Primary care groups and primary care trusts

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What are primary care groups and primary care trusts?

With the abolition of fundholding, primary care in the UK is being restructured, with the formation of primary care groups (PCGs) in England, local health groups in Wales, and local health care cooperatives (LHCCs) in Scotland. Primary care groups represent all general practitioners (GPs) within defined geographical areas, and covering populations of 50,000–240,000, mostly 80,000–150,000. Following local negotiations, the boundaries of PCGs were defined at the end of 1998. GPs do not have a choice about joining a PCG: their membership is defined by their geographical location. PCGs have now all appointed chief executives, almost all from a management background, and PCGs went ‘live’ on 1 April 1999.

PCGs can operate at four levels. At level 1, they simply act in an advisory capacity to health authorities about the commissioning of hospital and community health services.

At level 2, there will be limited delegation of budgets from the health authority to PCGs for the purchasing of hospital and community health services. Level 2 PCGs therefore start to have some resemblance to fundholders, with the important differences, first, that contracts are for the PCG as a whole and not for individual practices and, secondly, that the PCG has to operate within the overall strategic plan, including the health improvement plan, of the health authority. The chief executive of the PCG is employed by the health authority.

At April 1999, all PCGs were operating at levels 1 or 2, as the necessary legislation does not yet exist for them to proceed to levels 3 and 4.

Closer working with some other sectors is identified as a high priority for PCGs. Social services, the most important example, have representation on all PCG boards, though they currently lose this on the proposed primary care trust (PCT) boards. PCG boundaries have been developed, not always successfully, to map to social services boundaries, and in some cases social services have changed their boundaries to match those of GPs. However, there has been no similar formal attempt to align PCGs with secondary care provision, and there is no secondary care representation on PCG boards.

At level 3, PCGs become PCTs and engage in much wider and more autonomous commissioning of hospital and community health services, and may also make contracts with individual GPs.

At level 4, PCTs continue to commission most hospital and community health services, but also become providers of primary care in their own right, able to employ doctors and other staff. It is anticipated that about 50 PCTs will come into existence in April 2000, and there is likely to be political encouragement for PCGs to move fairly rapidly to trust status.

Some specialised services will be contracted for directly by the health authority or at the level of the regional office at all levels of PCG/PCT.

In Wales, PCGs are called local health groups, but have the similar planned development moving towards organisations with increasing roles in both commissioning secondary care and providing primary care. In Scotland, arrangements are rather different. Scottish LHCCs do not, and will not, have powers to purchase secondary care services which are retained by health boards. Furthermore, the constitution of LHCCs makes them much more multi-disciplinary than PCGs, whose constitution allows GPs to take a dominant role.

Previous purchasing models: fundholding, total purchasing groups and locality commissioning pilots

What can we tell about how PCG/PCTs will operate? The organisation of PCGs is new, but they build on previous NHS reforms, in particular on fundholding, locality commissioning and total purchasing groups.

Fundholding

From the point of view of purchasing secondary care services, the commissioning responsibilities of PCGs and PCTs will be similar to those of fundholding practices. However, they will have to commission for the locality as a whole (not for individual practices), and will be constrained to operate within the strategic plan set out by the health authority, including the health improvement plan.

Total purchasing groups and locality commissioning pilots

The closest previous models to PCG/PCTs were total purchasing groups and locality commissioning pilots. The former ranged in size from 22,000–80,000; they were therefore smaller than most primary care groups but often represented groups of practices making joint decisions. Furthermore, total purchasing groups were formally subcommittees of the health authority, and so had less freedom of action.
than 'regular' fundholding practices in that they were constrained to operate within a strategic framework provided by the health authority. In this way, there are considerable similarities between total purchasing groups and PCG/PCTs, which are also formally accountable to the health authority.

Locality commissioning pilots, which were somewhat larger, covering populations of 50,000–100,000 and including both fundholding and non-fundholding GPs, represented an attempt to broaden fundholding beyond the original single practice arrangement. They represent the best previous model of GPs working together in large groups to commission secondary care services.

There are lessons to be learnt from the way in which both these previous models operated, which may predict some future developments, and are outlined in the following section. Perhaps the most striking finding from studies both of total purchasing groups and of locality commissioning groups, however, is that change was slow1-3. The previous organisations took a large amount of professional time simply to set up. Furthermore, for total purchasing groups, large groups were significantly slower at producing change than smaller ones1. Bearing in mind both that PCGs are larger than almost all the total purchasing groups and that they do not necessarily represent a voluntary association of GPs, it seems likely that changes in service as a result of the new NHS arrangements will not be rapid.

Primary care groups/trusts and the provision of primary care

One of the political reasons for the abolition of fundholding was that it led to substantial inequities between fundholding and non-fundholding practices. This enabled some of the former to develop services to a high level, often offering services normally provided within secondary care. For example, some fundholders were able to use budget savings to build operating suites on to their premises. One of the priorities of PCGs will probably be to even up the funding going to different practices; this will be unpopular with those who benefited from the previous regimen, and popular with those who felt their patients suffered from the inequities. Many specialists will have been associated with the more innovative fundholding developments, and will see changes in these as PCGs endeavour to spread the benefits of the ad hoc local developments possible under the previous schemes.

It is likely that prescribing budgets will be a major source of activity in PCGs in the early years. Experience with locality commissioning groups certainly suggests this; there is no less pressure on prescribing budgets now than when locality commissioning groups came into operation. It is also likely that there will be increasing pressure from PCGs on hospital prescribing, as many high cost prescriptions, particularly of new products, are perceived to originate from specialists. This may be associated with greater exchange of information about prescribing costs across the primary/secondary interface to identify, for example, new products intended for long-term use which are heavily discounted to hospitals to encourage consultants to initiate treatment.

Primary care groups/trusts and the provision of secondary care

The introduction of fundholding produced both improvements and tensions in the relationships between specialists and GPs. There is no doubt that it stimulated a great increase in contact between doctors working in the two sectors – a key aim of some total purchasing sites1. Experience from total purchasing pilots suggests that there could be significant benefits to relationships between primary and secondary care from the new PCG arrangements, but that there may well also be problems.

A number of total purchasing groups planned to reduce hospital admissions and length of stay in hospital, and most who had this specific aim were successful in achieving it1. Groups focusing on mental health problems also encouraged a move of care into the community by encouraging the attachment of specialist staff (usually community psychiatric nurses) to primary care teams and the establishment of community based mental health teams. This was generally welcomed by the staff involved2, but previous work in other specialties has suggested that outpatient outreach services are not necessarily a cost-effective model for widespread use3-6. One of the problems in extrapolating any of the fundholding models to PCGs is to know whether benefits that can be purchased for small patient populations can be generalised when purchasing for a larger population when equitable provision of care is also a priority.

A second lesson from the total purchasing experience is that the priorities identified by primary care practitioners may be different from those identified from within secondary care. In mental health services, priority has increasingly been given to those with severe mental illness, but the priorities of total purchasing groups were more clearly oriented towards the needs of patients with mild to moderate mental illness4,7. PCGs and PCTs will be required to purchase within the overall health improvement plan of the health authority, but it is clear that primary care practitioners will still have a strong voice in this debate.

Fundholders were able to produce rapid, and occasionally destabilising, changes to secondary care services. Experience with total purchasing groups suggests that changes resulting from PCG/PCTs will be more measured, and probably slower. This is partly because of the size of the new organisations, partly because of a greater emphasis on equitable provision of services, and partly because of the requirement for PCGs to operate within the strategic planning framework of the health authority.
What difference will moving from primary care groups to primary care trusts make?

At present, all primary care groups have started at levels 1 or 2. The speed with which PCGs move to levels 3 and 4, and thereby acquire trust status, is unclear and likely to be associated with considerable political controversy. In many ways, a move towards trust status looks attractive to those PCGs who want to increase their influence on the health service. Large total purchasing groups and locality commissioning groups are likely to be among those wanting to advance rapidly towards trust status. There will probably be about 50 PCTs in the first wave in April 2000.

It has also become clear that there will be some losses for PCGs who move towards trust status. The constitution of PCGs gives GPs almost exclusive influence. PCGs must have a majority of GPs, they are guaranteed a GP chairman if they want one, and a PCG board meeting is only quorate if a majority of those present are GPs. Recently announced regulations for PCTs make it clear that the influence of GPs will be considerably reduced in PCTs. The composition of trust boards, as currently proposed, will include the chairman, chief executive, finance director, five lay members and three professional members drawn from the trust executive. This executive is expected to include up to ten clinicians drawn from general practice, community nursing, and community and public health professionals. There is no formal input proposed from either local secondary care providers or social services.

PCTs will be free-standing, legally established, bodies with responsibility for commissioning both primary care and the majority of secondary care. At level 4, they will be able to employ staff and own premises. Their relationship with GPs is initially likely to be that of contracting for the services of individual GP practices. However, they may take on an increasing role as direct employers of GPs. There seems a real possibility that significant amounts of general practice will in future be provided by GPs employed by PCTs rather than as independent GP contractors. At level 4, current community trusts are likely to become merged with PCTs, although how this will happen remains one of the major uncertainties about PCTs.

Many physicians will regard as anomalous the absence of secondary care representation on PCT boards. The justification for this is certainly not related to maintaining a purchaser-provider split, since PCTs will become both providers and purchasers of primary care services, while having strong representation of primary care practitioners on their executive. Specialists will certainly argue that a board with responsibility for purchasing primary and secondary care services for local areas should have representation from secondary care practitioners. This will not be the case, however, as the regulations are currently drawn up, except where specialists are coopted on to trust boards. Indeed, they appear consciously to have been drawn up in this way, as the draft regulations have ‘putting primary care professionals in the driving seat’ as one of four criteria which PCT governance arrangements would need to satisfy.

Primary care groups/trusts and clinical governance

Clinical governance is defined by the Department of Health as:

the means by which NHS organisations are accountable for monitoring and improving the quality of their services.

Clinical governance is intended:

to safeguard high standards of care by creating an environment in which excellence in clinical care will flourish9.

The Royal College of Physicians’ definition of clinical governance emphasises the corporate responsibility of physicians towards the organisation for which they work, and also the reciprocal responsibility of that organisation to provide the conditions under which they can practise high quality medicine10. The corporate notion of clinical governance is likely to be slow to develop in primary care where the challenge is to involve GPs in a cultural shift towards valuing quality improvement.

Clinical governance is intended to impact on care much more broadly than in previous attempts to improve quality, including audit. Indeed, it may well have a significant impact at the interface between primary and secondary care, as PCGs will regard themselves as having responsibility not only for making high quality purchasing decisions but also for ensuring the quality of the services they purchase. This could be seen as a threat, but it is also an opportunity. In anticipation of the formation of PCTs, GPs are already having to think how their clinical governance arrangements can be aligned with those of community trusts. In the same way, there can only be gain from early discussion between clinical governance leads in primary and secondary sectors. Long-standing problems at the interface between primary and secondary care (as viewed from both sides) could start to be addressed through a clinical governance framework.

Primary care groups/trusts and information technology

There will be major changes in information technology over the next few years. All GPs will be connected to the NHS-net within three years. Many hospital laboratories already download their results directly into GPs’ electronic records, and the government is piloting schemes in which GP computer systems are linked directly into hospital outpatient computer systems. There are clearly enormous opportunities to develop improved communication between primary and secondary care over the next few years by electronic transfer of data, including patient details, clinical guidelines, use of e-mail between GPs and consultants, etc.
The PCG/PCT is likely to become the key organisation involved in this, both in terms of integrating and funding information systems within primary care, and acting as the link with secondary care.

**Conclusions**

The formation of PCGs and PCTs represents the current government's endeavour to take what was perceived to have been the best from the old fundholding scheme, but to minimise some of its problems. The change is a radical one: for the first time, GPs are required to have a corporate voice and, through clinical governance arrangements, an element of corporate responsibility for quality of care. The purchaser-provider split remains, with primary care professionals retaining major purchasing power over hospital and community health services. The principal problem of fundholding – the inequities it introduced – should be reduced under the new organisations, though it remains to be seen how purchasing decisions (for both primary and secondary care) will be made within PCGs. However, the general theme of purchasing for populations, not for practices, is in line with the increasing importance attached by the government to a public health perspective on the provision of health care.

The new arrangements do not appear to have been designed to foster relationships between primary and secondary care. They provide a forum in which improved coordination of care and relationships between health professionals could develop, but the absence of representation of specialists on PCTs is likely to be a source of concern in secondary care. It remains anomalous that there is a 'complete' purchaser-provider split for the purchasing of secondary care, but that PCTs will be both purchasers and providers of primary care.

**References**

1. Goodwin N, Mays N, McLeod H, Malbon G, Raftery J, on behalf of the Total Purchasing National Evaluation Team. Evaluation of total purchasing pilots in England and Scotland and implications for primary care groups in England: personal interviews and analysis of routine data. Br Med J 1998;317:256–9.
2. Lee J, Gask L, Roland M, Donnan S. Total purchasing and extended fundholding of mental health services. Final report, 1999. University of Manchester: National Primary Care Research and Development Centre, 1999.
3. Regan E, Smith J, Shapiro J. First off the starting blocks: lessons from GP commissioning pilots for PCGs. University of Birmingham: Health Services Management Centre, 1999.
4. Gask L, Lee J, Donnan S, Roland M. Total purchasing and extended fundholding of mental health services. London: King's Fund, 1998.
5. Black M, Leese B, Gosden T, Mead N. Specialist outreach clinics in general practice: what do they offer? Br J Gen Pract 1997;47:558–61.
6. Gosden T, Black M, Mead N, Leese B. The efficiency of specialist outreach clinics in general practice: is further evaluation needed? J Health Services Res Policy 1997;2:174–9.
7. Lee J, Gask L. Past tense – future imperfect. Health Service J 1998;28 May:24–5.
8. Department of Health. A first class service: quality in the new NHS. London: Department of Health, 1998.
9. Royal College of Physicians. Physicians maintaining good medical practice: clinical governance and self regulation. London: RCP, 1999.

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