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OHE briefing

GP COMMISSIONING GROUPS – THE NOTTINGHAM EXPERIENCE

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1. INTRODUCTION

From 1 April 1999 the structure of the Health Service in the United Kingdom will look radically different. In England there will be Primary Care Groups (PCGs), in Scotland Primary Care Trusts, and in Wales Local Health Groups. The pattern in Northern Ireland is still awaited. These different solutions for England, Scotland and Wales have one thing in common; they are being introduced across the board for the whole population untried and untested.

A criticism made of the introduction of fundholding was that it was not piloted before its introduction. However, fundholding was at least introduced in waves of successive practices joining each year. This allowed the lessons learned by the first wave fundholders to be passed on to subsequent waves. As from next April the whole of the NHS will be in the 'first wave' of the new structures. Because there are no pilots to learn from we have to look elsewhere for examples of similar initiatives that can help us to predict what the likely problems will be in the setting up of these new groups. Three obvious places to look are the Primary Care Act Pilots, Total Purchasing Pilots and Total Commissioning Pilots.

Contents

This paper is looking at the experience of the Nottingham Total Commissioning Project (TCP), one of the largest to be set up. The experiences of this group in attempting to commission secondary care services will be valuable in predicting the likely impact of PCGs in their commissioning role. For reasons that will become apparent later on, the TCP has also given us experience of trying to tackle clinical governance issues; in particular in relation to prescribing. For these reasons the TCP can be seen as a model for the commissioning roles of PCGs and should shed some useful light on this area.

Background

Nottingham Health Authority serves a population of 637,000 which includes the City of Nottingham and surrounding urban and rural areas. Within the city are a number of areas with significant deprivation and high unemployment. Prenatal mortality, teenage conception rates and sexually transmitted disease rates are all above average for the Trent Region.

There are 322 GPs working in 118 practices. Of these, 87 GPs are in fundholding practices and there is one Total Purchasing Pilot with a practice population of 11,000. There are five NHS Trusts in Nottingham: two Acute Hospital Trusts, a Mental Health Trust, a Community Health Trust and an Ambulance Trust. Historically GP prescribing is consistently low (currently 8% below the Trent Region average). Also, Nottingham is a historically underfunded district for the Hospital and Community Health Services (HCHS) allocation (currently 3.5% below target). Nottingham is a Teaching District with Nottingham University Medical School and compared with other Teaching Districts this under-resourcing of HCHS is even more dramatic

making it the third most underfunded teaching district after Kensington and East London. Nottingham has an excellent record of collaborative working and over the years very good relations have been built up between the Health Authority, Local Medical Committee (LMC-representing general practice) and the secondary care sector.

Development of the commissioning group

On 30 September 1997 Frank Dobson, Secretary of State for Health, announced outline approval for 42 pilot commissioning projects in England. Nottingham's Total Commissioning Pilot was one of those approved. With the involvement of 288 GPs it is the largest of the 39 national GP Commissioning Group Pilots that went live on 1 April 1998.

However, the history of this group goes back to 1992. It developed out of the Nottingham Non-Fundholders Group, which was set up to represent the views of non-fundholding GPs to the Health Authority who were purchasing services on their behalf.[1] Through this influence the group hoped to avoid the two-tierism of fundholding and this was reflected in its guiding principles of equity and co-operation.

Fundholding never really took off in Nottingham and even at its height little more than a quarter of the population were covered by fundholding practices. Part of the reason for this lack of enthusiasm for fundholding may well have been the very success of the Nottingham Non-Fundholders Group in securing a seat at the table in negotiations on the placing of secondary care contracts in Nottingham. GPs felt that they had a say in the decisions being made, but they themselves could delegate the administrative burden of contract setting and monitoring to the Health Authority and the small group of GPs representing their views via the Non-Fundholders Group.

From its outset this group represented the views of about 200 GPs (67% of Nottingham GPs) serving a population of about 400,000. In practical terms the group represented the main source of GP advice to the Health Authority on healthcare commissioning matters and was the major purchaser as far as local NHS Trusts were concerned. This position of strength allowed the Health Authority to adopt a 'most advantageous purchaser status' in contracts, whereby the Health Authority would contract with a provider on the basis of the most advantageous specification in use in Nottingham – in this way any two-tier provision was avoided.

By the end of 1994 it became clear that the model of a purchaser-provider split was here to stay whatever government came to power and plans were drawn up to widen the scope of the Non-Fundholders' Group to become a Total Commissioning Project (TCP) in line with EL(94)79 'Developing NHS Purchasing and GP Fundholding'. The proposed TCP was to have the ability to vire money between HCHS and General Medical Services (GMS) budgets. It was also hoped that the scheme would attract money analagous to the fundholders' management allowance which could then be used to support the scheme and develop the information management and technology (IM&T) strategy for Nottingham GP commissioning. Over the following two years discussions with the Department of Health resulted in the final shape of the Nottingham TCP. Significant changes introduced by the Department of Health included a prescribing budget cash-limited at district level.[2] Elections to the 16 places on the GP forum took place in September 1997 and the first meeting was held in October 1997.

From 1 April 1999 Nottingham is to have six PCGs. The current plan is that three GPs from each of the six PCG boards will sit on a Nottingham-wide Collaborative Commissioning Mechanism. This takes over the role of the TCP from 1st December 1998. The plan is for this to be paid for out of the management allowances of the PCGs. It has yet to be seen whether all the PCG boards will be happy with this arrangement and to what extent they will wish to keep control over secondary care commissioning at a local level. There is also some debate over whether 18 GPs are required for this job, or whether these could be made up by other board members such as social services, nursing or lay members.

2. ORGANISATION OF THE NOTTINGHAM TOTAL COMMISSIONING PROJECT

Who is involved

288 GPs have signed up to being part of the Nottingham TCP. These include fundholders as well as non-fundholders. 58 of the current 87 fundholding GPs in Nottingham have joined the TCP. A 'TCP Forum' of 16 GPs was elected by the GPs signed up to the TCP. The election was carried out under the Single Transferable Vote system and was conducted on behalf of the TCP by the LMC secretariat. The election was from a single constituency and this did create some anomalies in the geographical location of GPs, for example three of the 16 come from one practice! Four of the 16 are fundholders. Overall the group

represents a wide range of expertise with amongst the 16 GPs: two who are involved in national medical politics; a GP advisor to the NHS Executive on IT; the secretary of the LMC; academic GPs; inner city GPs; rural GPs; and several leading members of the former Non-Fundholders Group. This high degree of experience and outside involvement has proved useful in the 'boundary-spanning' role of the TCP needing, as it does, to keep abreast of the rapidly changing health scene. The disadvantage of this form of election is that being district wide there are not necessarily direct links between any one TCP member and a defined constituency. To try and get around this each member was allocated a group of between four and nine practices to be responsible for as their constituency; the idea being that they would act as a two way channel of communication between these practices and the TCP.

Who they work with

As well as relating to their GP colleagues, the TCP works in partnership with the Health Authority. This partnership takes place at a number of different levels. At the top, a Project Board made up of four of the TCP members and the five executive members of the Health Authority is the body that oversees the day to day running of the project. It meets fortnightly and is a key focus for liaison between the TCP and the Health Authority at an executive level.

Each of the 16 TCP Forum members is attached to a Programme Team. There are four Programme Teams covering different areas of commissioning, described in Figure 1. At this level the GP members are working with Health Authority staff involved in commissioning and in the Public Health function, and there is also Community Health Council (CHC) representation on the teams. Through the Programme Teams and through Specialty Fora, meetings are held with particular clinician groups from the provider Trusts to discuss specific issues.

Much of the work done at Specialty Fora is background work for decisions later taken at the TCP Forum. Examples of decisions made at Speciality Fora are:

- production of district-wide gastroenterology guidelines including the introduction of testing for H.pylori in general practice;
- production of ophthalmology guidelines;
- agreement not to introduce pre-school eye screening due to lack of evidence;
- agreement to include clinical quality and service delivery improvements in the business case for a new-build scheme for ENT and ophthalmology at the local acute hospital;
- production of clinical guidelines in urology.

Each of the Programme Teams also has lead responsibility for particular provider Trusts and works with the management of those Trusts in the contract setting process. On some issues, groups involving GPs and Health Authority staff work on particular subjects outside the programme structure, for example: information and IT, prescribing advice, resource allocation.

Figure 1 **Nottingham Health Programmes of Care**

Programme 1 – A Healthier Future

Aims to ensure that the next generation of adults is as healthy as possible.

Encompasses the health of women (including maternity services), children and young people and sexual health.

Programme 2 – Health Maintenance

Aims to ensure swift access to services which meet short term needs and most effective delivery of these services.

Encompasses the whole of the adult population, dealing with mainly short term problems which can be resolved. The main specialties involved are accident and emergency medicine and the surgical specialties.

Programme 3 – Ill Health and Disability Management

Aims to manage long term problems in a caring and locally sensitive way.

Encompasses the specific problems of elderly people together with mainly chronic and long term health problems of the whole population requiring high cost provision, extensive rehabilitation and care.

Programme 4 – Mental Health, Substance Abuse and Learning Disabilities

Aims to ensure high quality, locally based services for people with mental health problems or learning disabilities.

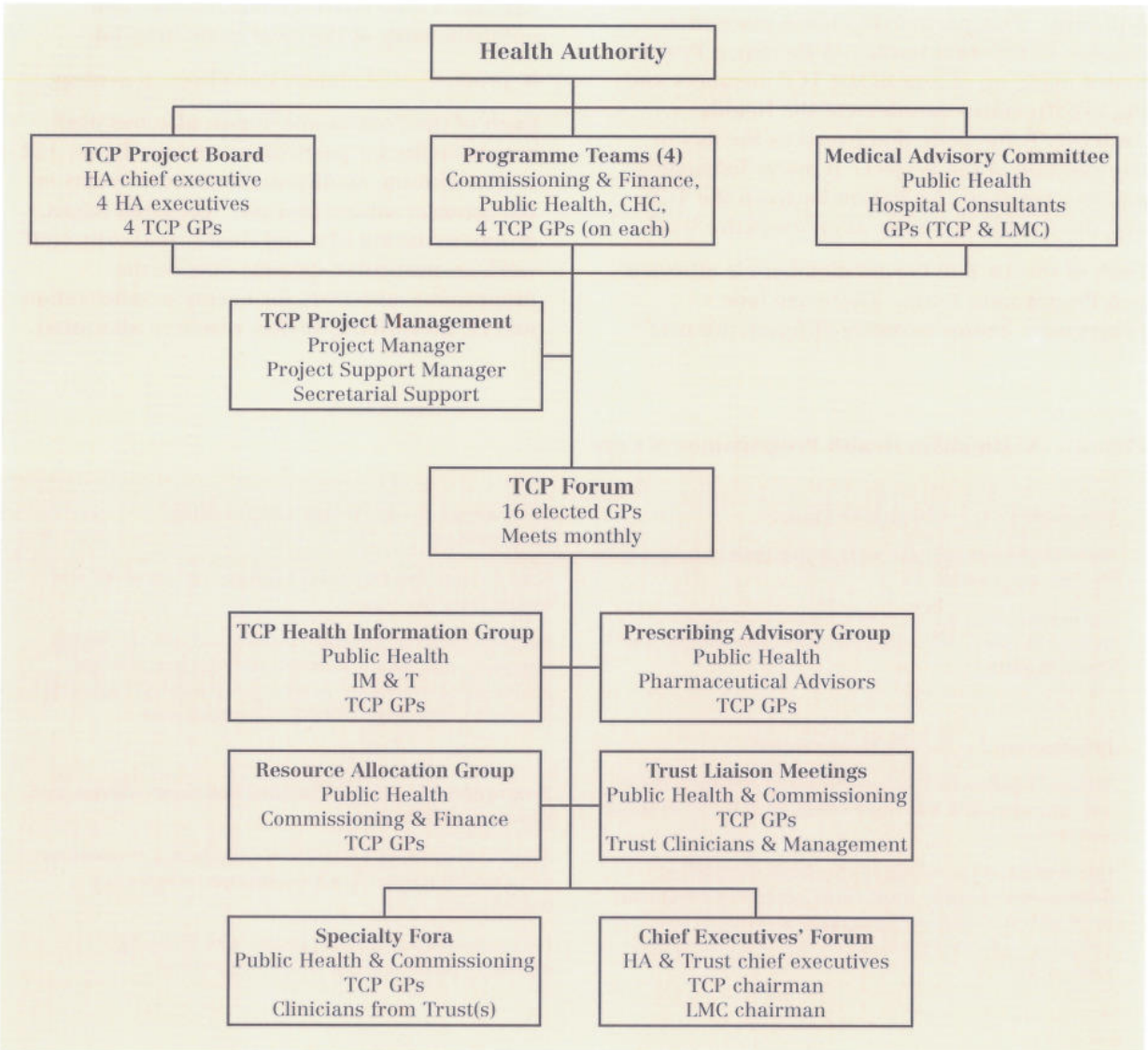
Encompassing all mental health and learning disability issues for the adult community.

Structures

The structure of the TCP and its related committees is illustrated in Figure 2. The TCP Forum of 16 GPs elects from within itself the four GPs who sit on the Project Board along with the five Health Authority executives. The TCP has representation on the Medical Advisory Committee, which is a committee of the Health Authority made up of clinicians from primary care, secondary care and public health, whose function is to provide advice to the Health Authority and by implication the TCP on medium to long term strategy on clinical issues. The Programme Teams advise on contracting within their specialty areas and have membership made up of GPs from the TCP, public health clinicians, commissioning managers and a representative from the CHC. The Chief Executives' Forum is a liaison group comprising the Chief Executives of the five Trusts, the Health Authority Chief Executive, The TCP chairman and the LMC chairman. It meets regularly and its aim is to keep the different key players aware of developments and to allow a united strategy to develop for healthcare in Nottingham.

The LMC has been generally supportive of the TCP whilst retaining its role of representing all of general practice. A number of TCP members are also elected members of the LMC and this has helped communication. The LMC continues to be the body that advises the Health Authority on primary care matters.

Figure 2 **Structure of Nottingham Total Commissioning Pilot**



External relationships

Historically relations between the Health Authority and GPs have been good in Nottingham. The Non-Fundholders Group was seen as being an opportunity to reduce the isolation of the Authority and the development of the group was described as 'empowering the Health Authority'. The Health Authority have been supportive of the move to a TCP and the setting up of this has been very much a joint venture. There is however little doubt that the relationship between the TCP and Health Authority is still in a state of flux. In these early days it is still not clear where the power lies. The wording of the agreements is one of power sharing, but with a Project Board that has five Health Authority members to four GPs one must be a little sceptical about who has real power. Ultimately financial responsibility rests with the Health Authority Chief Executive as accountable officer and this must always colour the decision making however much lip service is paid to sharing power. Another aspect of this is that the TCP members are paid on a sessional basis by the Health Authority. Does this make them salaried employees of the health authority and what implications does this have for their independence when making commissioning decisions?

Within the Health Authority itself the relationships are also complex. On the whole the commissioning and contract setting managers see the GPs as being very useful members of their negotiating armamentarium and the relationships are generally good, likewise with other members of the Programme Teams which generally function well. There are at times tensions between the Health Authority's Public Health Department and the TCP. It would seem that Public Health has yet to find its role in relation to the TCP which at times is seen as 'invading its territory'. Conversely the TCP has perhaps been reluctant to make full use of its Public Health colleagues for expert advice, preferring to rely on its internal sources of information.

The relationship with the provider Trusts is much more at arm's length. The Programme Teams meet with Trust clinicians and management to discuss particular contracting and development issues. To date many of these meetings have been more confrontational than collaborative. Some secondary care consultants have found it hard to work with the TCP and the Health Authority in a collaborative way. They still see the Health Authority as the body who should come up with the money for their latest schemes without asking too many questions and are quite affronted by the need to justify their activity to GPs and Public Health physicians sitting across the table from them. The Chief Executives' Forum has helped to develop strategic planning, but at the specialty level the discussion is often over short term funding issues rather than taking the longer view. There have been some attempts to set up specialty fora with clinicians from different provider Trusts sitting round the table to try and sort out common policy within their specialty. These have been of varied success to date, largely because the different secondary care clinicians have found it difficult to present a united front.

The relationship between GPs and the TCP is also still being worked on. The lack of a clear locality focus has resulted in some GPs feeling that they don't have a voice at the TCP table. This is despite the setting up of an artificial constituency structure. The respective roles of the TCP and the LMC are not always clear. The LMC has the statutory responsibility to represent general practice, but in support of the TCP has withdrawn from giving commissioning advice and is developing its role as the source of advice on primary care matters. This distinction is at times subtle and there is still a fair degree of confusion amongst GPs and the Health Authority staff about the respective roles of the TCP and the LMC. With the increasing realisation by the TCP members of the workload involved, they are anxious not to take on the role of the LMC in dealing with primary care matters. It is perceived by both the TCP and the LMC that there is more than enough work to go round and the two organisations are working hard to develop complementary roles. Generally the TCP is perceived to be 'a good thing', but perhaps rather distant and remote from everyday general practice.

Perhaps more worrying is the lack of any attempt to date to involve other professional groups in the TCP. The forum is entirely made up of GPs. Little attempt has been made to engage with nursing or social service colleagues. The English NHS White Paper 'The New NHS: modern, dependable', makes specific reference to the involvement of community nurses in Primary Care Groups and this is an area that the TCP will have to face up to if it is to progress to PCG status in the future. In some ways the structure and perhaps also the attitudes of the TCP are rather old fashioned in being doctor dominated and very much GP led rather than primary care led. The wider aspects of working with Social Services, Education and Housing as espoused in the White[3] and Green[4] Papers is something that the TCP has yet to take on board.

It is interesting to compare this with a local

Primary Care Act Pilot, 'PRIME', which is being set up in one part of the City of Nottingham to pilot joint management of primary and community health services. This pilot has from its inception had involvement from the local community, from the City Council and Social Services, from community and practice nursing and the CHC; a very different model of collaborative working.

Decision making

The TCP is expected to advise the Health Authority on a wide range of broadly commissioning issues. However, the distinction between advice giving and joint decision making with the Health Authority is still unclear. Decisions are made at the level of Programme Teams, the monthly TCP forum of 16 GPs, and the fortnightly TCP Project Board of four GPs sitting with four Health Authority executives and the Health Authority Chief Executive. There is no formal mechanism for involvement at a level below that of the TCP Forum. Constituencies, so far as they exist, are for consultation purposes only. All GPs in the TCP are sent a monthly newsletter giving details of general matters to do with the TCP on the first page and on the second page news of developments from each of the four programme teams. However, apart from the annual election of Forum GPs, which is not done by constituency, individual GPs have no direct input into the decision making processes. Most of the day to day decision making is done at the Programme Team level, although major decisions are sent to the Forum for discussion, and many decisions are reported to the Forum. Decisions are sent to the Forum from both the Programme Teams and downward from the Project Board. Major decisions then go back up to the Project Board for the agreement of the Health Authority executives. Examples of some of the decisions taken at the TCP forum level during its first eight months are given in Figure 3.

It will of course be obvious that the TCP GPs are in a minority on the Project Board of four out of nine. This means that the ultimate decision making power is retained by the Health Authority. It is hard to equate this with true 'power sharing' and in terms of possible PCG level as set out in the White Paper this puts the TCP at level 1, acting merely as advisors to the Health Authority, although with a cash limited budget for GMS Prescribing. It could be argued that the GPs are being used to dilute the responsibility held by the Health Authority in the face of criticism of rationing decisions. On the positive side, however, there is no doubt that the GPs are being listened to, particularly at the

Figure 3 **Examples of decisions made at the TCP Forum**

Fertility services

Decided that IVF services on the NHS in Nottingham would finish as from 1/4/98.

Termination of pregnancy

Agreed that this was a form of gynaecological emergency and should therefore be given high priority, even if this meant disinvestment from other services. Decision to pay for a pilot scheme to provide medical terminations.

Prescribing Incentive Scheme*

Decision to have a ringfenced prescribing incentive scheme at a practice level. (Later overturned by the Project Board)

ENT/Ophthalmology new build

Ongoing involvement in the decision making process on this major PFI scheme.

Gender reassignment

Decision to limit expenditure to the level required to treat one or at most 2 patients per year.

Substance abuse

Decision to set up satellite specialist clinics.

Complementary therapies*

Decision not to set up a contract for the provision of complementary therapies and not to approve ECR payments for complementary therapies.

Psychological therapies

Agreed to redistribute staff providing psychological therapies on the basis of need rather than on historical practice pattern that currently exists.

Fast-track physiotherapy service for back pain

A scheme for rapid access physiotherapy for patients with back pain to be made available across the district.

(*Indicates decisions on which a formal vote was taken, neither of which was passed unanimously.)

Programme Team level. The working relationship between GPs, Health Authority commissioning management and Public Health is mostly good and in many cases these Programme Teams are truly working as teams.

Most of the tensions so far seem to be arising at the TCP Forum level at which GPs are being asked to make decisions, but it is not clear what influence these decisions then have on the final outcome at a Health Authority executive level. The quality (and quantity) of Public Health input at a Forum level is often less than that in the Programme Teams. This leaves the GPs in the difficult situation of being asked for their opinions on investment decisions relying largely on the knowledge base of the 16 GPs seated round the table. The lack of any direct input from either the Public Health or Finance functions of the Health Authority at these Forum meetings reduces the effective decision making capability of the Forum, which instead relies to a large extent on the intuitive decision making of the GPs.

In management terms the TCP is operating in a fairly simple but unstable environment. The number of provider Trusts is limited, but the pace of change in medicine is rapid with the evidence base for these changes lagging behind the demand for new services. To cope with such an environment one would expect to see an organic structure with active teamwork, decentralised decision making and evidence of extensive boundary spanning. This is certainly the structure found at a Programme Team level, but seems to be lost at the Forum level. The Carnegie model[5] of organisational decision making suggests that in such circumstances, when the decisions to be made are both ill defined and conflict laden, the formation of coalitions between different interested parties is vital to the successful implementation of the decision. The formation of coalitions in the decision making process is difficult to achieve when the forum consists solely of GPs! It is self evident that many of the decisions are, and for the forseeable future will continue to be, made in circumstances of 'bounded rationality' with inadequate information, and a lack of time for truly rational decision making. In view of this, it cannot be wise to deliberately exclude potential sources of information from the decision making process in the way that the Forum appears to be doing.

Decisions about services cannot be made in isolation from the key providers and a number of fora have been set up between the TCP, Health Authority and Trusts. These have covered specific clinical areas such at Ophthalmology, Gastroenterology, Urology etc. The meetings have consisted of managers and clinicians from the provider Trusts along with Programme Team GPs, public health clinicians and commissioning managers. These have proved a very effective way of communicating across the purchaser provider split and are a positive move towards true collaborative working. The active involvement of Trust clinicians is essential if decisions to reorganise services are to be implemented. Clinicians wield considerable power to facilitate or disrupt change whether or not they have been included in the management process leading to that change. Their role is far more likely to be a positive if they are part of the decision making process and feel that they are collaborating with the TCP.

3. QUALITY AND COST ISSUES

Contract setting with trusts

Routine contract setting and monitoring takes place at the level of Health Authority Programme Managers dealing with their managerial counterparts at the Trusts. The TCP members are only really involved when changes to contracts are envisaged either for new services or marked changes to existing services. The development of quality measures in contracts is still very much in its infancy, but attempts are being made to develop quality-based contracts with one of the provider Trusts on an experimental basis, initially looking at surgery. The TCP has been actively involved through specialty fora in trying to solve problems in areas seen as presenting particular difficulties. These are often the high waiting list specialties, but also areas of high cost.

The TCP also plays an active role in the production of clinical guidelines. The lead for these is from the Public Health Department of the Health Authority and there is active participation by the relevant specialist Trust clinicians. The intention of this collaborative approach is to reach a consensus document that will then be implemented across both primary and secondary care. However, to date the experience has been that these guidelines are seen by secondary care clinicians as being an educational tool for GPs, but not something that they are expected to follow themselves! The other problem with writing these guidelines has been the time taken to reach a consensus view across the district, particularly when clinical behaviour varies considerably between clinicians, one of the key reasons for trying to implement guidelines. There is therefore a conflict between evidence-based guidelines and

pragmatic guidelines which reflect the spectrum of clinical opinion. As a tool for modifying clinical behaviour such guidelines are perhaps still in their infancy, but growing up fast!

Prescribing budget

One of the features of this TCP is the agreement to a district wide, cash limited budget for GP prescribing. Hitherto non-fundholding GPs have not had a cash limited budget, although they have been encouraged by means of the Prescribing Incentive Scheme to live within an Indicative Drug Budget. Under this arrangement practices who came in within their practice target budget and met certain other targets in relation to their prescribing were entitled to money from the Prescribing Incentive Scheme to use in their practice. This could amount to about £1,000 per GP. The idea behind the scheme was to provide a financial incentive for non-fundholding GPs to reduce their prescribing costs and to prescribe more rationally.

Under the new system of the cash-limited budget for TCP prescribing the need to control costs becomes more acute, since any overspend in GP prescribing will have a direct impact on the money available for HCHS commissioning. This is new territory for non-fundholding GPs and it was decided that there needed to be some form of continuation of the Prescribing Incentive Scheme in order to encourage non-fundholding GPs to keep within the district wide budget. The scheme that has been set up allows for payments to be made to all practices if the TCP keeps to within 2% of its budget. There would also be individual practice payments based of the achievement of quality targets within the practice. However, these practice based payments would only become available if the district wide target is met. The sum available for these payments is dependent on the final district outturn. If the budget is achieved then £250,000 would be available. This would fall to £100,000 as the 2% overspend limit is reached and beyond that no incentive money would be available. (To set these sums in context: the 2% overspend limit is equivalent to about £1 million across the whole TCP). 20% of this incentive money would be distributed equally to all practices should the district wide target be achieved. The remaining 80% would be distributed to practices achieving their practice targets, (but would still be dependent on achieving the district target). For 1998/9 these practice targets have been agreed as follows:

- total practice prescribing costs are less than or equal to the practice's indicative budget or less than or equal to the average Nottingham Health Authority practice cost. (50% of practice based incentive payment dependent on this);
- practice costs for proton pump inhibitors are less than or equal to the average PPI costs for Nottingham Health Authority or are reduced by 20% from costs in 1997/98. (25% of practice based incentive payment dependent on this);
- practice generic prescribing rate is greater than or equal to the average generic prescribing rate for Nottingham Health Authority or is increased by 5% from the rate in 1997/98. (25% of practice based incentive payment dependent on this).

The areas that have been identified as providing potential cost savings that need to be addressed in order to achieve the district wide budget are: proton pump inhibitors (omeprazole alone accounts for 5% of the total prescribing budget), combination diuretics, Minocin MR for acne therapy, increased use of generics. It is proposed that these topics would form the basis of practice visits by Prescribing Advisors. Also the assistance and co-operation of local pharmacists in the scheme is being encouraged through discussions with the Local Pharmaceutical Committee. Possible schemes for employing pharmacists to work with practices to rationalise their prescribing for individual patients are also being investigated. In particular, repeat prescribing, polypharmacy and medication for patients in residential and nursing homes would be looked at.

Major risks to the TCP as far as not achieving the district wide budget are seen to be:

- increased costs of new drugs (e.g. Donepezil, Orlistat, Clopidrogel, Raloxifene);
- increased usage of existing drugs (e.g. ACE inhibitors, statins, enteral nutrition);
- extended prescribing rights (nurse prescribing and pharmacist prescribing).

Nottingham is a historically low cost prescribing district and estimates of the potential to make savings on the existing spend are substantially less than the average for Trent Region. This puts the district in a vulnerable position as far as coping with a cash limited budget. It is likely that the increased cost of new and high cost existing drugs will more than offset the effects of any potential savings from rationalising GP prescribing by 1999/00. It has been a point of much debate as to whether the Prescribing Incentive Scheme as proposed will help to achieve the desired savings. The dependence on a district wide target being achieved before any practice based incentive payments could be made could be seen as weakening the incentive

value of the scheme. From the perspective of the individual practice they have not only to achieve their own targets but are relying on their peers also achieving the district wide target. This dilution of responsibility could lead practices to undervalue the incentive since they may feel powerless to influence whether the district wide target is achieved or not. In the end this will prove to be a test of the power of peer pressure and corporate responsibility across the TCP GPs. Only time will tell how successful this will be, but the outcome will be interesting to note in view of the proposed co-operative working of Primary Care Groups. This point has been picked up in recent guidance to come out on GP commissioning group pilots[6] which includes the following paragraph:

> *16. It is recognised that, where large numbers of GPs whose prescribing was not previously cash limited share a joint prescribing budget, there may be some initial difficulty in bringing the whole group within spending limits in the short term. In such cases the incentive offered by savings may be unrealistic for individual practices. Therefore, it is proposed to amend regulations and directions as necessary, to allow prescribing incentive schemes, similar to those for non-fundholders, to be made available to practices within these groups. Funding for such schemes may be drawn from a top-slice of the group's prescribing budget or from the HA's general funds. HAs will need to specify the uses which practices may make of these monies.*

It is not yet clear whether the Nottingham TCP will be revisiting their decision in the light of this new guidance.

Incentives for GPs to abide by decisions

The TCP also has to implement change in General Practice if it is to deliver on its prescribing budget. To date the efforts to include GPs in this process have been less visible. Although GPs were asked to sign up to the cash limited prescribing budget as part of the TCP it is by no means clear how many GPs on the ground actually feel any responsibility for helping to stay within a district wide budget. As already explained, the Prescribing Incentive Scheme set up as part of the TCP is dependent on the district wide budget being achieved rather than on individual practice behaviour. This weakens the effectiveness of this as an incentive to change behaviour. Since, as we have seen, the constituency structure is really rather weak and does not truly engage individual GPs or practices, it is not clear what leverage the TCP can exert on practices should prescribing or referral patterns be out of line.

Looking to the future, a possible development that could come with Primary Care Trust status[7] would be the ability to bulk buy pharmaceutical products, just as an acute Trust does now. This would have considerable implications for the role of community pharmacists within PCGs. Such schemes would, however, allow scope for cost savings and for the enforcement of rigid formularies within the PCG structure. This may address some of the cash limited prescribing concerns within the Nottingham TCP and other current GP commissioning group pilots.

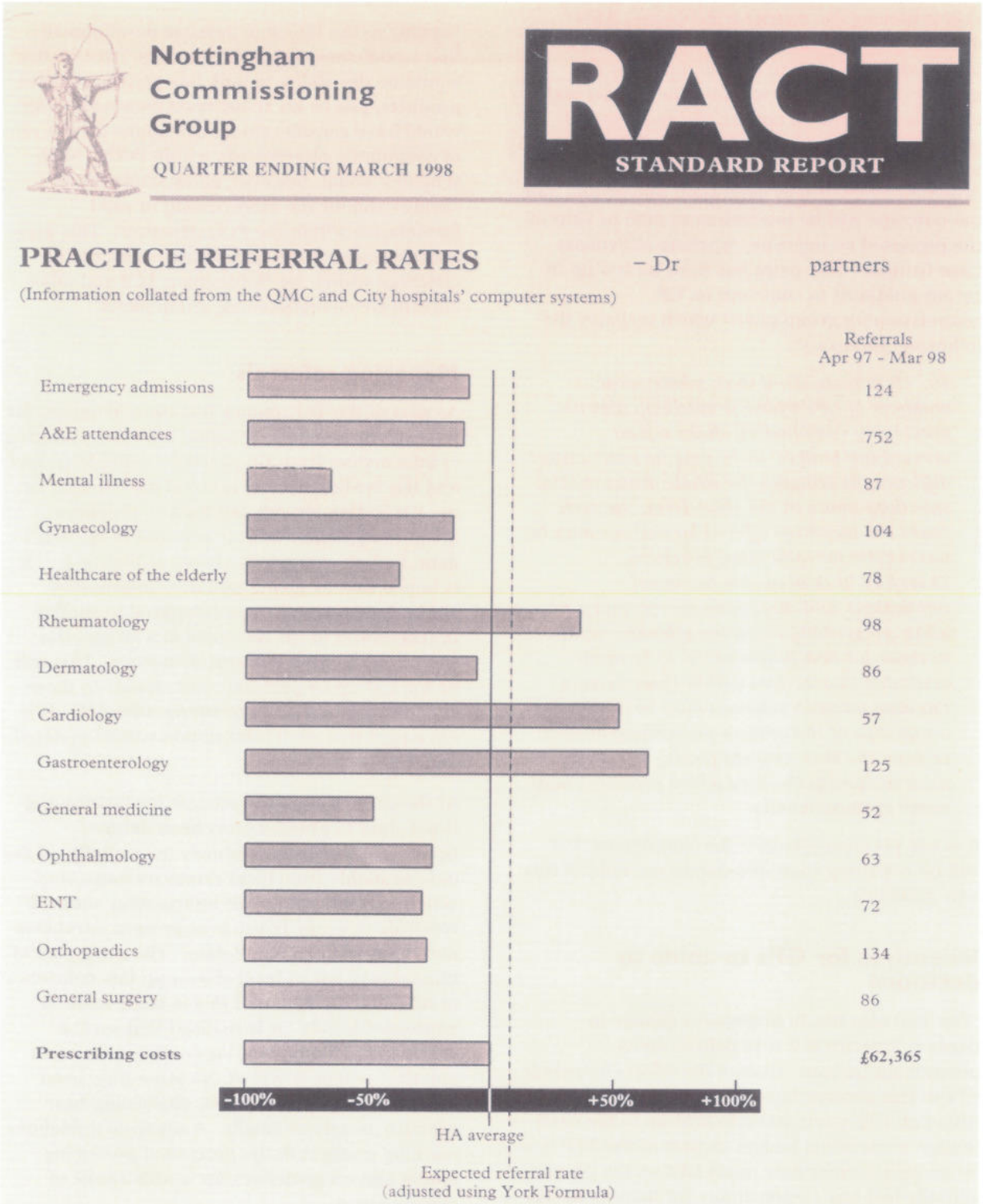
Managing referrals

As part of the TCP, money has been identified for information services including both the gathering of information from GP practices using MIQUEST and the feeding back of referral data similar to the PACT data already fed back to practices about prescribing. This is referred to as 'RACT' data, and an example is shown at Figure 4. It is hoped that by giving practices information about their referral rates compared to similar practices and to the Nottingham average, this will influence their referral behaviour. This will be backed up by practice visits similar to those currently offered by Prescribing Advisors. It is envisaged that such information will be updated monthly.

At the present time the scheme for distributing RACT data to practices has been delayed because of the disappointingly poor quality of the data available from local Trusts on outpatient activity. Even quite basic information about GP referrals to acute Trusts is at present unreliable and many months out of date. The setting up of this scheme has at least shown up this deficiency in NHS activity data and this is being actively addressed locally. It is realised that such a scheme is unlikely to be successful in isolation and that practices will at the same time need access to referral guidelines illustrating best practice as agreed locally. A separate guidelines working group is in the process of producing jointly agreed guidelines for a wide range of clinical areas.

It is less obvious at this stage what use is to be made of the data collected from practices using MIQUEST. The plan is to use TCP money to upgrade practice computer systems to enable them to run MIQUEST software and to pay practices for collecting data. The obvious problems are that practices are at very different levels of computer usage; ranging from virtually

Figure 4 **An early version of RACT referral data feedback document**



no computer use to having full morbidity registers and activity logs at the other extreme. How reliable will the data collected from such a range of practices be? It is hoped that such data will allow commissioning to become more locally sensitive to need. But it remains to be seen whether the quality of the data collected will be sufficiently good to add much to the mortality data collected centrally.

Management costs

In the initial proposal for the TCP, management costs of £1 per capita for the practices in the TCP (approx. £450,000) and a separate computer and information allowance of £10,000 per practice were proposed (approx. £1million). This was revised in the light of EL(97)37 and a final bid was put in for recurrent management and IT costs of £498,200, this was in addition to £85,000 already ringfenced by the Health Authority for GP advice on commissioning. The final bid for non-recurrent Information Technology support was for £556,400. The breakdown of the 1998/99 recurrent management costs is given in Figure 5.

Figure 5 **TCP business case – recurrent costs 1998/99**

GP advice (TCP Forum members' sessional payments)	£80,000
GP ad hoc advice	£10,000
GP training (TCP Forum members)	£5,000
Partnership with professionals and community (for advice)	£10,000
Project management	£46,000
Information needs:	
Senior information professional	£32,000
Additional provider costs	£10,000
Data collection/verification	£100,000
CHDGP (data collection from GP practices using MIQUEST)	£40,000
Specialty fora and guidelines production	£37,200
Prescribing advice:	
Pharmacist advice	£57,000
Administrative assistant and computer support	£17,000
TOTAL	£444,200

Source: Nottingham TCP revised business case, June 1998

The GPs taking part in the TCP Forum are paid a sessional rate of £90 per session for two sessions per week as ordinary Forum members and four sessions a week as Project Board members. To date this does seem to reflect the overall workload of the TCP Forum members, but is insufficient to pay for full Locum cover at current BMA rates for this time. There is the additional point that Locum Cover is worth less to a practice than time spent in the practice by the patients' own GP. The opportunity costs of taking a GP out of a practice are greater than the simple cost of employing a locum since locums do not do the practice administrative work and do not take on the long term care of chronic patients. A number of the GPs try to fit commissioning meetings into 'spare time' such as half days or lunch times in order to avoid cancelling surgeries. The monthly TCP Forum meeting takes place in an evening and typically lasts over three hours. This is, of course, time in addition to the normal working week of the GPs involved. It is questionable whether this concept of commissioning activity being a 'spare time activity' for GPs can be sustained in the long term once the initial enthusiasm wanes.

4. FUTURE RELATION TO PRIMARY CARE GROUPS

The Health Service Circular Guidance Notes for GP Commissioning Groups[6] issued in March 1998 not only sets out guidance on the current running of commissioning groups, but also gives an indication of the future direction that commissioning groups are expected to take. Commissioning groups are seen as part of a two year evaluation starting in April 1998. It clearly states that PCGs will replace existing forms of GP commissioning from April 1999. GP commissioning group pilot projects will be expected to evolve into PCGs. The second year of the evaluation process will therefore look specifically at this process of transition. The immediate problem that this raises is that GP commissioning groups do not readily fulfil the characteristics expected of a PCG. Although GP commissioning groups do fit, in terms of commissioning responsibility, with level 1 or 2 of the structure of PCGs[3] (Figure 6); in other respects they do not sit easily with the PCG structure. In particular, PCGs cover all GPs in a geographically defined area and are somewhat smaller than the Nottingham TCP, covering populations of around 100,000 on average, although some flexibility is allowed on this.

Perhaps more fundamentally, the reason behind setting up GP commissioning groups was different from the reasons driving PCGs.

Figure 6 **The four levels of Primary Care Groups**[3]

'5.11 There will be a spectrum of opportunities available for local GPs and community nurses. Primary Care Groups will develop over time, learning from existing arrangements and their own experience. None will affect the independent contractor status of GPs. There will be four options for the form that Primary Care Groups take. They will:

i at minimum, support the Health Authority in commissioning care for its population, acting in an advisory capacity

ii take devolved responsibility for managing the budget for healthcare in their area, formally as part of the Health Authority

iii become established as freestanding bodies accountable to the Health Authority for commissioning care

iv become established as freestanding bodies accountable to the Health Authority for commissioning care and with added responsibility for the provision of community health services for their population.'

Although PCGs have as part of their role the commissioning of healthcare; the driving force behind the desire to set up PCGs is to tackle issues of quality and budgetary control in the delivery of primary care. The thrust of the White Paper and subsequent guidance is directed at issues such as partnership working at a local level, local clinical governance, developing local Health Improvement Plans and, of course, holding local budgets. These are very different issues from those primarily being addressed by a GP commissioning group. In the guidance on establishing Primary Care Groups[7] it states that *Primary Care Groups are not there simply to commission health services, but also to improve primary care itself.* It also makes the point that *in considering the structure of Primary Care Groups, the form of the organisation must follow the proposed functions to be carried out by the Primary Care Group.*

It is a local decision whether the new PCG retains the current configuration of the GP commissioning group, or whether a new configuration is more appropriate. The criteria by which PCGs are approved are set out in the

Figure 7 **Criteria for assessment of Primary Care Groups in HSC(98)065**[7]

Based on the presumption that Primary Care Groups will be based on natural geographical communities (typically with a population of around 100,000). The following questions will need to be considered locally in reviewing a proposed Primary Care Group configuration:

- does the configuration allow the wider public health needs of the local community and the continued development of primary care to be addressed, in addition to the commissioning of health care?
- does the configuration allow the Primary Care Group to contribute to the development of the Health Improvement Programme, to contribute to the effective delivery of health gain as defined in the HIP and form appropriate healthy alliances with other agencies?
- does the configuration allow meaningful consultation of local populations (ie covering a population base that makes sense to them) about decisions to spend NHS money on primary and secondary services?
- does the configuration embrace natural communities that make sense to the local populations and allow inequalities to be addressed (ie reflect transport links, consumer habits, language, culture etc) as well as meeting the needs of the mobile (homeless, travellers and refugee) population?
- does the configuration allow specific localised health problems to be tackled coherently?
- is the configuration geographically congruent with the distribution of any minority group which would be advantaged by a relationship with one Primary Care Group?
- has the configuration proposed been discussed by all key stakeholders (GPs, LMCs, Local Authority, community nurses, community and acute NHS Trusts, other health professionals, Health Authority and public etc) and does it command their support?
- does the configuration provide a basis for effective working relationships within primary care and with social care professionals and does it have the active support of the social services department?
- does the configuration allow cost effective and meaningful discussions with secondary care providers? (ie do the GPs in the group have unacceptably disparate interests because of their relationship with different secondary care providers)
- do the arrangements include all practices within the boundary of the Primary Care Group?
- does the configuration represent effective use of available management resources and avoid logistical difficulties for effective operation of the group?
- does the configuration form part of a coherent structure of Primary Care Groups within the Health Authority area as a whole?

guidance notes[7] (see Figure 7). The guidance highlights the following areas as being essential:

- being fully representative of all GP practices working with the group;
- the central steering body overseeing the project locally should include representatives from GPs working in the area as well as other community based professionals and social services;
- the groups should take note of the common core requirements for Primary Care Groups set out in paragraph 5.15 of the White Paper (Figure 8) and consider how best to work towards these in their own operational arrangements as the pilot proceeds.

In terms of these functions and requirements for transition from GP commissioning group to Primary Care Group, it will be evident that the GP commissioning group form does not necessarily fulfil them. This is of course largely because the GP commissioning group was set up with a different set of functions in mind, primarily the commissioning of secondary healthcare. By way of example, the Nottingham TCP with 450,000 patients and 288 GPs is considerably bigger than the 100,000 patient 50 GP size for a 'typical' PCG. The TCP has been able to demonstrate an effective mechanism for secondary care commissioning which could become a model for PCGs, particularly acting together in a collegiate structure. Such joint working between PCGs is envisaged in the guidance issued in August 1998 which states that: 'Primary Care Groups will be expected to work collegiately with other Primary Care Groups in order to secure both the best value from the management resources available and to ensure that local health services are planned and co-ordinated through the agreed local Health Improvement Programme'[8].

Some would argue that in the light of the King's Fund evaluation of Total Purchasing Pilots[9], 100,000 may be too large. They found that as the size increased, the transaction costs involved in managing a larger organisation with more GPs to be consulted also increased. On the other hand it is generally accepted that the transaction costs in contracting with secondary care providers are reduced by having one large commissioning group. One possible solution to this would be to have a number of small PCGs of 60-100,000 patients who jointly owned a single federal commissioning group which would carry out the commissioning of specialist services on their behalf. This would allow the PCGs to get on with developing local collaborative working and developing clinical governance in primary care without the risk that their efforts were swamped by the agenda of secondary care commissioning. Such a scheme has been proposed in Nottingham and is being actively looked at as one way in which the GP commissioning group may develop. Over the next few years as PCGs become established and progress to Trust status, it is envisaged that they may well wish to take back their commissioning role.

Figure 8 **Paragraph 5.15 of The New NHS: Modern, Dependable, December 1997[3]**

'5.15 Whatever functions they take on there will be a common core of requirements for all Primary Care Groups. Each Group will be accountable to the Health Authority and required to:

- be representative of all the GP practices in the Group
- have a governing body which includes community nursing and social services as well as GPs drawn from the area
- take account of social services as well as Health Authority boundaries, to help promote integration in service planning and provision
- abide by the local Health Improvement Programme
- have clear arrangements for public involvement including open meetings
- have efficient and effective arrangements for management and financial accountability

Local Medical Committees will continue to be consulted on, and have a key role in, ensuring that general medical services resources are used wisely.'

The management budget for the TCP is £1 per capita for the population served. (£455,000) However, this does not include the separate non-recurrent IM & T and preparatory costs budget of £557,000. PCGs are expected to have management budgets of £3 per capita. If the scheme were to continue in its present form with running costs of £1 per capita, this would leave PCGs with £2 per capita for all their other management costs. This may be an achievable figure, although with the full implications of the PCG role at a primary and community care level still unclear, it is difficult to predict what the costs will be. It seems likely that to make PCGs of the 100,000 patient size into effective organisations will take both considerable time and investment. Fears have been expressed that both the time involved and the cost of setting up PCGs have so far been underestimated[10].

One thing that has already come out of the GP commissioning groups is that the work of simply

advising the Health Authority on commissioning is of itself very time consuming and can become a considerable burden on the GPs involved, especially if they are trying to continue with full-time general practice as well. There is no doubt that GPs and other professional groups involved in the running of PCGs will need protected time to carry out their new roles and their colleagues will need compensation for the loss of time out of the practice. If the experience of the TCP is anything to go by then this time commitment for key members in each PCG could well be a whole day each week at a minimum with the chair of the group perhaps having up to a half-time commitment. This would have a significant impact on practices whose members were involved in the running of the PCG. One suggestion that has been made to try and relieve this situation is for PCGs to employ salaried GPs specifically to cover those GPs spending time out of their practices to attend PCG related meetings. This may be of more practical use than paying GPs locum expenses at a time when finding suitable locums can be very difficult.

Another important issue that has already been noted in the TCP is that of the balance of power between the Health Authority and the commissioning group. PCGs, like GP commissioning group pilots, would start life as sub-committees of the Health Authority. However, the plan is that they should progress to independent Trust status. It has already become apparent that some Health Authorities may see it as being in their interest to encourage PCGs to remain at levels 1 and 2 and not to go down the route of Trust status. This could be seen as Health Authorities protecting their power base, something we have already seen as a motivating factor in the support of Health Authorities for GP commissioning group pilots. While PCGs remain, like GP commissioning groups, as sub-committees of the Health Authority, then the final sanction, and therefore effective power, rests with the Health Authority and not with the locality group. Over the next few years we will no doubt see a tension develop between those who wish to see PCGs progress as fast as possible towards Trust status (and away from Health Authority control), and those who want to remain in a purely advisory capacity with the Health Authority holding ultimate power (and taking ultimate responsibility for rationing decisions etc.).

If the PCGs do go down the line of becoming Primary Care Trusts then this government will have achieved a change more radical than fundholding with total budgetary control being held at a local level. It is not clear whether the desire all along was to roll out fundholding (or rather, Total Purchasing) to all practices; thereby achieving something the previous, Conservative government failed to achieve, or whether this is all an accidental by-product of the desire for local accountability and involvement.

The major acheivement of the TCP so far has been to demonstrate that collaborative working between GPs and the Health Authority can work and can be an effective lever for change in a health district. The TCP has a number of concrete achievements: the production of a wide range of clinical guidelines; and the introduction of schemes for the community availability of four-layer bandaging for leg ulcers, for fast-tack physiotherapy for acute low back pain, and for occupational therapy input to prevent hospital admissions. Currently in the pipeline and due to be launched this year are: a change in the system for acute medical admissions to allow both major hospitals to be 'on take' every day; and the feedback of comparative referrals data to GPs. The success of the TCP in controlling GP prescribing will not, of course, be known until after April 1999. However, so far the scheme is coming in within target.

Overall the TCP has been welcomed locally by GPs, the provider Trusts and the Health Authority and this is witnessed by the strong desire from all quarters to continue with some form of collaborative commissioning mechanism once PCGs are established.

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