Primary Health Care Research and Development 2001; **2**: 167–172

Variations in primary care provision in PCGs in England

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The objectives of this study were to identify the variation in primary care provision in primary care groups (PCGs), to describe the developmental challenges that they face, and to show where investment in primary care should be targeted. Face-to-face semi-structured interviews and postal questionnaires were used. The setting was a 15% (n = 72) random sample of PCGs in England, stratified by NHS region, and the study subjects were PCG Chief Officers, Chairs and health authority PCG leads, as well as PCG board members. In total, 21 PCGs (31%) reported no GP recruitment and retention problems and anticipated none in the next 5 years, but 13 PCGs (19%) had major problems. A total of 13 PCGs (19%) had no problems with staff shortages in general. Problems with access were often confined to particular areas or practices. Fundholding services that were either discontinued or under threat included counselling, physiotherapy, complementary medicine and outreach clinics. A total of 22 PCGs (24%) planned to redistribute GMS cash-limited budgets to practices, but 44 PCGs (49%) had no such plans. In addressing poorly performing practices, the emphasis was against taking punitive action. It is concluded that PCGs have inherited diverse practice groupings which have not previously been united in a single organization. Most of them face staffing problems, but few have developed detailed workforce plans. The main priorities for investment are prescribing support, information, nursing staff and clinical governance. Many PCGs had discontinued fundholding services in the interests of equity. Without a committed workforce, and an infrastructure to support improved services, the goal of improved services for all will be difficult to achieve.

Key words: primary care; primary care groups; service provision; variations

Introduction

PCGs have inherited a system of general practice provision based on independent practices, many of which have been unused to working together. In their first year, PCGs have had to take stock of this inheritance and begin planning for the future (Department of Health, 1997). Among the important tasks facing them were the need to (1) itemize their basic practice infrastructure, (2) assess their needs for investment in primary care, (3) establish priorities for the development of local general practice (4), establish criteria and systems for allocating resources and promoting service development and (5) manage the abolition of fundholding.

Furthermore, the considerable variation in the quality of primary care provision was exacerbated by the differential resourcing of fundholding practices (Le Grand *et al*., 1998). The advent of PCG/PCTs presents an opportunity to rectify these inequalities (Hart, 1974; Leese and Bosanquet, 1995; Ennew *et al*., 1998) and raise the standard of all practices to the level of the best.

The application of clinical governance in PCGs is dependent on the existence of an adequate infrastructure (human resources, premises and equipment) on which the provision of high-quality, accessible and appropriate services depends. Each PCG has drawn up a Primary Care Investment Plan (PCIP) (Department of Health,

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1463-4236(2001)PC062OA

1998) which sets out existing levels of investment in resources, identifies gaps and provides an implementation plan to rectify underprovision. The combination of clinical governance, PCG/PCTs and PCIPs is an important tool for improving service provision in primary care.

As part of the National Tracker Survey of a sample of PCGs in England, we have collected baseline data on general practice infrastructure and the ways in which this might be changed to improve services (Wilkin *et al*., 2000).

Methods

In March 1999 the Department of Health commissioned the National Primary Care Research and Development Centre and the King's Fund to undertake a longitudinal survey of a representative sample of PCGs in order to support the development of PCG/PCTs and inform policy formulation and implementation. In the first year, the National Tracker Survey has concentrated on describing how PCGs are approaching their core functions, their priorities for service development and their goals for the future.

The survey is based on a 15% (n = 72) random sample of all 481 PCGs in England, stratified by NHS region. Data were collected by means of face-to-face semi-structured interviews with the Chief Officers and Chairs of the sample PCGs, and the relevant health authority leads. Postal questionnaires were sent to selected members of the PCG boards. The data presented here are mainly derived from the interviews with Chairs, 94% of whom were GPs. The data were collected during September and October 1999, and were analysed using the Statistical Package for the Social Sciences (SPSS 9).

Results

The basic infrastructure

PCGs have inherited a diverse collection of experience, resources and people that had not previously been united within a single organization. Most PCGs in the study could call on some experience among their practices of working collaboratively in the various models of commissioning and in out-of-hours co-operatives. Those PCGs with no experience other than fundholding were primarily urban in character, but could be expected to benefit from the greater experience of adjacent PCGs in the same health authority.

Only 22 PCGs (30%) included a first- or second-wave PMS pilot at this stage, and 17 PCGs (22%) had Beacon practices within their locality. Over the next year, 24 PCGs (33%) anticipated having access to a Healthy Living Centre.

Human resources

Adequate numbers of general practitioners are crucial for providing a service that is able to respond to clinical governance demands. A total of 21 PCGs (31%) reported no recruitment problems and did not anticipate any in the next five years, but 13 PCGs (19%) had major problems. At this stage, just one-third of PCGs had policies to deal with GP recruitment and retention.

Many PCGs were considering salaried general practice as one solution to the problems of recruitment and retention. In total, 17 Chairs (24%) reported definite plans and a further 25 Chairs (36%) were considering salaried GP schemes. Most commonly this was to improve services to particular local areas.

Only 13 PCGs (19%) had no problems with staff shortages in general. In total, 28 PCGs (40%) had practice nurse shortages, 33 PCGs (47%) had shortages of professions allied to medicine, 19 PCGs (27%) had shortages of administrative/clerical staff, and 9 PCGs (13%) had problems recruiting pharmacists.

Little detailed workforce planning had yet been undertaken by PCGs, despite the fact that this was an important plank in the NHS policy changes. Support for PCGs in this area from health authorities was regarded as poor, and 29 PCGs (40%) would welcome more support. Information is crucial for tackling workforce problems. A total of 61 PCGs (87%) had information on staff numbers for all practices, but only a minority had information on practice staff qualifications and skills (n = 32, 46%) or staff turnover for all practices (n = 20, 30%). A total of 40 PCGs (58%) had assessed the adequacy of their primary care workforce in terms of the numbers of staff, and 37 PCGs (54%) had assessed the adequacy of their workforce in terms of types of staff and their location in practices, usually as part of the PCIP. Only 12 PCGs had a written primary care workforce strategy.

Finally, initiatives to develop and improve primary care provision will often depend on a small number of 'innovators' – general practitioners known locally for their forward thinking and ability to enthuse others (Bosanquet and Leese, 1988; Ennew *et al*., 1998). A total of 59 PCG Chief Officers (83%) and 55 Chairs (83%) felt that this description applied to less than 20% of their constituents (see Table 1).

Premises and equipment

Although most practice premises have improved substantially in recent years, 47 Chairs (72%) reported that they had at least one practice with premises falling below minimum standards. In addition, 27 Chairs (39%) reported that at least one practice in their PCG was under-resourced in terms of equipment, whilst 49 Chairs (83%) reported that at least one practice was under-resourced in terms of staff. In addition, one-third of respondents identified infrastructure deficiencies as a principal obstacle to success in improving services to patients.

Primary care investment

Only 34 Chairs (49%) felt that the health improvement plan (HImP) had strongly influenced the formulation of their PCIP. A total of 33 PCGs (47%) had guidelines in place for prioritizing primary care investment bids, and a further 32 PCGs (46%) either had definite plans or were involved in discussions. Similarly, 39 PCGs (56%) had guidelines for assessing the continued funding of practice-based services, as had 21 PCGs (30%) for broadening access to practice-based equipment or services.

Some PCGs definitely planned to redistribute GMS cash-limited budgets to practices. For 22 PCGs (24%) this was a possibility, but 44 PCGs (49%) indicated that they had no plans in this area. Such unwillingness to redistribute resources is likely to change over time as PCGs develop incentive schemes.

There are a number of approaches which can be used to address the problem of poorly performing practices. The response of PCG Chairs is shown in Table 2. The emphasis was on rewarding those that were performing well, rather than taking punitive action against those in difficulties.

On a scale of 1 to 5 (where 1 = very low priority and 5 = very high priority), Chairs identified the highest priorities for their PCGs as prescribing support, information technology, nursing staff and clinical governance, with the lowest priorities being equipment and out-of-hours services (see Table 3).

At this stage, PCG Chairs tended to couch community health services priorities in terms of general principles. For example, 26 respondents (36%) emphasized equity of access to services such as

Table 1 PCG Chief Officer and Chair views of the percentage of innovator GPs and poorly performing and excellent practices per PCG

Percentage	Number (and percentage) of PCGs with stated percentage of innovator GPs		Number (and percentage) of PCGs with stated percentage of poorly performing practices		Number (and percentage) of PCGs with stated percentage of excllent practices	
	Chief Officer	Chair	Chief Officer	Chair	Chief Officer	Chair
0	2 (3)	2 (3)	14 (22)	23 (38)	1 (2)	1 (2)
1–10	30 (42)	25 (38)	15 (24)	11 (18)	3 (5)	2 (4)
11–20	27 (38)	27 (41)	23 (37)	19 (32)	10 (17)	1 (2)
21–30	6 (8)	5 (8)	9 (14)	6 (10)	10 (17)	7 (13)
31–40	3 (4)	4 (6)	2 (3)	1 (2)	14 (24)	9 (17)
41–50	2 (3)	1 (2)	0 (0)	0 (0)	4 (7)	2 (4)
51–60	1 (1)	1 (2)	0 (0)	0 (0)	6 (10)	3 (6)
61–70	0 (0)	0 (0)	0 (0)	0 (0)	1 (2)	9 (17)
71–80	0 (0)	0 (0)	0 (0)	0 (0)	2 (3)	5 (10)
81–90	0 (0)	0 (0)	0 (0)	0 (0)	4 (7)	5 (10)
91–100	0 (0)	1 (2)	0 (0)	0 (0)	4 (7)	8 (15)
Total	71 (100)	66 (100)	63 (100)	60 (100)	59 (100)	52 (100)

https://doi.org/10.1191/146342301678227860 Published online by Cambridge University Press

Table 2 Approaches for dealing with poorly performing practices (n = 70)[a]

Approach	Not using approach	Using approach	Approach planned
Even up resources so that there is an equitable distribution of staff between practices	19 (27)	24 (34)	27 (39)
Reward practices which have achieved high standards	24 (34)	26 (37)	20 (29)
Target additional resources to practices which experience difficulty in meeting standards	15 (21)	19 (27)	36 (51)
Look for improved performance from practices to justify further investment	23 (33)	15 (21)	32 (46)
Gradually withdraw resources from failing practices	60 (86)	1 (1)	9 (13)

[a]Numbers are shown, with percentage values in parentheses.

Table 3 Priority attached by PCGs to specified categories of primary care investment

Investment priority	Mean score	Percentage scoring 4 or 5
Prescribing	4.41	90
IM&T hardware and software	4.37	87
Nursing staff	4.32	82
Clinical governance	4.18	81
Medical staff	3.88	65
Other practice staff	3.85	67
Premises	3.81	66
IM&T staff	3.47	51
Out-of-hours service	3.19	46
Equipment	3.06	31

IM&T, Information management and technology.

physiotherapy and chiropody. More specifically, the development of intermediate care was urged, and many hoped to commission 24-hour nursing care where this was not already available. There was also widespread interest in establishing or extending 'hospital at home', rapid response schemes and community hospital provision as alternatives to acute hospital care. Community mental health services and substance misuse services were other areas where closer integration was required. The importance of collaboration between social services and community health services was emphasized, and joint training initiatives were suggested to encourage the sharing of information and skills.

Abolition of fundholding

Many former fundholding practices have been concerned that the services which they were able to provide under the scheme might be discontinued. A total of 33 PCG Chairs (47%) said that there had been some reduction or discontinuity of fundholding services, and 19 Chairs (27%) indicated that services were under threat. Most commonly these were counselling, physiotherapy, complementary therapies and practice-based outreach clinics.

Availability and access to care

Most PCGs reported some problems with access to general practitioner services, but these were often confined to particular areas or practices. A total of 16 PCGs (23%) reported substantial problems caused by insufficient doctors, 17 PCGs (24%) reported problems due to large list sizes, and 20 PCGs (29%) reported problems caused by long waiting times for appointments. In some areas improved access was already being promoted through, for example, telephone advice and management by community pharmacists in 15 PCGs (21%) and provision of information on self-care in 24 PCGs (34%). At the time of the survey, NHS Direct was active in 29 PCGs (38%), but only two (3%) had Walk-In Centres.

PCG Chief Officers and Chairs had no difficulty in identifying the numbers of excellent and poorly performing practices in their PCGs. All except one were able to identify at least one 'excellent' practice, but 49 (78%) and 37 (59%) Chief Officers and Chairs, respectively, identified at least one practice

which they felt was providing a poor service to its patients.

Impact to date

Chairs and GP board members were asked to indicate on a scale of 1 to 5 whether the PCG had so far made an impact on specified areas of health care. The mean scores are listed in Table 4. None of the mean scores was higher than 3, indicating that, in the respondents' opinion, PCGs had had little impact on any of the issues specified. Both groups held similar views, with prescribing perceived to be the area where there had been the greatest impact. Unsurprisingly, PCG Chairs viewed the health authorities' capacity to support primary care development less positively than did health authority leads.

Discussion

In order for clinical governance successfully to deliver a quality service to all patients, regardless of the nature of the area in which they live, an adequate infrastructure has to be in place. This includes staff, premises and equipment, and should precede any change in service provision.

Our study has highlighted the variability in the PCGs/PCTs' inheritance. PCGs/PCTs with little or no experience of collaborative working may find it difficult to reach agreement about how to prioritize services and move forward in the difficult area of reallocation of resources which may be necessary in order for an equitable service to be delivered to all. Although many PCGs/PCTs contain some practices which have worked collaboratively in commissioning, most practices are used to competing for new resources. Total purchasing pilots expended considerable effort initially on building relationships and learning to work together (Mays *et al*., 1999). Similarly, PCGs/PCTs must foster a new climate of co-operation, and will need to build on their earlier experiences where possible.

Table 4 Impact of the PCG

Impact area	Chairs' mean score	GP board members' mean score
Prescribing	2.58	2.53
Prevention and health promotion	2.10	2.19
Care of patients with chronic illness	2.01	2.00
Referral to specialists	1.82	1.89
Access to general practice	1.61	1.85

Their first task is to gain collective ownership of the priority-setting process in support of the PCIP. PCGs/PCTs have to find ways of redistributing scarce resources so that they have maximum impact. The challenge of targeting under-resourced practices in a manner that is both efficient and rewards good practice is bound to be contentious, but it needs to be tackled imminently. Failure to gain support for this process could destabilize PCGs/PCTs. Support from health authorities in terms of information management and technology infrastructure is necessary to ensure that PCGs/PCTs have the information they require regarding their workforce and practice infrastructure.

Our study underlines how variable is the different PCGs/PCTs' inheritance. PCGs/PCTs with a larger burden of primary care investment are bound to be limited with regard to what they can spend in other sectors. Many PCGs, particularly those in urban and inner-city areas, face problems with staff recruitment and retention. The increasing numbers of PMS pilots may help in some areas, not only by recruiting salaried general practitioners, but also in providing more accessible services to under-served groups in the population (Lewis and Gillam, 1999).

Workforce shortages affect all primary care disciplines. Some PCGs/PCTs will have to invest considerably in premises and equipment in order to provide an improved service. In addition, the contentious issue of sharing resources between practices will have to be addressed.

Similarly, poorly performing practices will have to be tackled by PCGs/PCTs in order to implement clinical governance, and many have already started this process. At least initially, the emphasis is on rewarding practices that are performing well, but it is difficult to say how long such measures will be possible where resources are fixed. However, these issues are eventually likely to cause some difficulties in some areas unless PCGs/PCTs are prepared to centralize some services – that is, some practices will have to give up some of their services in order for the wider population of the

PCG/PCT to derive benefit. This is likely to be the case, particularly for those services that were previously provided under fundholding. These issues will need to be addressed if clinical governance is to deliver the desired changes.

The findings of this study strengthen the case for many of the initiatives set out in the NHS Plan (Department of Health, 2000). These include provision of funds for investment in GP premises, and for more doctors and nurses to deliver an improved service, coupled with a resolve to 'increase and improve primary care in deprived areas'.

Subsequent rounds of the Tracker Survey will measure the progress of PCGs/PCTs in developing primary care. Without a committed workforce that is willing to encompass change, high-quality information, and premises and equipment capable of supporting new and improved services, the drive to eliminate variation in primary care provision will be long and hard.

Acknowledgements

This study was funded by the Department of Health. However, any views expressed are those of the authors and not of the Department of Health. We would like to thank the interviewers and participants in this study.

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