A SNAPSHOT SURVEY OF LONDONS CHCS EXPERIENCES OF CONSULTATION ON THE CONFIGURATION AND THEIR INVOLVEMENT IN THE DEVELOPMENT OF PRIMARY CARE GROUPS

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ABOUT GLACHC

The Greater London Association of Community Health Councils (GLACHC) is a voluntary organisation founded in 1984, in recognition of the need for an organisation to give a voice to Londoners as users of the National Health Service.

The main aims of GLACHC are:

* To provide research, information, training and support to Community Health Councils (CHC's) in London;
* To promote co-operation between London CHC's, user groups, and voluntary organisations on all matters concerning health services in London;
* To provide a forum to examine and comment on London's health services from the point of view of users and potential users of the NHS;
* To strengthen the voice of London users in policy making and decision-taking forums.

GLACHC aims to fulfil these aims through a variety of activities including:

* Research on a variety of health service issues from the users' perspective;
* Information on health policy issues and CHC initiatives;
* Publications of research findings, discussion documents and conference papers;
* Conferences
* Training for CHC's, voluntary organisations and statutory organisations;
* Consultancy on issues to further the interest of NHS users and potential users;
* Liaison between CHC's and with other organisations.

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FOREWORD

In July 1998, GLACHC established a Primary Care Groups (PCGs) Working Group for London's Community Health Councils (CHCs), to support their emerging role in the development of PCGs, and share ideas, experiences and good practice.

Judith Blakeman, Chair of Kensington, Chelsea and Westminster CHC, undertook to develop a questionnaire to ascertain 'where CHCs were' in relation to the consultation about the configuration of PCGs, and their involvement in the development of these groups.

The questionnaire was further developed by GLACHC staff, and piloted with Croydon, Enfield and Hammersmith & Fulham CHCs, who made valuable contributions to the contents.

All 29 Greater London CHCs took part in the survey.

What emerges, is that *all the CHCs are pro-actively involved in the development of PCGs to a varying degree*. The majority of health authorities see CHCs as having a vital role to play in developing links between local communities and PCGs.

93% of CHCs are/have negotiated observer status and speaking rights at PCG board meetings, and the majority are considering developing training and support for 'lay' members.

The report of the survey makes fascinating reading.

GLACHC is seeking funding to continue to support CHCs in developing their role with PCGs, particularly in relation to helping to involve users, carers, the public and 'hard to reach' groups in their work.

Thanks are due to London's CHCs for giving their very valuable time to take part in the survey.

Sue Towns
Director

November, 1998.

SUMMARY

In late October/early November 1998, the Greater London Association of Community Health Councils (GLACHC), undertook a survey of all twenty-nine Community Health Councils (CHCs) in Greater London to ascertain 'where CHCs were' in relation to consultation about the configuration of PCGs, and their involvement in the development of these groups.

All twenty-nine CHCs, covering sixty-seven PCGs, responded to the survey.

What emerges, is that *all the CHCs are pro-actively involved in the development of PCGs to a varying degree.* The majority of health authorities see CHCs as having a vital role to play in developing links between local communities and PCGs.

Configuration of PCGs

* The length of the time scale for consultation on the configuration of PCGs was limited and considered inadequate by the majority of CHCs.

* 20% of CHCs indicated dissatisfaction at the level of consultation with the voluntary sector.

* 17% of CHCs said that Black and minority ethnic groups were not consulted.

* Of the 67 PCGs covered by the CHCs, 40 cover populations of over 100,000, and 4 over 200,000.

* 27% of CHCs have 11 PCGs that cross borough boundaries.

CHCs' relationships with PCGs

* 76% of CHCs are currently working/liaising with shadow PCGs.

* 93% of CHCs are currently negotiating both observer status and speaking rights on PCG boards. Barnet CHC has recommended the promotion of a recent GLACHC publication 'Behind 'open' doors', and the manual of good practice 'Opening the door' to public involvement, as a guide to ensure 'openness and transparency' for newly established shadow PCGs.

* The interaction of GPs with other professionals and in particular CHCs, is variable with comments from CHCs ranging from 'very proactive' to 'badly'.

Accountability issues

* 76% of CHCs will be/have been involved in the selection of lay members onto PCG boards. This involvement in the majority of cases will be participating on the interview panel for lay members.

* 65% of CHCs state that equal opportunities policies are being followed in the selection process for lay members.

* Only 9 CHCs are currently being consulted on accountability mechanisms for the lay PCG member.

* The majority of CHCs are considering developing training for lay members on PCG boards as well as offering them support.

* All 29 CHCs intend to advise on establishing mechanisms to consult 'hard to reach' groups.

Training for GPs on user/public involvement role

* Only 24% of CHCs know of any form of training being proposed or undertaken for GPs to enhance their expanding role of partnership and involvement with CHCs, users, carers and the public.

Conclusions

* The rate at which PCGs are developing across London varies greatly, including the membership of PCG boards.

* The appointment of the lay representative has been at the bottom of everyones agendas, and some PCG boards will not have lay representatives until long after the initial shadow boards have met.

* CHCs have been pro-active in establishing relationships with shadow PCGs, and are seen by health authorities as having a vital role to play in developing links between local communities and PCGs.

* The great majority of CHCs have already negotiated observer status and speaking rights on the PCG shadow boards, and have been/will be involved in the appointment of lay representatives.

* All CHCs have stated that they wish to develop and working relationship with lay representatives by providing training, support and sharing areas of concern. One CHC has even offered office space.

* CHCs have expressed concern at the accountability of PCG boards, and how the lay representative will be accountable to the people they are there to represent.

SURVEY ANALYSIS

All 29 CHCs in Greater London responded to the Survey.

1. **Were you consulted by your health authority about the configuration of PCGs?**

All 29 CHCs stated that they were consulted by their health authority on the configuration of PCGs.

Barnet CHC added that they were only given a few days to respond whilst others in the borough were given up to a month.

Greenwich CHC - following a request from the CHC, their health authority carried out a public consultation.

Harrow CHC regarded the consultation process as not being fully exercised with the only form of consultation taking the form of the CHC Chair meeting with the proposed groups and being on the steering committees.

2. **Are you satisfied with the level of consultation and length of time you were given? please explain.**

Only 15 (52%) CHCs said they were satisfied with the level of consultation. Out of those 15 CHCs, 6 added the length of time was inadequate mainly due to time constraints imposed by the government.

One CHC added that the level of consultation needed more public exploration and explanation.

Another CHC was dissatisfied with the way their response was treated.

A South Thames CHC said they were fairly dissatisfied with the level of consultation and thought that the health authority could have explored the setting up of a workshop to explore change and potential problems with voluntary groups and CHCs.

2 CHCs were half satisfied with the level of consultation with one adding that they had to take the 'running'.

One CHC also pointed out that the level of consultation for the voluntary sector was poor.

10 CHCs said they were dissatisfied with the level and time of consultation with reasons including:-

* 'The process was rushed due to time scale set by the government, limited consultation and a state of confusion'.

* 'The consultation document was difficult to understand as well as the short length of time given to respond'.

* 5 CHCs also added that the time scale imposed for the consultation was unsatisfactory.

* Another CHC also pointed out the shortness of the timescale and added that the consultation process showed no indication of the possible consequences for service users.

3. **What size populations do your PCGs cover?**

100,000 and over	**Under 100,000**
Lambeth CHC - 2 PCGs North Lambeth - 103,890 South Lambeth - 128,354	
Harrow CHC - 2 PCGs approx 120,000 in each	
Barnet CHC - 3 PCGs 137,000 114,000 111,000	**Barking, Dagenham & Havering CHC** - 5 PCGs ranging between 70,000 and 90,000
Newham CHC - 1 PCG 230,000+ estimated	**Brent CHC** - 3 PCGs ranging from 83,000 - 105,000
Islington CHC - 1 PCG Islington North - 140,000	**Islington CHC** - 1 PCG Islington South - 79,000
Camden CHC - 2 PCGs North Camden - 124,000 South Camden - 127,000	**Hammersmith & Fulham CHC** - 2 PCGs approx 80,000 each
Wandsworth CHC - 1 PCG Tooting and Wandsworth - 127,000	**Wandsworth CHC** - 3 PCG's Putney & Roehampton - 62,200 Battersea - 98,000 East Merton & Furzedown - 92,000
Waltham Forest CHC - 2 PCGs 173,000 116,000	**Hillingdon CHC** - 3 PCGs 94,000 69,000 85,000

Redbridge CHC - 2 PCGs Redbridge - 154,000 Chingford, Wanstead & Woodford - 108,600	**Merton & Sutton CHC** - 1 PCG East Merton & Furzedown - 92,000
Tower Hamlets CHC - 1 PCG 170,000	**Ealing CHC** - 3 PCGs Southall - 87,473 Northolt & Greenford - 83,377 W/Ealing - 69,084
Merton & Sutton CHC - 2 PCGs Sutton - 135,000 West Merton - 154,600	**Richmond & Twickenham CHC -** 2 PCGs 83,516 74,000
Kensington, Chelsea & Westminster CHC - 3 PCGs approx 140,000 each	
Bexley CHC - 1 PCG 220,000	
Greenwich CHC - 1 PCG 220,000+	
Ealing CHC - 1 PCG 128,791	
Richmond & Twickenham CHC - 2 PCGs 104,431 each	
Kingston CHC - 1 PCG approx - 150,000	
City & Hackney CHC - 1 PCG 202,000	
Lewisham CHC - 2 PCGs Lewisham North - 103,890 Lewisham South - 137,605	
Croydon CHC - 1 PCG 140,000	**Croydon CHC** - 1 PCG 70,000
Enfield CHC - 1 PCG Enfield North - 105,037	**Enfield CHC** Enfield South - 90,852
Haringey CHC - 2 PCGs East Haringey - 136,474 West Haringey - 161, 048	

Southwark CHC - 1 PCG 100,000	
Bromley CHC - 3 PCGs 100,000 each	
Hounslow CHC - 1 PCG 102,000	**Hounslow CHC** - 2 PCGs Feltham - 63,000 Brentford, Chiswick & Isleworth - 87,000

This table shows that there are 40 PCGs with over a 100,000 people in each, and 4 with over 200,000.

4. **Do any cross borough boundaries?**

8 CHCs said their PCGs cross borough boundaries. Of these 8, in Redbridge, Chingford, Wanstead and Woodford PCG will be related to by both Redbridge CHC and Waltham Forest CHC, as will Wandsworth CHC and Merton & Sutton CHC who will both relate to East Merton and Furzedown PCG. In Merton & Sutton, several major practices geographically based in Sutton will be in a PCG covering a different area.

20 shadow PCGs do not cross borough boundaries. Irrespective of this **Barnet CHC** is wary about their PCG boundaries as one is alongside the community hospital and there is a need to secure purchasing by PCGs to protect the hospital and its long term viability.

Bexley CHC however, points out that although their PCG does not cross borough boundaries, it does cross internal local authority boundaries; social services.

5. **If so how many ?**
   11 boundaries are crossed

6. The following table shows the 9 CHCs who's PCGs cross borough boundaries and the local authority boundaries they cross.

CHC	**Local Authority Boundary Crossed**
Barking, Dagenham & Havering (1 boundary crossed)	Barking, Dagenham into Havering
Wandsworth (1 boundary crossed)	Wandsworth into Merton
Brent (1 boundary crossed)	Brent into Harrow

Waltham Forest (1 boundary crossed)	Waltham Forest into Redbridge
Redbridge (1 boundary crossed)	Redbridge into Waltham Forest
Merton & Sutton (2 boundaries crossed)	East Merton into Wandsworth 7 Practices in SW London spread across all 3 boroughs
Kensington, Chelsea & Westminster (2 boundaries crossed)	Royal Borough of Kensington & Chelsea into City of Westminster
Harrow (1 boundary crossed)	Harrow into Brent
City & Hackney (1 boundary crossed)	The City of London into Hackney

7. **Was this agreed or opposed by the local authorities affected?**

Of the 9 CHCs that stated that their PCGs crossed borough boundaries, only 4 local authorities agreed with the crossing of boundaries. These 4 local authorities are :- Haringey, Barking, Dagenham & Havering, Brent and Harrow.

The local authorities who opposed boundaries being crossed in configuration are - Wandsworth, Merton, Sutton, Waltham Forest, Kensington & Chelsea, City of Westminster and the City of London.

8. **Was the local voluntary sector consulted about the configuration?**

22 CHCs said the local voluntary sector was consulted about the configuration.

6 CHCs qualified their affirmative answer with the following:-

* 'The consultation document to the voluntary sector came with a short time scale'.

* 'The consultation document was inaccessible'.

* 'The Council for the Voluntary Sector was consulted but not the wider voluntary sector or community groups except through the local press'.

* 'There was not enough consultation with voluntary sector organisations'.

* 'We are unsure of the level of consultation with the voluntary sector but this would have probably been nominal'.

* 'Cursorily'.

Only one CHC stated that they were not aware of steps being taken to involve the voluntary sector in the consultation of PCG configuration. They maintain that the voluntary sector in their patch still remain unaware of the evolution of PCGs. Recently, there has been a move to organise an event to publicise PCGs and HImPS.

9. **Were these just the local/voluntary umbrella groups? If not, who else?**

YES	NO (who else?)	DON'T KNOW
City & Hackney CHC	Hammersmith & Fulham CHC *no one else was consulted	Ealing CHC
Redbridge CHC	Croydon CHC * Residents Association	Barnet CHC
Barking, Dagenham & Havering CHC	Wandsworth * Stakeholders	Harrow CHC
Enfield CHC	Waltham Forest CHC * Wide range of groups and individuals	
Lewisham CHC	Hillingdon CHC * Hillingdon Association of Voluntary Services	
Kingston CHC	Bromley CHC * Range of activities Bromley HA; 'open space' meetings for those interested on the issues	
Richmond & Twickenham CHC	Lambeth CHC * All voluntary and community organisations in the LSL area	
Haringey CHC	Brent CHC * Other smaller groups	
Merton & Sutton CHC		
Kensington, Chelsea and Westminster CHC		
Greenwich CHC		

Bexley CHC		
Hounslow CHC		
Tower Hamlets CHC		
Southwark CHC		
Islington CHC		
Camden CHC		
Newham CHC		

10. **Were local Black and minority ethnic groups consulted?**

YES	NO	DON'T KNOW
Brent CHC	Kensington, Chelsea & Westminster CHC	Ealing CHC
Newham CHC * only as an umbrella group	Enfield CHC * not specifically	Bromley CHC
Harrow CHC	Redbridge CHC * not specifically	Hounslow CHC
Lambeth CHC	City & Hackney CHC	Richmond & Twickenham CHC
Camden CHC * 1 of umbrella race & health group	Hammersmith & Fulham CHC	Barnet CHC * not sure have doubts as to whether Black & minority groups consulted
Islington CHC		Ealing CHC
Southwark CHC * an umbrella group		
Hillingdon CHC * not individually, but under the umbrella group		
Bexley CHC * not individually but under the umbrella group		

Greenwich CHC * through Greenwich CRE		
Merton & Sutton CHC *only able to identify 1 black voluntary group in the 31 consulted		
Waltham Forest CHC * within a wider consultation		
Wandsworth CHC		
Haringey CHC * mainly through umbrella groups		
Kingston CHC		
Lewisham CHC * via BEMMAG		
Barking, Dagenham & Havering CHC		
Croydon CHC		

Looking to the future.....

1. **Are you liaising/working with shadow PCGs?**

YES	**NO**
Brent	
Ealing CHC	Lewisham CHC * not yet, as the CHC does yet know who comprises the shadow PCG
Hammersmith & Fulham CHC	Merton & Sutton CHC * They hope to be when they are set up
Barnet CHC	Bexley CHC * They will be
City & Hackney CHC	Bromley CHC * A shadow PCG is not yet in place

Redbridge	Newham CHC * invited as observers to shadow PCG meetings and allowed to speak
Barking, Dagenham & Havering CHC	
Enfield CHC	
Croydon CHC	
Kingston CHC	
Richmond & Twickenham CHC	
Haringey CHC	
Wandsworth CHC	
Waltham Forest CHC	
Kensington, Chelsea & Westminster CHC	
Greenwich CHC	
Hounslow CHC	
Hillingdon CHC	
Tower Hamlets CHC	
Southwark CHC	
Islington CHC	
Camden CHC	
Lambeth CHC * In the North of Lambeth but not in the South	

2. **What involvement will your CHC have in assisting their development?**

* This CHC is on the steering group with 1 PCG, on large GP group with 1 PCG and no contact with 1 PCG.

*' Less than they would wish'. They expect the relationship with the PCG to remain the same as it was with the fundholding GPs which in the past has not been close.

* This CHC is corresponding with PCGs asking for discussions on their future development.

* They have secured observer status at PCG board meetings and either the CHC or the voluntary sector or both will have input into the shortlisting of lay members and take part in the selection process by being on the interviewing panel.

* The Chief Officer sits on the Primary Care Synergy Group.

* This CHC is actively involved in discussions with one PCG and HA. The other PCG was invited and accepted to speak with the CHC.

* The CHC has observer status on 'Transition Group'.

* The CHC is a member of the advisory and reference group panel of interviews for lay members.

* A CHC Officer is represented at PCG meetings with observer and speaking rights. Being consulted on lay member selection. CHC to establish 3 'User Panels'.

* The Chief Officer sits on LMC and is working with GP's, voluntary sector and nurses.

* Observer at PCG board, working with designated members on locality groups.

* Involved in all planning groups and in the appointment of lay member.

* One CHCs position is not yet clear. They expect observer status and speaking rights as a minimum level of involvement.

* It is too early to tell what they are going to support and get involved in. Their current aims are to secure equity of services within and between PCGs.

* They would like to have an active part in the setting up of Partner Participation Groups and also to explore specific feed back methods.

* They sit on the PCG steering group and attend a multitude of meetings and inter-related committees.

* They are involved in locality commissioning project which will become a PCG, invited to join task force of PCGs, involved in discussions about formation, board make up, public involvement etc.

* They are working with the health authority to develop training/support for lay members. Possible co-optioning of CHC onto PCG, but not yet agreed.

* They have assisted PCGs with the publicity of public meetings. They have also observed the development of PCGs and advised on consultation issues. Their working sub-group for PCGs liaises with outside agencies. Also liaising with other PCGs at intervals on several issues.

* This has yet to be discussed by the council.

* They are striving for maximum involvement at all levels of the PCGs.

* They have set up a patients network of organisations and individuals for input on PCGs. They are also seeking to adopt a 'patient partnership' framework for community involvement for each PCG which will also include CHC speaking rights.

* They want to ensure easy contact to the CHC from lay members so as to aid feedback. They are also pressing for observer status with speaking rights on PCGs.

* They are looking towards getting observer status at PCG board meetings. They are also on the PCG steering group.

* They are part of a resource group supporting the development of PCGs; they share membership with the local council of voluntary sector. They were members of the interviewing panel for nurse members on PCGs and will be for lay members. They have also offered to provide support for lay members.

* They have produced a paper on user participation which was consequently sent to the board of the shadow PCG.

* They will be offering support/information to the lay member.

* They have so far had an informal involvement with their shadow PCGs and this has depended on the level of interest of each individual PCG. They stated that 1 PCG seems to be very disorganised and therefore they have not had much contact with them, but the other PCG is keen to talk to the CHC.

* They have representatives on every shadow PCG and are working towards gaining observer status on PCGs by 1999.

3. **How are GPs interacting with other professionals, and in particular CHCs?**

*' GP interaction has so far been patchy. GPs on one PCG have interacted better than the other one'.

* 'They have not really, they have still not got out of the 'them' and 'us' mentality'. It is noted by this CHC that GP fundholders backgrounds are far more professional.

* The CHC Chair was invited to attend the LMC meeting.

* The GPs on their PCGs are interacting well with the CHC but are not sure as to the level of interaction with other professionals. They note that the pharmacists

are not happy with recent developments and community mental health workers feel left out.

* To date, the GPs are mainly focused on their own agendas. GPs are wary of CHC involvement.

* Interaction is at an acceptable level and the CHC are made to feel quite welcome.

* ' How indeed?'.

* Interaction with GPs by this CHC has included being invited and well received at away days for shadow PCGs.

* Cannot comment at present.

* Interaction is of an acceptable level at present.

* GPs are liaising with the CHC on issues of concern.

* This CHC states that they have not seen much evidence of interaction.

* 'Very proactive'.

* Contact with PCGs is very much Health Authority driven via PCG steering meeting. This CHC is also attending clinical meetings with Trusts.

* This CHC has had a number of conversations with a number of GPs who have proved sympathetic to CHC involvement.

* 'Do not know'.

* This CHC has held meetings with GPs and GPs also attend CHC arranged locality forums.

* Lead GPs are in communication with CHCs. This CHC states that GPs are becoming more defensive and looking at their own interests.

* GPs are interacting well.

* GPs are interacting well and with respect. They are also interacting well with other professionals.

* GPs are not interacting at all with this CHC and it is not known how well they are interacting with other professionals.

* GPs attend CHC meetings and the CHC chair meets regularly with the PCG chair and members of the PCG board.

* Interaction so far has been good. There has also been regular contact with the proposed chair of one of the PCGs.

*'Generally a positive culture is developing'. This CHC states that relationships with local GPs has never been 'so good'.

*'Things are pretty much the same as always - not much interaction'.

* This CHC has seen more interaction in the north of the borough than the south. In the north, the PCG meets with the CHC. The general feeling is that at present they are more concerned about local elections than interacting with others.

* This CHC states that they are not aware of how they are interacting with other professionals. They do not expect any increased interaction between GPs and the CHC.

* 'Badly'.

* They are exploring co-option for CHC members.

4. **Have GPs been offered any special training for their enhanced role, particularly about CHC, user/carer/public involvement?**

CHC	YES	NO
Brent	On the agenda	
Newham	workshops organised by HA included CHC. Unsure of rest	
Lambeth	Being dealt with by HA. Training included in consultation document	
Camden		CHC and Voluntary Sector informed HA of offer to feed into induction. No firm arrangements
Islington		Not as far as they know
Southwark		Not as far as they know
Tower Hamlets	Training offered for GPs but not on user/carer/public	

Bromley		Unlikely
Hillingdon		Details of a 6 month course circulated, unsure if GPs joined. No training offered on the rest
Hounslow		No
Bexley		Not by the HA
Greenwich		'Not sure, probably not'
KCW		Not that they are aware of
Merton & Sutton		Thinks training has been discussed by Project Dev. Board - no details of what sort of training
Ealing		No
Richmond & Twickenham		No
Kingston		No
Lewisham		Don't know
Croydon		No
Enfield	CHC putting material into an ongoing resource pack	
Barking, Dagenham & Havering		No
Redbridge		No, but CHC to pursue
City & Hackney	A series of workshops of which CHC doing one	
Barnet		No response
Hammersmith & Fulham		None, although the CHC has asked for it
Waltham Forest	Early training undertaken.	
Wandsworth		CHC currently looking into this

Haringey		No
Harrow		Not as far as they are aware

7 (24%) CHCs said GPs have been offered training while **22(76%)** CHCs did not know of any training being offered to GPs on their enhanced role of 'Partnership'.

5. **Will you be involved in the selection of the lay PCG members?**

22 (76%) CHCs stated that they would be involved in the selection of lay members onto PCG boards. Their involvement has or will be to be on the interviewing panel for the selection. **Hillingdon CHC** has also been asked to write a paper with suggestions on how to proceed and they may also be on the selection panel.

Brent, Hammersmith & Fulham and Waltham Forest CHCs are not sure of their involvement at present. **Islington, Hounslow and Harrow CHCs** are not being involved in the selection of lay members.

6. **Are equal opportunities procedures being followed in the selection of your lay PCG board member?**

19(65%) of CHCs said equal opportunity policies were being followed in the selection of their lay PCG board member. 7 CHCs did not know and Camden CHC objected to questions of political affiliation and ethnic monitoring being included on the application form that will be used for shortlisting. One CHC stated that equal opportunities procedures on the selection process for their lay member PCG board member was merely a 'lip service exercise'. One CHC also stated that equal opportunity policies were not being followed in the selection of their lay PCG member.

7. **Are you being consulted about accountability mechanisms for the lay PCG board member?**

Only 9(31%) CHCs said they were being consulted about accountability mechanisms for the lay PCG member. 19(65%) of CHCs in Greater London said they had not yet been consulted with 1 CHC not knowing.

8. **What support and links are you considering developing with the lay member?**

* Their chair is resigning to take up a role on the PCG and will be a future link for them, and they intend to contact the other lay member as soon as possible.

* They intend to meet regularly with the lay member and work on developing an

agenda and links with the voluntary sector.

* They intend to offer training and support to the lay member subject to agreement by the HA.

* They have already offered training to the lay member, they expect an arms length but supportive relationship which will depend on the attitude of those appointed.

* They will be speaking to applicants, they need to link with the CHC via CHC primary care committee and via the CHC organised patient forums.

* They intend to provide training, CHC awareness and the opportunity of office space.

* To be considered.

* They are not sure yet.

* They are holding preliminary discussions with the health authority to arrange for the lay member to liaise and consult with CHCs.

* They have written to the health authority offering support to the lay member. They also intend to invite the lay member onto their primary care committee as co-optees and then will they have access to CHC training.

* They intend to provide the lay member with regular briefing meetings.

* They intend to provide an independent support group.

* They intend to address the negatives and follow best practice.

* They intend to develop close links with lay members to ensure that they are aware of issues around service review, where the setting up of PCGs is given as a reason by the health authority for not progressing their recommendations.

* They have been invited to attend meetings as observers and have also been invited to join a forum with voluntary organisations which there is one in existence.

* They intend to have regular contact and liaison, through inviting the lay member to CHC meetings of the full CHC as well as community and primary care working groups.

* They are currently discussing how support can be offered as part of the more general work on community involvement and PCGs.

* Question not responded to.

* The lay member is to be encouraged to liaise with the CHC and they will be sent CHC information to aid them in their new role.

* Support will be via a CHC/Voluntary sector partnership group.

* They intend to offer training, information and support to the lay member.

* They have not yet decided what form of support to provide to the lay member.

* They intend to meet with the lay member and develop issues around local involvement. This will include determining what is feasible as well as determining roles.

* They intend to involve lay members in working parties and as observers at CHC meetings.

* They will involve lay members by assisting in the establishment of a local forum for all lay members and by organising regular meetings with them.

* They intend to provide training and discuss with the lay members what support they need.

* They will provide training.

* They will involve lay members by inviting them to attend CHC meetings as observers.

* They will suggest that the lay member attends CHC meetings and they will also provide them with information on issues of concern.

9. **What is your CHC negotiating with your PCG around CHC representation on PCG boards, eg. observer only status, speaking rights?**

27(93%)of CHCs are currently negotiating both observer status and speaking rights on PCG boards. Hammersmith & Fulham CHC did not respond to this question and Hounslow CHC is negotiating observer only status.

* **Barnet CHC stated that they will be recommending to their PCG boards to enable Openness and Transparency, the use of the GLACHC publication and Good Practice Guide 'Behind Open Doors' and 'Opening the Door'**

10. **Do you intend to advise on establishing mechanisms to consult 'hard to reach' groups?**

All 29 CHCs in Greater London said they intend to advise on establishing

mechanisms to consult hard to reach groups.

11. **Any other comments?**

* The election of the PCG chair should take place at the first meeting of the board and by all the members of the board, not just GPs.

* They are working towards the PCG structure succeeding and responding to the 'Patient' in primary care.

* All CHCs should be involved in the selection of lay members. It is bad practice for the shadow PCG to be set up with no lay members.

* One CHC is seeking an annual Statutory meeting. Shadow PCGs have been set up with no lay members and the CHC have protested at this being 'Bad Practice'. The changing relationship between CHCs and health authorities in the advent of PCGs calls for a review of the relationship between them.

* CHCs need to share strategies for dealing effectively with PCGs.

* A CHC has appointed a 'White Paper lead' member in each working group to follow developments. Strategic objectives encompass the White Paper.

* A CHC is concerned at the absence of a mechanism for removing under performing PCG board members and they also express concern at the poor response to the advertisement for lay members.

* A CHC is concerned at the power struggles taking place between shadow PCGs and the health authority. The health authority wish to consolidate their power base during the next few years.

* A CHC would like a lead from GLACHC on the training of lay members.

* A CHC would like to see equity observers ensuring no inequalities between groups and clinical priorities. They are waiting to see what their health authority is going to do about monitoring.

* This CHC is currently bidding for research funds to assist PCGs in public involvement.

* This CHC would like the public to be informed on what changes there might be. The CHC would also like to follow up satisfaction levels with vulnerable groups.

* A CHCs shadow PCG recently met for the first time with no health authority representative present. After about 20 minutes all non-GPs present were asked to leave. GPs were asked to remain as it was considered a GPs meeting.

* A CHC reports that 1 of its 3 shadow PCGs has no lay member and has been offered an executive director of the health authority, a place on the board until they are able to appoint an associate. Lay members will not be appointed until after Christmas resulting in decisions being made by shadow PCGs with no public representation except the observer status of the CHC.

THE GREATER LONDON ASSOCIATION OF COMMUNITY HEALTH COUNCILS

SNAPSHOT SURVEY OF LONDON CHCS' EXPERIENCES OF CONSULTATION ON THE CONFIGURATION AND DEVELOPMENT OF PRIMARY CARE GROUPS

Please will you complete this questionnaire and return it to GLACHC in the enclosed stamped, addressed envelope.

Person completing the questionnaire .....

CHC .....

Configuration of PCGs

1) Were you consulted by your health authority about the configuration of PCGs?

2) Are you satisfied with the level of consultation and length of time you were given? Please explain.

3) What size populations do your PCGs cover?

4) Do any cross borough boundaries?

5) If so, how many?

6) Which local authority boundaries are crossed?

7) Was this agreed or opposed by the local authorities affected?

8) Was the local voluntary sector consulted about the configuration?

9) Were these just the local umbrella groups? If not, who else?

10) Were local Black and minority ethnic groups consulted?

Looking to the future....

1) Are you liaising/working with shadow PCGs?

2) What involvement will your CHC have in assisting their development?

3) How are GPs interacting with other professionals, and in particular CHCs?

4) Have GPs been offered any special training for their enhanced role, particularly about CHC, user/carer/public involvement?

5) Will you be involved in the selection of the lay PCG member?

6) Are equal opportunities procedures being followed in the selection of you lay PCG board member?

7) Are you being consulted about accountability mechanisms for the lay PCG board member?

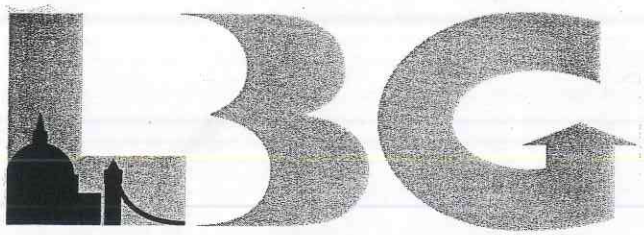
8) What support and links are you considering developing with the lay member?

9) What is your CHC negotiating with your PCGs around CHC representation on PCG boards, eg. observer only status, speaking rights?

10) Do you intend to advise on establishing mechanisms to consult 'hard to reach' groups?

11) Any other comments or ideas you would like to share?

Thank you so much for taking your valuable time to complete this questionnaire. Please return to GLACHC.



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