PCG/Ts and increasingly with non-NHS bodies in order to provide the services that the local population needs. For example, many of the initiatives to extend services in primary care and develop extended professional roles have been based on making resources available across practices, while partnerships with the private sector were enabling the building of new accommodation or the provision of training in partnership with private sector companies.

12.12 PCG/Ts have made great progress in establishing themselves as part of multi-agency and multi-disciplinary networks whose combined goal is to improve the health of the local population. Health policy continues to encourage closer collaboration between the NHS and other agencies working in areas such as health promotion and health improvement through local strategic partnerships, regeneration and other mechanisms.

12.13 Whilst collaboration within and between the various organisations continues to develop, barriers to ‘seamless’ service provision still exist. These include the physical boundaries between organisations, professional divisions, and priorities set nationally as opposed to the fundamental development of trust and understanding at a local level. The integrated service envisioned in the NHS Plan (Secretary of State for Health, 2000) is still a long way from being realised.

Information

12.14 Our first report highlighted the importance of information to support the core functions of PCG/Ts, but noted the inadequacy of existing information systems. The latest survey suggests that, although there has been some progress, information systems were still perceived to be inadequate. Gaining good quality information at the appropriate time is vital to support functions such as developing primary care, managing budgets, commissioning, quality improvement through the implementation of clinical governance, and in developing partnerships between PCG/Ts as well as with other organisations.

12.15 It is encouraging that after 3 years of development PCG/Ts were making good progress in the IM&T arena. Connectivity (NHS Net, email and internet) rates are high, use of information management tools had increased, and more than half of the PCG/Ts in our sample were involved in the PRIMIS initiative. PCG/Ts have begun to grasp the nettle regarding improved data quality by introducing data standards. However, to maintain this momentum more staff
specifically to support IM&T need to be employed and continued training is required to keep up the improvement of data quality.

12.16 The recently published strategy ‘Delivering 21st Century IT Support to the NHS’ (Department of Health, 2002) stressed the crucial role PCTs have in delivering the IM&T agenda. Furthermore, of the monies allocated in the 2002 spending review, a substantial amount is likely to be invested in IM&T. It will be vital that this new money is used to invest in staff, support and training as well as developing further IT links and raising quality standards.

Commissioning and Providing

12.17 The separation between purchasers and providers of health care services that came into place in the early 1990s has been modified (but continued in principle) in the ‘new’ NHS that has operated since the establishment of PCGs in 1999. The concept of purchasing has been replaced with commissioning. This reflects an intention to introduce a more collaborative process in which the commissioners work with providers in a collaborative framework to plan and improve the supply of services.

12.18 The Tracker Survey showed that in 1999/2000 commissioning was not a high priority for many PCGs, although it became more important in the following year, 2000/01. The responsibilities that primary care organisations had for commissioning grew over those first two-years, and the trend for PCG/Ts to extend their involvement in commissioning care continued in 2001/02. In the third survey we have shown that steps are being taken through the commissioning process that should have a positive effect on health care provision. For example, quality standards are being introduced into service agreements, as are integrated care pathways. Also, infrastructures required for the commissioning function are now largely in place.

12.19 However, there are areas of concern. Trends in simple measures of commissioning performance suggest that how well or less well PCG/Ts perform as commissioners may be linked to the degree of leverage they hold. Yet many PCG/T commissioning leads think their organisations hold little leverage over providers. If the link between leverage and commissioning performance is genuine, steps may need to be taken to find ways of extending commissioners’ leverage.
12.20 With PCTs tending to takeover the responsibility for providing community services, their commissioning of hospital-based services will need to complement their management of community care. Indeed, the introduction of PMS contracts for GPs will make the commissioning of general practice services by PCTs more common. This situation could provide a good opportunity to examine and compare the effects of services being determined by direct and possibly more hierarchical management structures with those that are shaped by perhaps a more collaborative commissioning framework.

**Organisational Development**

12.21 With the substantial increases in NHS funding announced in the past year, an ambitious agenda for modernisation of the NHS, and the abolition of the old health authorities, PCTs face tremendous challenges. While the Tracker Survey has shown substantial progress in organisational development, it has also highlighted a number of areas of concern.

12.22 Local versus national priorities: Tensions between national priorities and local autonomy in the NHS have been apparent since its foundation in 1948. The creation of PCGs and PCTs, and subsequent organisational changes in the NHS, were intended to promote a stronger local focus, allowing health professionals and local communities greater scope to develop local initiatives and determine how best to provide services for their patients. In practice, the imperatives of national policies, targets and guidance have often left little scope for PCG/Ts to focus on issues perceived to be important locally, but which may not be among the highest priorities nationally. The perception that there were insufficient opportunities to address important local issues was apparent in our first and second surveys. In this latest survey, nine out of ten chairs said that they would like more opportunities to focus on local issues and two thirds said that the balance between national and local priorities was wrong.

12.23 Stakeholder engagement: An essential feature of PCG/Ts and of other recent policy initiatives has been the emphasis placed on involving front line health professions in decision-making and engaging with local communities. Shifting the balance of power has become a recurring theme in government policy. However, as mentioned above, there are signs of an increasing frustration, which suggest that the rhetoric may not match the reality. PCG/Ts have worked hard to secure and retain the engagement and commitment of local primary care professionals, but our survey indicates that there remain significant minorities of GPs and nurses who are not supportive. Most PCG/Ts had also made efforts to inform and consult local communities, but almost two
thirds of chairs felt that local people were unaware of the existence of the PCG/T and more than four fifths felt they did not know how to contribute to the decision-making process. If PCTs are to avoid the danger of becoming modified versions of the old health authorities, they will have to continue to work hard to ensure the continued engagement of professional and community stakeholders.

12.24 Expectations and capacity: We have highlighted in previous years a perceived gap between the expectations on PCG/Ts and their capacity in terms of staff and other resources. This gap has not been resolved over time. Virtually all the chief executives mentioned some combination of inadequate infrastructure, shortages of management staff, resource constraints and the pace of change as obstacles to progress. Implementing change whether it be developing new services, increasing access, raising quality standards, delivering better information, or improving information requires high quality management and support services. Many PCG/Ts were experiencing problems in providing these, often because of a lack of money to employ appropriate staff and sometimes because of difficulties in recruiting staff with the necessary expertise and experience.

12.25 Organisational change: The three years since the formation of PCGs has been a period of massive organisational change for most of them. All have progressed from PCG to PCT status, which has brought major changes in organisation, governance and responsibilities, often combined with changes in key personnel. Two thirds of our sample had also been involved in mergers with neighbouring PCG/Ts, often driven by a desire to achieve economies of scale and increase their influence in the local health economy. Whether or not the resulting larger PCTs will realise these anticipated benefits, they are also likely to face increased problems in maintaining a local focus and sustaining the engagement of local stakeholders. Managing these organisational changes inevitably places considerable strain on already stretched managerial resources, with the possible consequence that less effort can be devoted to delivering improvements in services.

12.26 These areas of concern are closely interconnected. The perceived imbalance between national and local priorities may exacerbate problems of engaging local stakeholders. The gap between expectations and capacity may force PCTs to focus on nationally prescribed targets rather than issues perceived to be important locally, and thus frustrate local health professionals and communities. Constant organisational change puts further pressure on already stretched resources and risks alienating stakeholders who may feel less involved in and committed to the new organisation. The creation of PCGs and PCTs was a brave attempt to shift the balance of power in the NHS by bring-
ing decision-making closer to front line health professionals and local communities. The concerns highlighted above represent threats to the realisation of this shift in the balance of power. If PCTs revert to an older style of NHS governance and management that is perceived as distant and bureaucratic, they will have missed an opportunity to transform the NHS by bringing it closer to the people who provide health care and those who use it.

**Taking Responsibility**

12.27 Three years after the birth of PCGs, these fledgling organisations have moved rapidly to full maturity. Their parent organisations, the old health authorities, have gone, and from April 2002 PCTs have become the pivotal organisations in NHS modernisation. They are directly responsible for the provision of primary and community services and indirectly responsible for shaping hospital provision through their role as commissioners. Three quarters of the total NHS budget will now be managed by PCTs. It is no exaggeration to say that the success of the government’s modernisation strategy for the NHS will be dependent on the performance of PCTs. Over the three years of the Tracker Survey, we have highlighted the many achievements of PCG/Ts in putting in place the infrastructure and mechanisms to deliver change, and more recently in developing a host of initiatives to raise quality standards and deliver better services for patients. Given the necessary resources and the time to build on their early successes, we are confident that PCTs can play their role in modernising the NHS. However, in each of our reports we have warned of the risks of a gap between expectations and capacity and of the need to ensure that the initial commitment to promoting local ‘ownership’ and participation is sustained. Most PCTs are only too well aware of the importance of these problems and are making efforts to address them. But they must also be recognised and addressed by government, through the provision of adequate resources to manage change, realistic expectations, sensible timetables for achieving targets, and a willingness to accept that for devolution to become a reality there must be greater scope for PCTs to determine locally what is most important for their patients.


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Glossary

Listed are commonly used terms and abbreviations within this report:

- **CHC** Community Health Council
- **CHD** Coronary Heart Disease
- **CHI** Commission for Health Improvement
- **GP** General Practitioner
- **HImP** Health Improvement Plan
- **HNA** Health Needs Assessment
- **IM&T** Information Management and Technology
- **MIQUEST** Morbidity Information Query Export Syntax
- **NHS** National Health Service
- **NICE** National Institute for Clinical Excellence
- **NSF** National Service Framework
- **PACT** Prescribing and Cost
- **PCG** Primary Care Group
- **PCT** Primary Care Trust
- **PCG/T** Primary Care Group/Trust
- **PMS** Personal Medical Service
- **PRODIGY** Prescribing Rationally with Decision Support in General Practice Study
- **PSG** Prescribing Subgroup
- **SLA** Service Level Agreement
- **TPP** Total Purchasing Pilot