National evaluation of general practitioner commissioning pilots: lessons for primary care groups

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SUMMARY

Background. *The national evaluation of general practitioner (GP) commissioning pilots was commissioned by the Department of Health in 1997 as part of its Policy Research Programme. It was conducted by the Health Services Management Centre at the University of Birmingham.*

Aim. *To monitor the development of the 40 national pilot sites, identify the factors that inhibited or facilitated progress, and consider the implications for the implementation and development of primary care groups (PCGs).*

Method. *Semi-structured face-to-face interviews with GPs, health authority (HA) managers, and pilot managers from each of the 40 pilot sites (141 interviews in total) and focus group discussions with nurses, social services officers, and community health council officers in the 40 sites.*

Results. *Stakeholders reported the key achievements of the pilots during their first six months as being improved collaboration between GPs, the establishment of organisational arrangements, and work towards managing the group prescribing budget. Obstacles for the groups included changes to government policy regarding primary care, the workload involved for clinical staff, the pilots' relationship with the local HA, and problems with information management and technology (IM&T). A more detailed analysis of the pilots' management arrangements, prescribing work, IM&T support, and stakeholder involvement points to a set of lessons for emerging PCGs.*

Conclusions. *In their early stages of development, PCGs are likely to focus on issues of structure and process. Prescribing will be an area receiving particular attention, prefiguring some of the challenges of clinical governance in primary care. IM&T will prove to be more problematic than first assumed. The involvement of a wider range of stakeholders will be addressed by primary care groups, particularly in relation to GPs and nurses.*

Keywords: primary care groups; commissioning; prescribing.

Introduction

AS a result of the 1990 National Health Service (NHS) reforms and the Conservative government's intention to develop a primary care-led NHS,[1] the 1990s witnessed the evolution of a plurality, or 'mosaic', of commissioning models.[2,3] The incoming Labour government inherited this diversity of approaches and set about determining policy for the future of NHS commissioning 'beyond fundholding'.[4] In June 1997, the Minister of State for Health announced plans to pilot new approaches to the commissioning of health services[5] and 40 general practitioner (GP) commissioning pilots were launched in April 1998.

Although the origins of the pilots pre-date the 'New NHS' White Paper,[5] in effect these initiatives provided an opportunity for volunteer groups of general practices to have a one-year trial of aspects of possible primary care group (PCG) working. The groups all assumed responsibility for an actual cash-limited prescribing budget and were exhorted to work in partnership with nurses, social services, and the public.[6] In addition, they assumed a varied range of other commissioning responsibilities, such as actual or notional hospital and community health services budgets, and elements of general medical services budgets.

In December 1997, when the government declared its intention to develop a national network of PCGs,[4] it became clear that the national evaluation of the pilots was expected to provide early lessons for the establishment and implementation of PCGs. In this paper, the findings from the initial phase of the evaluation are presented, representing an examination of the progress of the pilots during their first six months of operation (April to September 1998).

It should be noted that, with effect from April 1999, all the pilots became PCGs. Twelve of these groups continue to be subject to in-depth case study evaluation by the Health Services Management Centre, as part of a wider Department of Health programme of evaluation of PCGs.

Method

At an early stage of the evaluation, it was recognised that much of the initial impact of the commissioning pilots was likely to be in the area of relationships and processes rather than on the delivery of services, given that the pilot programme was to last only one year. As a result, an evaluation framework was developed, which conceptualised and analysed the pilots in terms of their structures, processes, and outcomes.[7] In terms of the substantive areas explored in the research, the investigation of structure focused upon issues such as the size of the pilots and management arrangements, as well as systems for budgetary control and information management and technology (IM&T) support. Issues of process included an examination of prescribing management strategies and the involvement of stakeholders. An ongoing analysis of outcomes will assess the impact of the groups in terms of out-turn against budget, prescribing activity, impact upon patients, and achievement against pilot objectives.[8,9]

The findings presented in this paper are based upon fieldwork visits to all 40 sites between August and October 1998. Semi-structured face-to-face interviews in each site were conducted with the lead GP, an 'uninvolved' GP (as determined by the

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pilot), the health authority (HA) lead manager for the pilot, the pilot manager, and the HA's director of commissioning. The rationale for choosing these interviewees was the need to capture the perceptions of those closely involved in the setting up of the pilots. In addition, focus group discussions were held with nurses, social services representatives, and community health council officers involved with the pilots.

Results

Achievements and obstacles

As Figure 1 illustrates, the key achievements of the pilots related to the establishment of organisational arrangements and management structures and the involvement of GPs and other stakeholders in the pilot. Improved GP collaboration was highlighted by over half the interviewees, while the engagement of other stakeholders was cited as a key achievement by over one-third of interviewees. Innovations relating to the management of the group prescribing budget also emerged as an important achievement, being mentioned by just under half of those interviewed. In addition, some interviewees reported progress in relation to service development objectives, including developments in primary and secondary care provision.

Figure 2 provides an overview of the main obstacles reported by the pilots. The move towards PCG status was seen as a major obstacle, both in terms of impeding the ability of the pilots to make progress and in terms of undermining their perceived status or value. One of the most pressing problems reported in terms of the functioning of the pilots concerned the amount of time and workload involved for clinical staff. For many, there was a greater amount of work associated with the pilot than they had anticipated, which was only managed at some personal sacrifice and with support from colleagues and GP partners. A further area of difficulty, reported by approximately one-fifth of interviewees, concerned the relationship between HAs and pilots. Problems centred upon the apparent reluctance of some HAs to devolve information and responsibility to pilots and difficulties in securing public health input and advice.

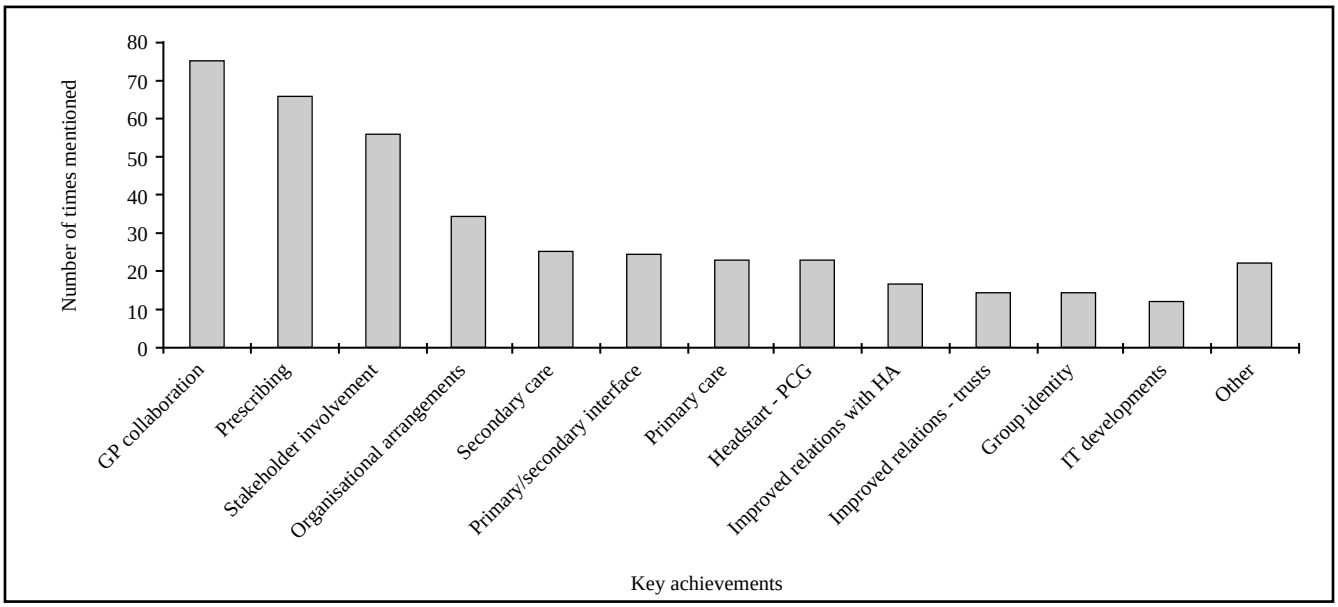

Figure 1. Stakeholders' perceptions of key achievements (n = 141).

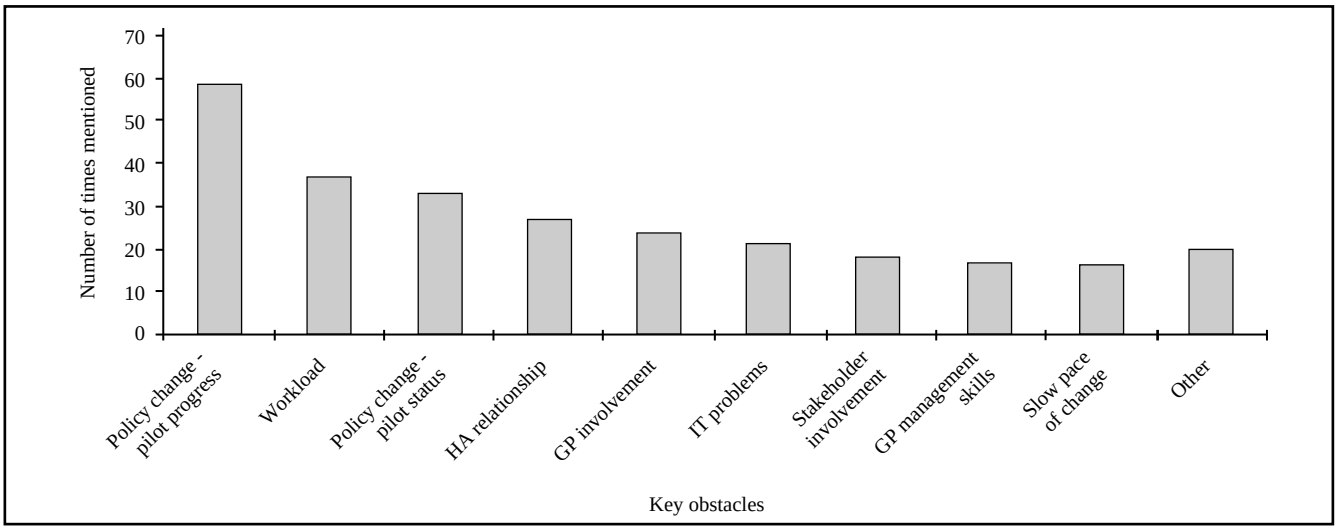

Figure 2. Stakeholders' perceptions of key obstacles (n = 141).

Management arrangements

The pilots were free to determine their own management arrangements. Over half of the groups chose to distinguish between strategic and operational roles when establishing their arrangements, setting up separate bodies for the performance of these two activities. In order to reflect the specific needs of particular localities, several of the pilots adopted a 'groups within groups' approach, dividing their areas into localities, sometimes with separate management structures. Almost all of the pilots had established subgroups related to their objectives and saw these as an effective way of delegating areas of work and engaging a wider cohort of GPs and other primary care stakeholders in the overall activities of the group.

The experience of the pilots underlines the importance of securing high quality, dedicated management support, a factor also noted in evaluations of total purchasing.[10,11] Almost all groups had appointed project managers, and those who had full-time managers described the particular value of this input. The background of the manager was reported to be less important than their ability to operate effectively at the boundary between the group and the authority and, likewise, between the group and its constituent practices. Finally, a number of pilots highlighted the need for personal and organisational development for those involved at board level. Some groups had held team-building events and provided individual skills training for GPs and nurses. These events were reported to be of significant value.

Prescribing

All pilots assumed responsibility for a cash-limited prescribing budget. The research findings reveal a major focus by the pilots on prescribing, this being the second most frequently reported achievement of the groups (Figure 1).

As indicated in Figure 3, the pilots employed a range of techniques for managing the prescribing budget. One-third of sites reported that they had allocated an actual or notional prescribing budget to practice level and, in almost all pilots, prescribing expenditure and activity patterns were being monitored at practice level. Many pilots had developed a prescribing group to oversee and manage prescribing activity. These groups commissioned and received reports on prescribing expenditure, developed disease-specific, pilot-wide strategies and guidelines for dissemination to all doctors in the pilot, and devised prescribing training and education activities.

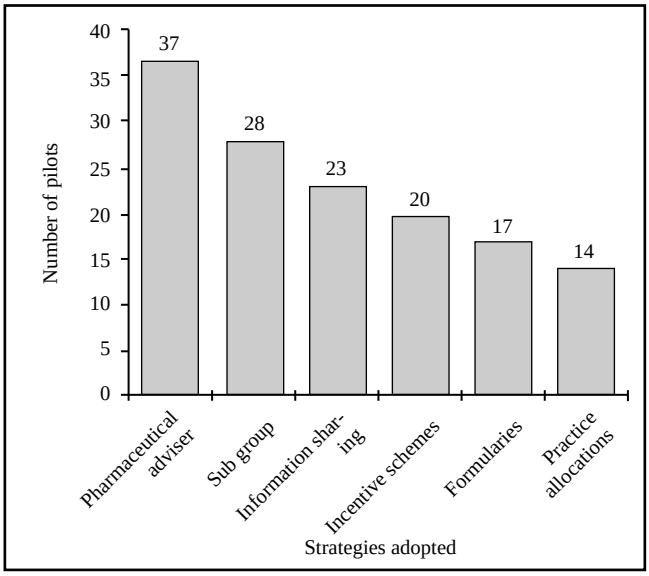

Figure 3. Strategies adopted for the management of group prescribing budgets.

All except three of the pilots reported having secured professional prescribing advice for the group. The most frequently reported role of the prescribing adviser was that of collating, analysing, and reporting on pilot prescribing data. This information was typically fed into a programme of targeted visits by the adviser or pilot lead GP to practices deemed to be 'outliers' according to a range of quality or financial markers for prescribing.

The open sharing of these prescribing data within pilots, on a named individual practitioner basis, was cited as a key issue by 23 pilots. Whether or not to name doctors when sharing prescribing data had been an issue for many groups and nine pilot groups specifically reported that they had moved to a position where they felt that there was sufficient mutual trust within the group for this to be possible.

Seventeen of the pilots developed pilot-wide formularies, sometimes jointly with local hospital trusts. Half of the pilot projects reported that they had used incentives to manage prescribing, typically involving a combination of group and practice level incentives, with the latter usually taking the form of additional resources for investment in primary care services.

In this initial phase of the evaluation, issues of structure and process were the focus of the research. Outcomes related to prescribing activity in the pilots, and their relationship with techniques for managing the prescribing budget, are reported in a parallel research paper.[8]

Information management and technology

Most of the pilots had established sub-groups to identify and address their particular IM&T needs. The main information technology (IT) priority for the pilots was the establishment of electronic methods of communication and information exchange, as opposed to the collection of activity and clinical data for commissioning. Over half of the pilots expressed a desire to establish links between practices within the commissioning group, while several others mentioned the need to develop links with HAs or trusts. The establishment of a reliable electronic communication infrastructure was seen as crucial in supporting the overall organisational development of the group.

The willingness of the pilots to address IM&T issues was not matched by tangible progress, owing to a range of internal and external problems. In terms of the latter, technical difficulties, the reliability of NHSnet, and the delay in the publication of the national IM&T strategy thwarted the attempts of many groups to establish electronic methods of communication. In addition, our research highlighted great variation between practices within commissioning groups with regard to their access to IT resources (hardware and software), level of IT 'literacy' and usage, the clinical systems in use, and methods of data collection.

The involvement of stakeholders

The involvement of a wide range of stakeholders in the work and management of the pilots was cited as one of the key achievements of the groups to date (Figure 1).

The engagement of non-lead GPs was reported as being good in most cases and typically took place through involvement in subgroup activity. Findings suggest that non-lead GPs were also able to exert influence via their practice or 'patch' representatives on pilot boards. In addition, the experiences of the pilots provide many positive examples of nursing involvement. These include the readiness and enthusiasm of nurses to participate in the boards and also in subgroup work, not only as group members but also as group chairs and leaders. However, many nurses

taking part in focus groups questioned their real influence at board level and this was supported by the responses of non-nurse interviewees.

Health authorities were cited by responders as being the most influential and enthusiastic stakeholder group involved with the pilots. On the whole, HAs were seen as supportive and enabling, providing management, prescribing, and IT support to the pilots. However, it should be noted that one-fifth of the pilots reported difficulties concerning the involvement of HAs. Some groups felt that HAs had 'lost interest' in them or were too controlling and unwilling to devolve responsibility and information.

Our research found little evidence of direct patient or public involvement in the work of the pilots. Many groups had 'good intentions' here but reported that they lacked practical knowledge of how to engage service users and members of the public in a meaningful way. The involvement of community health councils (CHCs) was more advanced. Approximately half of the pilots had CHC representatives on their boards who saw their role as facilitating direct user involvement by 'providing a route into the community'.

Discussion

The key achievements and obstacles reported by the pilots provide an insight into the issues likely to be encountered by PCGs in their early stages of development. The findings suggest that PCGs will focus initially on issues of structure and process, with an emphasis on establishing their internal organisational arrangements and securing the involvement of GPs. The management of the prescribing budget is likely to dominate the activity of PCGs in their initial phase, representing an early example of the operation of clinical governance in primary care. The evidence suggests that groups will take their corporate budgetary and prescribing responsibilities very seriously and will utilise a variety of methods to monitor prescribing practice at individual, practice, and group levels. Improved control of prescribing budgets may be expected as a result and will be examined later in this study.

The need to ensure effective electronic communications will be an early priority for PCGs seeking to support the organisational development of the group. The findings suggest that PCGs will deem IM&T to be an important issue and that the resulting needs assessment and action planning carried out will prove to be more complex and time-consuming than initially expected.

Problems concerning the amount of time involved for clinical staff associated with the pilots sound a cautionary note for those involved in PCGs at board level. In order to combine clinical and PCG duties in a successful and sustainable manner, such individuals will need practical support, organisational 'backfill', and appropriate remuneration.

Finally, it is important to reiterate that the pilots were operating in a rapidly changing policy environment. At times, this impeded their progress and frustrated those involved with them. The findings suggest that if PCGs are to establish effective organisational arrangements, build relationships with other stakeholders, and achieve their service objectives, they will need some stability in the policy context as well as a realistic timescale for implementation.

The findings from this initial stage of the national evaluation of GP commissioning pilots reveal a number of important messages for PCGs. The pilots, in their role as shadow PCGs, saw themselves as having had a head start in many aspects of PCG working.[12] The overall messages emerging from this initial assessment of a cohort of embryonic PCGs are summarised in Box 1.

- PCGs will focus initially on issues of structure and process as they establish themselves as effective organisations.
- PCGs will need to determine arrangements for carrying out both strategic and operational work and this may entail structures of a greater complexity than simply the PCG board.
- The time commitment for clinical staff will be considerable and the impact on individuals, practices, and trusts will need to be kept under review.
- High quality dedicated management support will be a vital prerequisite to PCG working.
- Prescribing will be a key focus for PCGs and will require the use of a range of management strategies.
- IM&T is more complex and time-consuming than PCGs may at first imagine and will require significant attention by groups.
- Nurses are enthusiastic about involvement in PCGs but groups will need to determine ways of ensuring that they are able to participate fully in decision-making.
- The HA–PCG dynamic is of particular importance to the effective development and functioning of the PCG.
- User and public involvement presents a real challenge for PCGs and is likely to remain a good intention unless there is clear guidance and support for groups about models of good practice in this area.
- There are many personal and organisational development needs to be addressed by PCGs, including work on team-building and effective board working.

Box 1. Overall lessons for PCGs.

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