HEALTH NEWS BRIEFING

ASSOCIATION OF COMMUNITY HEALTH COUNCILS FOR ENGLAND AND WALES

Primary Care Groups - the early guidance.

September 1998

Summary

Primary Care Groups are being established at an extremely fast pace. On the 1st April 1999 all GP practices will be operate as PCGs.

GP fundholding, locality commissioning and all the other forms of providing primary care will vanish. PCGs will bring together a wide range of health professionals, with some lay input, to supply and commission services for their local population. The Government believes that PCGs will ensure that primary care is responsive to local need and will reduce the variations in service provision that is found in the current system.

This Briefing examines the guidance "Developing Primary Care Groups" (HSC 1998/139) from a patient and carer perspective - particularly looking at how Community Health Councils will be able to play their role in ensuring the success of this new way of organising primary care.

This is the first edition of "Primary Care Groups - the early guidance"
At the time of preparing this briefing, guidance for the Local Health Groups in Wales had not been released. It is envisaged that a second edition will be published that will take into account developments in Wales and any further developments in England.

Contents

1. Introduction.

The 1990 NHS and Community Care Act, creating the internal market and GP fundholding, promised to make service delivery more responsive and directly accountable to patients. Yet it is often argued that these measures failed to make the NHS more responsive and appear to have increased costs and inequality in service provision.

Many patients are unaware of or confused by the concept of fundholding. Fundholding practices do not have to consult with the local population about what services they purchase and many Community Health Councils are frustrated in their efforts to be consulted.

In April 1999 Primary Care Groups (PCGs) will replace the current mix of fundholding and commissioning groups of GPs and will become the means of both delivering primary care and commissioning services for local patients. The Government argues that primary care professionals "*understand patients' needs and they deliver most local services. That is why they will be in the driving seat in shaping local health services in the future*".[1]

Around 480 Primary Care Groups are being formed in England. The Groups are being developed following local discussions throughout the country between health authorities, GPs, nurses, local authorities and Community Health Councils.

The groups will cover populations ranging from 50,000 to 220,000 people. Guidance issued to health authorities earlier this year indicated that there would be flexibility around the size of population that a PCG should serve, but that a typical PCG should serve a population of around 100,000.

Earlier guidance[2] outlined the functions of and potential benefits of PCGs; the configuration of the PCGs; the criteria for assessment and; the arrangements to enable the Groups to become operational from 1 April 1999.

The Groups will operate in shadow form until they come into full operation next year when GP fundholding is brought to an end. They will be run by a board consisting of GPs, nurses, a social services officer, a health authority representative, and a local member of the public (appointed by the relevant health authority).

When they are fully operational, PCGs will be able to take financial responsibility for planning and funding health services for the communities they serve.

This Briefing considers the guidance HSC 1998/139, issued in August 1998[3] "Developing Primary Care Groups". It focuses on how the Groups are to consult and involve users/carers and in particular Community Health Councils.

2. Roles and responsibilities of Primary Care Groups.

Primary Care Groups will bring together GPs and other health professionals. Their key aims will be to:

1. improve the health of, and address health inequalities in, their "community"

2. develop primary care and community services across the Group

3. advise, or commission directly, a range of hospital services for patients within their area which appropriately meets patients needs.

They will typically cover a population of between 50,000 to 220,000 with the norm being 100,000. The Groups will operate in shadow form until they come into full operation on 1 April 1999.

The Groups will operate at four different levels - although the guidance issued so far only addresses levels one and two.

Primary Care Groups: the options.

The White Paper, The New NHS Modern and Dependable[4] states that PCGs will begin at whatever point of the spectrum is appropriate for them. It is expected that over time all PCGs will progress towards level four.

Level One: PCGs act in support of the health authority in commissioning care for its population, acting in an advisory capacity.

Level Two: PCGs take a devolved responsibility for managing the budget for healthcare in their area, acting as part of the health authority.

Level Three: PCGs become established as free-standing bodies accountable to the health authority for commissioning care.

Level Four: PCGs become established as free-standing bodies accountable to the health authority for commissioning care, and with the added responsibility for the provision of community services for their population.

Note that at levels three and four the PCGs become NHS Trusts

2.1 Governance of the Groups and accountability to the health authority.

PCGs will be required to set up a "board" to run the Group - at levels one and two these boards will be sub committees of the relevant health authority. Each Group's board will consist of four to seven family doctors, one to two community or practice nurses, one social services officer; one lay member appointed by the health authority, one health authority non-executive member and one Primary Care Group Chief Officer/Manager. Each individual will serve a period that would not be expected to exceed more than three years before seeking re-selection.

The GPs have a right (but not an obligation) to be in a majority on the boards. It is for the GPs to decide if they wish to have a GP as chair. If they do, then it is for the GPs to decide who that chair will be. If they decide they do not wish to have a GP chair then it is for all members of the group (excluding the Chief Officer/Manager) to decide who will be the chair. In either event the health authority must approve the nomination.

At levels one and two the Groups will be responsible through their chairs to the chief executive of their health authority. The degree to which the health authority devolves responsibility to the group will depend upon local agreement.

2.2 Financial accountability and incentives to improve performance:

Health Authorities will receive a single cash limited allocation. This money will be allocated to cover Hospital and Community Health Services (HCHS) and General Medical Services (GMS) cash limited and prescribing budgets. The health authority and the PCGs will then agree the individual PCG budgets; this process will be monitored by the NHS Executive.

The guidance states that: "The freedom to refer and prescribe remains unchanged...there will be no question of anyone being denied the drugs they need because a GP or Primary Care Group has run out of cash."[5]

Over a period of time it is expected that indicative budgets will be set for individual practices as a tool for improving performance: overall savings made by Groups operating at level two will not result in the following year's budget being cut.

3. Accountability to, and involving, the public.

3.1 Health Service Circular HSC 1998/139

Health Service Circular HSC 1998/139 "Developing Primary Care Groups", sets out the mechanisms for accountability of the Groups to, and involving, the public.

The key points with regard to public accountability and public involvement issues are summarised below:

3.1.1 Improving health through involvement of the public.

Primary Care Groups will be responsible for improving the health of, and addressing health inequalities in, their community through the involvement of the public in the work of the Group so as to inform the delivery of appropriate services (par. 2).

> ***ACHCEW comment**: As statutory bodies representing the interests of patients and local communities in the NHS, Community Health Councils will be ideally placed to play a key role in assisting PCGs involve the public. Special emphasis should be placed on ensuring the views of "hard to reach groups" (such as black and ethnic minorities, people with disabilities and learning difficulties) are taken into account. CHCs have a wide experience of involving all sections of the community.*[6]

3.1.2 PCG board membership:

The composition of the Primary Care Group "boards" reflects the need to ensure public accountability and public confidence in the governing arrangements (par. 13). The boards will have two lay members - one who is a non-executive director of the health authority and another appointed by the health authority to represent the interests of the local community, following an open and fair process. These appointments will be open to any member of the public (except GPs, nurses and NHS staff) living in the PCG geographical area. The guidance states that CHC membership "would not disqualify individuals from applying" (par. 23).

> ***ACHCEW comment**: During the consultation period ACHCEW did not call for CHC membership, nor for individual CHC members to be allowed membership, of PCG boards. CHCs generally felt that such membership could raise conflicts of interest. CHCs and individual CHC members will have to consider very carefully whether there would be a conflict of interest if CHC members were to*

become a PCG board member. If the PCG were to take a decision that the CHC did not approve of, membership of the PCG board by a CHC member could be interpreted as the CHCs approval. CHCs may wish to draw up guidance for their members outlining the potential for conflict of interest.

However CHCs have both the expertise and the links with local communities to give help and advice to the appointed lay member; they could also advise the health authority on the appointment process. Lay membership of such a body so heavily dominated by professionals is daunting for even the most assertive individual. Any support the appointed lay members receive should help them effectively discharge their duties.

It is also worth noting that if the PCG were to become a NHS Trust then any individual CHC member who is on the board of the PCG may no longer be permitted to be a member of the CHC. This is because current legislation[7] does not permit members of a "relevant" NHS Trust becoming a member or being a member of the CHC.

3.1.3 Associate members:

PCGs will have the power to co-opt others on to the board; who may be considered appropriate for dealing with specific elements of the PCG's work. These co-opted members will become associate members of the board but will not have a right to vote (par. 15).

ACHCEW comment: *PCGs will benefit from co-opting CHC members onto the boards to obtain a wider community viewpoint on health needs and service delivery. GPs are very busy and they may only perceive health need from the perspective of people who present at their surgery. As demand for healthcare is not the same as need there is a role for CHCs to reflect the wider community perspective.*

ACHCEW called for CHCs to be given speaking observer status on Primary Care Groups. Associate Membership as outlined in the guidance would appear to offer CHCs this opportunity. ACHCEW are aware of CHCs that have already negotiated this status.

Early indications are that many PCGs and health authorities are already seeing the benefits of co-opting CHCs onto the board. ACHCEW welcomes this development and would like to see all PCGs in dialogue with their local CHC with regard to co-option.

3.1.4 Open board meetings:

It will be necessary for PCGs to have open and transparent processes (including open meetings that are accessible by the general public) to allow stakeholders and the public to see the basis upon which they take decisions (par 37).

The Guidance does however state that public access to meetings will recognise "the need to protect confidential business where necessary" without stating what is considered confidential business. (par. 39).

> ***ACHCEW comment:*** *ACHCEW welcomes this commitment to open and accessible meetings. Accessible must mean not only physically accessible for people who are disabled but also accessible by virtue of the timing and ensuring that the business of the meeting is understandable and not intimidating for the general public. ACHCEW has drawn up good practice guidance for NHS Trust meetings and we would welcome their adoption by PCGs.*[8]

3.1.5 Public documents:

PCGs will be required to produce annual accountability agreements setting out their plans and reflecting on their out turn performance. These documents will be public documents available through the health authority. (par 37).

The guidance states that the annual accountability agreement will contain key targets, objectives and standards for the delivery or commissioning of services. It will also set out the Group's Investment Plan (par. 36).

> ***ACHCEW comment:*** *ACHCEW welcomes the requirement to produce annual accountability agreements. We would expect these documents to be automatically sent to the relevant CHCs for their consideration and comment.*
>
> *We would also expect these documents to be written in a style that is clear and understandable to lay people. Where appropriate documents in languages other than English would ensure all sections of the community were involved.*
>
> *ACHCEW would also like to see any results of health authority audits or reviews of Primary Care made available to the public and to CHCs.*
>
> *Furthermore we also believe that PCGs should comply with the requirements laid down in the Code of Practice on Openness in the NHS. Presumably at levels one and two (i.e. as sub committees of the health authority) they will be bound by the section of the code covering health authorities. If they become NHS Trusts then presumably the section of the code covering Trusts will apply.*

ACHCEW would also like to see the Groups' annual accountability agreements set out the contact they have had with CHCs and the steps they have taken to involve patients in service planning, including measures such as the use of surveys and the establishment of Patient Participation Groups.

These agreements should also specify the lessons which have been learned from patient complaints. Practice based complaints systems must be a mechanism for airing and addressing problems, not for smothering them.

3.1.6 Training in involving patients and carers.

The guidance states that it will be the health authorities' responsibility to provide training and assistance to PCGs in involving patients and carers.

ACHCEW comment: *CHCs have an enormous range of experience in this field. Health authorities may wish to consider funding CHCs to undertake this work on their behalf. Many CHCs around the country have been involved with their local GP practices for many years assisting in setting up patient groups and ensuring that the views of such groups are taken into account in the wider debate about health care in their district. Health authorities would find enormous benefit in tapping into this existing expertise.*

3.2 Supporting guidance.

Supporting guidance was also issued with HSC 1998/139. It is within this supporting guidance that the issue of user/carer involvement and the role of CHCs is expanded.

3.2.1 Involvement of other groups not on the board.

PCGs must actively involve and engage all stakeholders in shaping the decisions and policies of the Group - the guidance clearly states stakeholders include the public. PCGs will need to develop "processes and structures which will allow participation by groups, organisations and individuals who are not represented on the governing board of Primary Care Groups." (par. 56)

ACHCEW comment: *We are pleased to see that the guidance considers the local population to be one of the stakeholders in the PCG. Whilst this may only be semantics it is very useful in reminding professional groups that the NHS is there for the benefit of patients.*

The guidance suggests some models of participation that focus on:

- geographical or community (e.g. ethnic, religious or cultural)
- specific tasks (e.g. budget setting, needs assessment)
- commissioning specific services (e.g. elderly, children)
- clinical areas or specific client groups (e.g. diabetes, mental illness)

Involvement of specific interest groups including patient groups "will best demonstrate the maturity and capability of Primary Care Groups to progress and develop to take on increased responsibilities from their host Health Authority", (par. 56).

> ***ACHCEW comment:*** *Most CHCs have sub committees that concern themselves with specific services or specific geographical or ethnic groups. PCGs would benefit from consulting with their local CHC to see which sub committees could assist them in focusing on specific areas. CHCs usually have co-opted members on the sub committees who bring with them specific areas of knowledge and expertise. CHCs could also direct PCGs to the relevant patient groups.*

The guidance goes on to states that "public involvement should be regarded as an integral part of Primary Care Groups' integral activities. It should not be seen as an 'add on', nor as being fulfilled by a one off activity such as an annual public meeting. (par. 89)

> ***ACHCEW comment:*** *ACHCEW welcomes the reminder that public involvement should not be seen as an add on to the PCGs' activities. This statement should serve as a reminder to the groups that patient and carer groups must be involved from the very beginning of the Groups' existence and should be involved at all stages of the Groups deliberations about changes to services offered or commissioning intentions. In the past some patient groups, and some CHCs, have felt that they have been invited to become involved in a new development only when it is effectively a fait accompli. Involving CHCs at the beginning will ensure that the local community has a chance to raise concerns and suggest possible improvements that professionals may not otherwise have considered.*

The Guidance goes on to state that "Primary Care Groups should:

- put in place plans for the early, systematic and continuous involvement of users and the public.
- be able to demonstrate how in carrying out their role they have involved users and the public

- provide feed back to users and the public on the outcome of their involvement" (par. 90).

A synopsis of useful publications about methods for obtaining involvement will be contained in a Organisational Development Starter Pack which the NHS Executive will be producing shortly. (par. 92)

> ***ACHCEW comment**: A synopsis of publications about methods for obtaining public involvement should prove useful. Public involvement is a developing process and CHCs will need to be involved both locally, regionally and nationally in the ongoing debate about the best means of pursuing this goal.*

3.2.2 The role of Community Health Councils:

Guidance states that Community Health Councils will not have their powers and remit extended to cover general medical services provision or the actions of and delivery of services by local social services authorities. (Par. 93).

> ***ACHCEW comment:** Paragraph 17 of The Community Health Council Regulations 1996 state that " It shall be the duty of each council to keep under review the operation of the health service in its district". This does not prevent CHCs reviewing the services provided by GP practices. ACHCEW maintains that the 1996 Regulations enable CHCs to consider all aspects of the health service within their district including GP practices.*
>
> *Indeed the guidance also states that CHCs will have the statutory right to be consulted by health authorities on substantial developments and variations proposed by Primary Care Groups. (Par. 93).*

The guidance recognises the valuable role that CHCs can play in assisting PCGs in carrying out their functions stating : "They have considerable knowledge of the operation of health services in their districts, direct knowledge from representing patients' interests where standards of service can fall down, and are able to provide an informed view of the issues causing patient concern. Community Health Councils will, therefore need to develop effective working relationships with Primary Care Groups as part of their strategic approach to user and public involvement." (par. 94).

4. Conclusion.

PCGs will need to operate openly and involve the local community in the decision making processes about the care to be commissioned. Special emphasis will need to be placed on ensuring that the views of "hard to reach groups" (such as black and ethnic minority communities and people with learning difficulties) are taken into account.

PCGs offer an exciting opportunity for real dialogue and consultation between the primary care professions and the local community that they serve. However PCGs will not automatically mean that services will be centred on the needs and wishes of users. The danger is that instead of patients' needs being taken into account, the views of their GPs will be taken as proxy.

If they are to succeed where fundholding failed, PCGs will need to work with the community they serve to identify the community's needs and aspirations of service delivery. Working in the new spirit of partnership that the Government is encouraging in the NHS, Community Health Councils will be in a unique position to contribute to the success of PCGs.

HSC 1998/139 addresses many of the issues that ACHCEW raised with following the publication of the White Paper "The New NHS: Modern and Dependable". CHCs now look forward to working with PCGs to ensure the success of primary care in the NHS.

Gary Fereday
September 1998

Appendix

In our response to the White Paper "The New NHS: Modern and Dependable" ACHCEW called for the following[9]:

ACHCEW would expect Primary Care /Local Health Groups to hold public meetings and to consult locally about their plans.

In preparing legislation to establish Primary Care Groups the Government must ensure that Health Authorities have reserve powers to take over the management of Primary Care Groups should they fail.

CHCs should have a legal, explicit right to be consulted on all significant changes to commissioning intentions of the Primary Care/Local Health Groups and any other primary care providers such as dentists, opticians and pharmacists.

We would also expect Primary Care/Local Health Groups to operate openly and involve the local community in all decision making processes about the care to be commissioned. Special emphasis should be placed on ensuring that the views of "hard to reach groups" (such as black and ethnic minority communities and people with learning difficulties) are taken into account.

CHCs should be given speaking observer status on the Primary Care/Local Health Groups' governing bodies and have a right to enter and inspect all Group premises and any other sites where NHS primary care services are delivered.

Results of health authority audits or reviews of Primary Care/Local Health Groups should be made available to CHCs.

Primary Care/Local Health Groups should comply with the requirements laid down in the *Code of Practice on Openness in the NHS.*

Health authorities should be required to publish annual summaries of Primary Care/Local Health Group Performance.

Primary Care/Local Health Groups should set out in their published performance reports, the contact they have had with CHCs and the steps they have taken to involve patients in service planning, including measures such as the use of surveys and the establishment of Patient Participation Groups.

The performance reports should also specify the lessons which have been learned from patient complaints. Practice based complaints systems must be a mechanism for airing and addressing problems, not for smothering them.

Bibliography

[1] Department of Health (1998) "The New NHS Modern and Dependable" Cm 3807

[2] NHS executive HSC 1998/065 "The New NHS Modern and Dependable - Establishing Primary care Groups."

[3] NHS executive HSC 1998/139 "The New NHS Modern and Dependable - Developing Primary care Groups."

[4] Department of Health (1998) "The New NHS: Modern and Dependable" Cm 3807.

[5] par. 53 HSC 1998/139

[6] see ACHCEW (1998) "CHCs Making a Difference" and ACHCEW (1998) "CHCs and Black and Ethnic Minorities."

[7] Community Health Council Regulations 1996, SI 640.

[8] see ACHCEW (1998) "NHS Trusts Meeting in Public".

[9] ACHCEW (1998) "CHCs and The New NHS".

Published by:

ASSOCIATION OF
COMMUNITY HEALTH COUNCILS
FOR ENGLAND & WALES
30 DRAYTON PARK LONDON N5 1PB

TEL: 0171 609 8405 FAX: 0171 700 1152

achcew@compuserve.com

Price: £4.00 (inc. p&p)