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The new NHS Modern and Dependable

Establishing Primary Care Groups

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CQC100278-0002

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The new NHS Modern and Dependable

Establishing Primary Care Groups

Summary

This HSC contains guidance for Health Authorities, GPs (and their practice staff), and community nurses on the establishment of Primary Care Groups. Guidance on Primary Care Trusts, which will operate at level 3 or 4, is subject to legislation and will be available later in the year.

This guidance contains information on:

- the purpose of Primary Care Groups (their functions and the potential benefits)
- the configuration of Primary Care Groups (including the approach to be taken, population base, and boundaries)
- the criteria for assessment and approval process
- the arrangements for migration from GP fundholding
- the arrangements to enable Primary Care Groups to become operational from 1 April 1999

Action

- **Chief Executives of Health Authorities and NHS Trusts** should bring this HSC to the attention of their staff, setting in hand the required action (summarised at paragraph 59) and to ensure that Local Authorities and the local community are fully involved in the decision making process
- **Chief Executives of NHS Trusts** should take action to ensure their frontline community nurses are fully involved in taking forward the development of Primary Care Groups
- **Health Authorities** should take action to establish Primary Care Groups
- **General Practitioners and community nurses** should work together with their health authority to take action necessary for the establishment of Primary Care Groups
- **Regional Offices** should ensure Health Authorities are taking action to establish Primary Care Groups in line with this guidance

This circular has been issued by:

CQC100278-0004

Alasdair Liddell
Director of Planning

Preface

This document has been prepared following a series of workshops involving GPs, nurses, other health professionals, social services and managers from a variety of agencies. It has also been informed by discussions at regional and national level with relevant representative bodies. These discussions will continue, and will inform the development of further guidance throughout the next year.

Introduction

1. From 1 April 1999, all GP practices (and their patients) will be represented within a Primary Care Group which. This guidance provides further information on the Government's proposals for the establishment of, and involvement of GPs, nurses and social services in, Primary Care Groups.

2. Annex 2 to HSC 1998/021 provided an approximate timetable for the production of guidance on various aspects of Primary Care Groups and Primary Care Trusts. In line with that timetable this guidance covers the following aspects about Primary Care Groups:

   - the purpose of Primary Care Groups (their functions and the potential benefits)
   - the configuration of Primary Care Groups (including the approach to be taken, population base, and boundaries)
   - the criteria for assessment and approval process
   - managing the transition from GP fundholding
   - the arrangements to enable Primary Care Groups to become operational from 1 April 1999
   - the relationship of Primary Care Groups with other initiatives and pilots

3. This guidance focuses on the development of Primary Care Groups over the next 12 months. Further guidance, including financial and governing arrangements of Primary Care Groups and the opportunities to progress to Primary Care Trust status will be produced in summer and in autumn 1998.

The purpose of Primary Care Groups

> "The Government will also build on the increasingly important role of primary care in the NHS."
>
> "The Government therefore intends to establish Primary Care Groups across the country bringing together GPs and community nurses in each area to work together to improve the health of local people."
>
> *The new NHS*
>
> "The contribution of new Primary Care Groups to drawing up and implementing Health Improvement Programmes will be vital, reflecting the perspective of the local community and building partnerships with key local organisations."
>
> *Our Healthier Nation*

4. Family doctors, primary care teams and community nurses, who are often the first port of call for patients seeking health advice or treatment, are at the heart of establishing Primary Care Groups. They will work together, through the establishment of Primary Care Groups, to improve the health of local people, shaping a new NHS.

5. Primary Care Groups are not there simply to commission health services, but also to improve primary care itself. Other health care professionals, social services and the local community also have an important role to play in informing and shaping the decisions that Primary Care Groups will need to make. As well as involving GPs, community nurses and social services, Primary Care Groups should ensure that they also involve other health professionals including PAMs and other primary care contractors (dentists, pharmacists and optometrists) as well as secondary care clinicians, on issues affecting their delivery of care.

The benefits of Primary Care Groups

6. Primary Care Groups are fundamentally about improving the health of the population they serve. They will provide a direct means by which GPs (and their primary care team) and community nurses, working in co-operation with other health and social care professionals, will lead the process of securing appropriate, high quality care for local people. Primary Care Groups should provide the structure, the tools and the skills necessary to secure these objectives. They will:

    - bring together the roles of commissioning secondary care with developing primary care and improving the public health thus allowing decisions taken by health and social services professionals within the Primary Care Group to be based on the whole system

    - build on the strength of the practice unit and enable GPs and nurses to improve the quality of services within the practice and, by working collaboratively with other healthcare professionals and managers, to organise and develop health services within their area

    - build better healthy alliances between GPs and the wider health community, for example with local schools, voluntary bodies and across local Government

- involve and work closely with social services to put in place (and possibly provide) integrated care packages for individuals and, through the inclusion of social services on the governing body, to co-ordinate services within the area

- allow health professionals to identify and tackle the problems of variation in the quality of primary and community services - to make sure that there is no underclass of patients receiving poor health care

- be capable of identifying and sharing good practice achieved within practices for the benefit of all patients in the area not just those in some practices

- allow the public to participate in decisions on primary, community and hospital services (further guidance will be issued in the summer on this topic)

- provide flexibility within the available resources to ensure that services can be available at the appropriate time and place, taking account of clinical effectiveness and user preference

- be well placed to influence Health Authorities in the development of truly integrated workforce plans across primary and secondary care

- reduce the isolation felt by some health professionals working in small practices

- be fully compatible with the independent contractor status of GPs

7. It is intended that members of the Primary Care Group will have the option of progressing to either a level 3 or 4 Primary Care Trust and becoming a freestanding body separate from, but accountable to, their Health Authority. The benefits that may be derived from taking on such added responsibilities may be increased through the flexibilities available to a Primary Care Trust. This will become clearer once guidance on Primary Care Trusts is available in autumn 1998.

The functions of Primary Care Groups

8. Primary Care Groups will, for the first time, bring together a number of important functions within one organisation's remit (see Annex A for details). In particular, Primary Care Groups will take responsibility in relation to the wider public health of the local community and the development of primary care in addition to the commissioning role. This is a challenging agenda which will require the skills and competencies of a variety of health and social care professionals. Each has something to contribute. No one agency or group of staff is likely to be able to achieve all that is being asked of Primary Care Groups on their own. Successful Primary Care Groups will be those that can harness the range of skills necessary to learn and work together for an effective partnership which will improve patient care.

Establishing Primary Care Groups

Configuration and approval

9. The benefits of Primary Care Groups will only be achieved if GPs, nurses, other health professionals, managers, social services, Health Authorities, NHS Trusts and the public are able to develop an effective partnership. It is essential therefore that such a partnership is established right from the beginning and this starts with the

process of configuring and determining the shape of Primary Care Groups. This also means involving staff and local/national representatives in the planning and implementation of change.

10. LMCs have an important role to play. Health Authorities will need to ensure that LMCs are fully involved in discussions about the establishment and development of Primary Care Groups and are consulted on the likely impact on General Medical Service provision resulting from the Health Improvement Programme. LMC's statutory right to be consulted by Health Authorities on issues including GPs' terms of service, complaints and the investigation of certain matters of professional conduct, as well as use of GMS cash-limited monies such as the out of hours development fund, is not affected by the development of Primary Care Groups or Primary Care Trusts.

11. HSC 1998/021 warned of the dangers of any party trying to establish Primary Care Groups without proper involvement of other stakeholders. It stated that there should be "no presumption that unilateral proposals from Health Authorities, GPs or NHS Trusts will necessarily be the basis for Primary Care Groups."

12. The process for getting into and deciding on Primary Care Group is as follows:

    - Level 1 and 2 Primary Care Groups will legally be established and operate as a committee (or sub-committee) of a Health Authority. Health Authorities therefore have ultimate responsibility to establish Primary Care Groups. However, proposals for the configuration of groups should be bottom up, emerging from discussions between Health Authorities, GPs, nurses, other health professionals, community and acute NHS Trusts, and social services. As Primary Care Groups are to be formed around natural geographical communities it is important that the views of local people are properly taken into account. Primary Care Groups will include any local PMS Primary Care Act Pilots and their clinicians and patients need to be involved in this process.

    - Primary Care Groups will be based on natural geographical communities of people, typically covering around 100,000 population, and taking account of social services organisational structures. Decisions on Primary Care Groups must be based on consideration of the criteria shown on the following page.

Criteria for Assessment

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?*

Configuration and approval cont.

13. Regional Offices of the NHS Executive will be available to give further clarification of these criteria if necessary and to advise on proposals that do not meet the criteria. Annex B sets out a list of Regional Office contact persons.

14. Health Authorities are charged with responsibility for establishing the Primary Care Groups and will be required to notify the NHS Executive of their local configuration by July 1998. This should specify both the list of member practices and the defined geographical boundary of the Primary Care Group's area - which will determine, for example, its responsibilities for non-registered patients. The NHS Executive Regional Offices will be responsible for performance management of Health Authorities in this task. Health Authorities will be required to demonstrate that they have undertaken this duty in an inclusive manner consistent with this guidance.

15. In demonstrating consistency with the guidance, Health Authorities will be required to provide evidence:

- that all the criteria were considered fully
- that the parties involved have reached a consensus over the proposed configuration and accept the proposal being put forward (this may be achieved where appropriate by parties signing up to proposals)

16. Health Authorities should notify Regional Offices of any parties that disagree with the proposals and set out what steps have been taken to address their views.

17. In the event that the Regional Office is not satisfied, Health Authorities will be asked to reconsider their proposals.

18. All patients registered with a GP must become the responsibility of the Primary Care Group of which the GP is a member. No patient should be counted in two Primary Care Groups and no Primary Care Group should be accountable to two Health Authorities. Primary Care Groups should not normally cross health authority administrative boundaries. This will help to minimise the administrative complexity and more complicated accountability arrangements inherent where more than one Health Authority (and local authority) is involved. However, where it is absolutely necessary for Primary Care Groups to cross health authority boundaries, the Primary Care Group or the Health Authority with the majority of the population should take lead responsibility. A Health Authority may formally delegate certain functions to another Health Authority (or committee of that Health Authority) in accordance with the NHS (functions of Health Authorities and Administration Arrangements) Regulations 1996.

19. This principle may affect the relationship between certain practices and their current Health Authority. Where proposed Primary Care Group configurations affect or are affected by existing Health Authority boundaries, the Health Authorities in question must give early notification to the Regional Office who will advise on handling. Further consideration is being given to the management of boundary issues. Guidance on this and allocations to Primary Care Groups will be provided in summer 1998.

20. Once decisions have been made about the initial configuration of Primary Care Groups, changes to the configuration (ie movement of the practices on the margins of Primary Care Groups) can occur where all parties concur. Health Authorities will

be responsible for approving such changes, which would be expected to occur at the end of the financial year so as to simplify arrangements for allocations.

Involvement of Community Nurses

21. The Government believes that involving frontline clinicians, both family doctors and community nurses, is the solution to providing better care for patients. In this context, the term community nurses is used to include all nurses who work in the primary and community health sector.

22. Primary Care Groups will need the active involvement of community nurses in order to carry out their responsibility of improving the health of the population it serves. The NHS Executive, therefore, expects Health Authorities and GPs actively to engage community nurses, both at management and operational level, in decisions on the configuration of Primary Care Groups, and in preparing for the functions to be performed by Primary Care Groups. How this is to be carried out can only be determined locally but in order to facilitate this process we expect Chief Executives of Community NHS Trust and units, and managers of community nurses to:

- *identify a lead community nurse within each provider unit to act as* liaison point for community nurses within that unit; once identified the name and contact details of this person should be notified to the relevant health authority, local GPs, community nurses and NHS Executive (Richard Armstrong)

- actively facilitate the involvement of community nursing staff employed by the trust in local discussions on the establishment and development of Primary Care Groups.

23. It will be for community nurses locally to decide who is to represent them in the governing arrangements for Primary Care Groups.

24. In addition, it is desirable for practice nurses to be similarly encouraged to be involved in the development of Primary Care Groups.

Preparatory Issues

25. Once it is clear that agreement has been reached between the parties involved on the configuration of Primary Care Groups (and this may be reached in advance of July 1998, providing due process has been observed) Health Authorities, GPs, nurses and social services will need to begin to make the necessary preparations for 1999 including the development of the governing arrangements of the new Groups.

26. It is suggested that 'shadow Primary Care Groups' are formed which will be required to undertake a number of functions throughout 1998/99. These include:

- taking necessary steps to go-live on 1 April 1999, including overseeing the appointment of staff to work on developing Primary Care Groups, creation of the governing arrangements for Groups and ensuring a smooth transition from existing fundholding or local commissioning arrangements

- working with Health Authorities to inform the development of the Health Improvement Programme

- working in partnership with the Health Authority on service agreements for 1999/2000

27. The issue of resources for undertaking these tasks is dealt with in paragraph 40.

28. It is envisaged that in the first instance, once the configuration is known, one or two individuals per group should be appointed who will be responsible for supporting the work of shadow Primary Care Groups. Appointments to these posts should be subject to the general arrangements for filling posts set out in paragraph 38. As the skills necessary to make preparations for Primary Care Groups may be different to those ultimately required to manage Primary Care Groups, it may be appropriate for these posts to be relatively short term in their nature, or subject to a review of their scope in 12 to 18 months.

29. Once appointed, one of the first tasks will be to create the governing arrangements for the Primary Care Group. As there will be no single model constitution for the governing arrangements of Primary Care Groups (although legislation later in the year will set out the requirements of level 3 and 4 Primary Care Trusts, about which there will be further consultation), shadow Primary Care Groups and ultimately Primary Care Groups will have flexibility to develop arrangements which suit the local circumstances, subject to the arrangements set out below.

Governing Arrangements

30. Primary Care Groups will be established as a committee or sub-committee of the Health Authority (the NHS Executive is looking at the regulations around the establishment of sub-committees and further guidance will be issued in the Summer). The Chief Executive of the Health Authority is the accountable officer and must ensure that proper arrangements are in place for ensuring that the Primary Care Group operates within the authority it has been delegated. In establishing a Primary Care Group as a sub-committee of the Health Authority, governing arrangements must:

    (i) adhere to 'The new NHS' commitments of:

    - allowing for a proper involvement of community nurses at both strategic and operational levels within a Primary Care Group. GPs and nurses have a distinctive contribution to make to the planning and provision of services within Primary Care Groups and this must be reflected in the governing arrangements

    - a lead member of the Primary Care Group, likely to be a clinical professional, responsible for clinical governance, working with a lead contact person in each practice and group of professionals who work together

    - establishing a partnership with social services through representation on the governing body. Local Authorities should be asked to nominate an officer at operational level relevant to that Primary Care Group to ensure that local service provision, as well as strategic discussions, can take place around providing better integrated care to local people; (the involvement of Social Services in Primary Care Groups is being discussed with interested parties at present and will be the subject of further guidance in summer 1998)

- promoting financial control by supporting the effective management of devolved budgets

- involving the public and openness of Group procedures

(ii) command the confidence of stakeholders (this may be achieved by ensuring leaders of Primary Care Groups are accountable to their stakeholders and that the procedures for appointing people to work with Primary Care Groups are agreed by stakeholders). There should be no question of Health Authorities or Primary Care Groups making unilateral appointments of Primary Care Group leaders without regard to these considerations;

(iii) take into account the need for the Primary Care Group to work with the host Health Authority, in accordance with the authority delegated to them;

(iv) allow Primary Care Groups to obtain the range of managerial and clinical competencies necessary for them to undertake their functions (see Annex A).

31. Further guidance on governing arrangements will be issued in the summer but the configuration of the governing body should reflect the size and functions of the Primary Care Group and its management costs. Consideration should also be given to the governing arrangements of a Primary Care Group below the governing body level. These arrangements should fully reflect the necessity to involve a wide range of professionals in the work of the Primary Care Group and draw on their relevant expertise and experience.

Relationships with other primary care professionals

32. Other primary care professionals, such as dentists, optometrists and pharmacists, will need to be drawn in to contribute to the identification of the health needs of the population and the provision of services. Each profession deals with a range of health care problems day to day and will have a continuing role to play. It will therefore be important for those involved in the development and running of Primary Care Groups to work with the providers of these local services about planned activity, and to consult them on the potential impact of any changes. This will facilitate a coordinated delivery of services across primary care.

33. Whilst the Defence Medical Services provide a comprehensive primary care service for its personnel and their families, they rely upon local NHS provision of community services and secondary care, particularly for emergencies. Therefore, in areas where there is a high concentration of armed forces personnel and their dependents, it will be important for those Primary Care Groups to ensure that Defence Medical Service primary care practitioners are included within the Primary Care Group.

Human Resources

34. After the configuration of Primary Care Groups have been determined, in the summer, one of the first tasks for the shadow Primary Care Group will be to determine, at least in outline, the number and types of staff acquired to work on establishing and developing the Primary Care Group. Shadow Primary Care Groups should aim to do this by September 1998, not least so that staff affected will have some clarity about the options that may be open to them.

35. *The NHS Executive would welcome views on whether further guidance is needed for the Summer on the expected general management and administrative roles and*

recommended staffing levels of Primary Care Groups. For the present, however, it is envisaged that there will remain a considerable degree of flexibility for Primary Care Groups to determine their own staffing priorities, within the management cost budget.

36. It is important that Health Authorities, in partnership with shadow Primary Care Groups, start working on a strategy to manage and identify the human resource issues which are likely to develop throughout the various stages of Primary Care Groups and during the establishment of Primary Care Trusts. This will need to include consideration of how to manage (including retraining) any displaced staff. This strategy should involve consultation at every stage of the proposed changes with staff and staff organisations and give proper consideration to their views. It is essential that handling of appointments to new posts is fair. Health Authorities will need to have policies in place which will ensure that recruitment to Primary Care Group positions are carried out properly. The need for equity, probity as well as equality of opportunity is paramount.

Appointment of Staff to Primary Care Groups

37. Level 1 and 2 Primary Care Groups will, in legal terms, be operating as a committee (or sub-committee) of a Health Authority and are therefore currently unable to directly employ staff in their own right. Staff appointed to work within a Primary Care Group will therefore need to be either:

- directly employed by a Health Authority
- employed (with the agreement of the Health Authority and other parties) via a lead GP practice to work with the Primary Care Group
- employed by, or seconded from, a Community NHS Trust or other NHS body to work within a Primary Care Group

38. Health Authorities will need to ensure that in all cases, staff appointed to posts have been subject to fair and open competition.In order to preserve the continued employment of fundholding and other health service staff, those with relevant skills or qualifications should be allowed to compete first. This means that there must be job descriptions, person specifications and advertisements for these posts and that any existing staff, whether employed by the an NHS body or by a GP, affected by the establishment of a Primary Care Group should be invited to apply for the posts where they are suitably qualified. GPFH staff employed under contract through a private company should also be eligible to apply for posts on the same basis. In making decisions on the appointment of suitably qualified staff, the interview panel should consist primarily of people drawn from the proposed Primary Care Group, with the Health Authority represented either as an assessor or as the employer for Primary Care Group staff. It is envisaged that decisions on most appointments will be reached during October - December 1998 although some staff may be designate until taking up appointments nearer 1 April 1999.

39. Consideration is being given to the establishment of regional or sub-regional clearing house arrangements. These would serve to reduce the potential for redundancy by enabling those staff not appointed to Primary Care Group posts but employed through the fundholding scheme to register with a clearing house and become eligible for redeployment within local health organisations. *The NHS Executive would welcome views on this proposal* and, if agreed, further guidance on this will be issued in summer 1998.

Preparatory Costs

40. The NHS Executive is currently reviewing arrangements for preparatory costs. It is recognised that shadow Primary Care Groups will require further resources to enable them to undertake preparatory work in 1998/9. There are some sources already available locally and in the first instance, Health Authorities in partnership with shadow Primary Care Groups should look to:

(i) the Health Authority's own management costs

(ii) GP fundholders who should aim to simplify where possible their fund management processes, to free up their own and their staff's time

(iii) GP fundholders who wish to leave the standard or community fundholding schemes in order to free up time and resources, may do so by applying, before 30 June 1998, for a "fast track" change of status. Formally they will become a "GP Commissioning Group" in terms of the fundholding regulations, ie they will continue to hold a budget for prescribing only. Subject to Health Authority confirmation that the former standard or community fundholding practice is intending to participate actively in preparations for Primary Care Groups, a proportion of the PFMA it no longer receives will nevertheless be paid to the Health Authority: 60% in the case of practices joining National GP Commissioning Group (GPCG) pilots or PMS plus pilot (under the Primary Care Act); 40% in other cases. Prior to applying for change of status, the practice should have discussed with the Health Authority how this money is to be shared between winding up their previous fundholding responsibilities, Primary Care Group preparation by the practice, and wider Primary Care Group action by the Health Authority or other practices. (Further guidance on the migration from fundholding is set out in paragraphs 45 - 46)

(iv) Primary Care Group pilots will be expected to work towards Primary Care Group implementation from within their support costs

41. Additional resources will be made available to Health Authorities (particularly those with low levels of fundholding) to supplement the existing resources and to support other preparatory work (including the involvement of practice staff and other primary care professionals). The levels of these resources will be confirmed by the summer. As with GP Fundholder management costs, spending of these sums and those identified at paragraph 40 (ii) to (iv) will not count towards Health Authority costs targets.

Management Costs (from 1 April 1999)

> "Redeployment of the GP Fundholding Practice Fund Management Allowance will provide about £3 per head of population to support the running costs of Primary Care Groups as part of the overall Health Authority/Primary Care Group cost envelope available locally. Further management support costs will be redeployed over time from Health Authorities as Primary Care Groups take on more responsibilities."
>
> *The New NHS*

42. From 1999/00, Health Authorities and Primary Care Groups will be allocated a single management cost envelope. The Primary Care Group management cost

allocation across all Health Authorities will average about £3 per head of population. At the same time allocations of GP fundholder management allowances will cease.

43. Health Authorities and Primary Care Groups will need to agree how to divide the single envelope between them. This division should be based on an objective assessment of the roles and responsibilities which will be held, respectively, by the Health Authority and by each Primary Care Group. The aim is that each party should receive a fair share of the management cost budget in accordance with the roles it is going to fulfil and that functions should be conducted in a way that maximises the efficient and effective use of management resources. In the event that agreement cannot be reached NHS Executive Regional Offices may be called upon to advise.

44. A firmer indication of the 1999/00 management cost envelopes will be made available to Health Authorities in the summer. Estimates on the distribution of management costs between Primary Care Groups and Health Authorities will need to be made locally at that point to inform the Primary Care Groups' identification of staffing requirements. For level 4 Primary Care Trusts, the management cost envelope will be further adjusted at the time of merger between the Primary Care Group and the provider of community health services.

Migration from Fundholding

45. There are a number of specific issues regarding the migration of fundholding practices to Primary Care Groups, which are spelled out below. Two principles should guide this process:

    (i) ***Continuity:*** The Government is committed to building on what worked in fundholding. Where fundholding has achieved benefits for patients, the aim should be for these advantages to be maintained and spread, although there may be occasions where a fundholding practice's advantages are based on a privileged budgetary position, and are unsustainable.

    (ii) ***New Accountability Arrangements:*** The decision making responsibility which currently rests with fundholders within the ***Accountability Framework for GP Fundholding,*** will shift to Primary Care Groups or Health Authorities in accordance with new arrangements. The long term decisions about what services to provide and how to deploy resources will rest at Group level, although Primary Care Groups may choose to allow some of these decisions to be taken at practice level.

46. Arrangements for the migration from fundholding to Primary Care Groups will be as follows:

    (i) Fund management staff

    Wherever possible, fund management staff should be encouraged and supported, including retraining where appropriate, in applying for posts within Primary Care Groups and Health Authorities. The skills and experience of many fundholding staff will be of great value in the new NHS and, where possible, it is desirable to keep these staff employed within the NHS family.

    If the local human resources strategy operates well, there should be limited need for redundancies. In any event, redundancies should not take place while there is still a need for the staff involved, for example, to complete

fund accounts. However where there is no alternative to redundancy, payment of statutory redundancy costs shall be met from the fundholding allotted sum. This cost should not fall on the practice itself unless the individual whose post is likely to become redundant had been employed on general practice duties as well as fund matters during their period of employment with the practice.

Redundancy payments should be charged to the accounts on the individual's last day of employment. Changes have been made to the fundholding regulations to permit these to be met from the management allowance, available savings or (where neither of these is sufficient) the remainder of the allotted sum. If this results in a budget overspend, the Health Authority will need to meet the deficit in accordance with the normal procedure for final determination of the allotted sum.

The NHS Executive will issue further guidance on redundancy arrangements in the Summer.

(ii) Fundholding accounts for 1998/99

Production of the final year fund accounts of those practices which stay in fundholding until the end of the scheme, will take place during the early part of 1999/00. The responsibility for completing the accounts is likely to fall to the members of the former fundholding practice, although this issue is still being considered.

Management support funding will be made available to enable this responsibility to be fulfilled. Accordingly, in 1999/00 it is proposed that the management allocation to each Health Authority should contain an element to reflect its number of former fundholding practices. Details on the level of this allocation will follow in guidance in the summer. Irrespective of whether Health Authorities or practices hold the formal responsibility for winding up the accounts, in practice both parties will wish to discuss, in advance of the end of the scheme, the most practical and cost-effective arrangement for securing the completion of accounts, involving former fund management staff where appropriate. (In cases where these staff are working for a local Primary Care Group, it is expected that the Primary Care Group will free up some of their time to complete the fundholding duties).

(iii) Savings

Financial incentives to improve services and deliver better value for money will have an important place within the arrangements for Primary Care Groups. In line with this, savings will be taken forward into the new Primary Care Group setting, to be used for the benefit of patients across the Primary Care Group.

(iv) Services

Many fundholders have developed additional services for their patients, often provided by dedicated staff within the surgery. In due course, as Primary Care Groups take overall responsibility for the deployment of resources, it will be for the Primary Care Groups to determine whether and in what form these should continue. However, where fundholding has achieved benefits for patients, the aim should be for these advantages to be maintained and spread. Shadow Primary Care Groups should therefore work closely with

fundholders and the Health Authority to ensure that, where appropriate, necessary patient services are not lost as a result of the transition to Primary Care Groups.

Financial Position of Primary Care Groups at April 1999

47. The devolution to Primary Care Groups of responsibility for managing all or part of the budget for healthcare in their area, will need to be accompanied by appropriate risk management arrangements. These arrangements, and the financial position of Primary Care Groups at April 1999, are subject to ongoing discussions and consultation, and guidance on these important matters will be issued later in the year. In any event, the allocation which each group receives will be affected by:

- the overall resources available to the NHS in 1999/00 and the allocation received by each Health Authority
- the identified level of existing spending on the Primary Care Group population ie: their initial unified baseline
- the national formula setting Primary Care Groups fair shares (targets) of Health Authority unified budgets
- the agreed pace of change towards Primary Care Group fair shares (targets)
- the existing financial position in each Health Authority and the fundholding practices or commissioning groups within it
- the risk management arrangements established between the Health Authority and the Primary Care Group or Primary Care Groups in question

48. As far as the national formula is concerned the aim is to ensure a consistent national approach. The current national formulas will therefore be used as far as the various elements within them are relevant and technically sound when applied at Primary Care Group level. Further guidance will be issued in the summer.

Information and IT

49. It is important that major investment in IT systems to support Primary Care Groups is not made prematurely (ie before the NHS IM&T strategy is published or before the detailed functions of Primary Care Groups have been clarified locally). IT solutions should be driven by the requirements of Primary Care Groups, not the other way round.

50. The NHS Executive will issue guidance in the summer setting out its expectations for the general handling of data and IT with detailed guidance to follow later in the Autumn. Until such guidance is issued and decisions reached, Health Authorities and fundholding practices should ensure that no data held under fundholding or other current systems is discontinued, lost or rendered unusable by failure to maintain them. On the other hand, fundholding practices should at this stage avoid long-term commitments for fundholder IT system maintenance.

Relationships with other initiatives and pilots

GP Commissioning Group Pilots

51. HSC 1998/030 provides detailed guidance for GP Commissioning Group Pilots (GPCGs) which were established from 1 April 1998. That guidance makes clear the Government's expectations that the evaluation of the new GP Commissioning Group pilot projects, their ways of working, and the benefits they are able to provide for patients, are expected to provide early lessons on the development of these new approaches so as to inform the general development of Primary Care Groups. However, national GP Commission Group pilot project practices are expected, as with other forms of GP commissioning, to evolve into Primary Care Groups. It will be for local decision whether the new Primary Care Group retains the current configuration of the Primary Care Group pilot project or whether a new configuration would be more appropriate.

Primary Care Act - PMS Pilots

52. A significant number of PMS pilots went live on 1 April 1998. These will provide an important opportunity to learn and develop practices that will be necessary to secure the objectives of "The new NHS" and the development of Primary Care Groups.

53. The types of organisational models available in PMS pilots are extremely valuable as a vehicle for Health Authorities and Primary Care Groups/Primary Care Trusts to:

- test out organisational models and behaviours in advance of moving to a different option on the Primary Care Group model spectrum (eg confidence building between primary and community services prior to moving into a level 4 Primary Care Trust)
- test out the move to a locally targeted contract, thus allowing exploration of the benefits of such contracts as a means to reward good clinical performance
- test out shared management arrangements for the provision of multi-professional primary care exploring opportunities for changes to skill mix in primary care provision
- tackle specific problems affecting the delivery of primary care services (eg creating greater equity of GMS usage, addressing recruitment and retention problems)
- tackle specific local health problems. (This ties in with "Our Healthier Nation" for example on cancer, coronary heart disease, accident prevention; or other areas such as asthma, diabetes, health of school age children, developing better services for vulnerable people, homeless patients)

54. However if PMS pilots are to be useful in delivering these objectives, and not allowed to be used by any practices as a means to operate independently of a Primary Care Group, the existing criteria for approval will need to be amended so that:

- pilot proposals for PMS will only be approved if they are consistent with the aims of the Primary Care Group/Primary Care Trusts in that area and;

- pilots must fit with proposed organisational and management arrangements for Primary Care Group/Primary Care Trusts in that area

- pilots must also fit within the Health Improvement Programme agreed for that area

55. Consideration is currently being given to a second wave of PMS Primary Care Act pilots and further details will be provided later this spring.

Health Action Zones

56. The White Paper pointed out that Health Action Zones (HAZs) aim to bring together organisations within and beyond the NHS to develop and implement a locally agreed strategy for improving the health of local people. 11 zones have been selected to go live from April 1998, covering areas of at least Health Authority size.

57. HAZs will form the strategic direction in which the local NHS and others will travel. As such Primary Care Groups will need to be involved in the developing of the detailed implementation plans for the successful first wave Health Authorities bids. Similarly second wave Health Authorities bidders will need to demonstrate active involvement of Primary Care Groups or shadow Primary Care Groups in developing their bids.

58. There are other links between HAZs and Primary Care Groups. Annex A of EL(97)65 elaborates on what HAZs might achieve, including:

- encouraging greater integration of services, perhaps supported by sharing of budgets between primary and secondary care

- continuing the expertise of the NHS, social services and the voluntary sector

- facilitating more care being delivered in the community

- encouraging increased dialogue with social services, for example, over admission and discharge procedures leading to reduced waiting times and emergency admissions

- co-ordinating targeted initiatives to address the health needs of particular groups and areas

- increasing blurring of the boundaries between primary and secondary care so that a genuinely patient centred service is created

- primary care teams fully utilising the skills of all professionals involved and broadening their focus from one based mainly on treating illness to encompass a public health approach to their role

Conclusion

59. Key tasks for action now are:

Health Authorities should:

- support and facilitate the discussions on Primary Care Group formation between participants

- ensure that decisions on the configuration of Primary Care Groups in their area are in line with the criteria set out in this guidance and that GPs, community nurses, staff and local/national representatives (including LMCs), Local Authorities and the local community have been fully involved in the decision making process

- notify decisions on the proposed configuration of Primary Care Groups to the relevant RO before 31 July 1998. Health Authorities are required to provide evidence that:

    - the criteria for Primary Care Groups have been met

    - the proposal is supported by local GPs, Community Nurses, Local Authority and the wider local community (or where parties disagree to set out what actions have been taken to address the concerns expressed)

- put in place appropriate HR and organisational development strategies to ensure the successful establishment of Primary Care Groups, including:

    - by September 1998 formation of shadow Primary Care Groups

    - the appointment of lead clinicians, managers and involvement of social services

    - managing closure of fundholding and migration to Primary Care Groups

- agree functions and level at which each Primary Care Group will operate, including the overall management resources available to carry out those functions

Primary Care Groups, to be ready to go live from 1 April 1999, should:

- identify a lead clinical professional responsible for clinical governance

- create and agree (with parties involved within the group and with the relevant Health Authority) the internal governing arrangements for the Primary Care Group, ensuring that GPs and nurses are properly represented in the governance arrangements

- identify required staffing structure and skills to carry out responsibilities of the Primary Care Group and ensure all appointments are fair to existing NHS and GP fundholding staff

- agree arrangements for other health care professionals to contribute to the planning and provision of services for the population served by the Primary Care Group

Community NHS Trust (or Units) should:

- identify a lead community nurse in each community provider unit who will be able to act as a facilitator and coordinator for Health Authorities, GPs and the NHS Executive to communicate with community nurses in that unit

- actively facilitate the involvement of community nursing staff employed by the trust in local discussions on the establishment and development of PCGs

Regional Offices should:

- advise Health Authorities on the contents of the guidance
- consider Health Authority's proposals for Primary Care Groups in their area to ensure that Health Authorities have taken action in line with this guidance. Where Regional Offices are not satisfied by the information submitted, Health Authorities should be asked to consider again that proposal
- performance manage Health Authority's implementation of the guidance on establishing Primary Care Groups

60. In line with the timetable outlined in HSC 1998/021 (see Annex C), further guidance will be issued over the next year. The guidance will be issued in a rolling programme throughout the year and will be produced with the involvement of national and local representatives drawn from across the health service and professions.

Queries or correspondence on the contents of this document should be sent to:

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Quarry Hill
Leeds LS2 7UE

ANNEX A

Purpose of Primary Care Groups - Functions

1. The precise form of Primary Care Groups will be flexible to reflect local circumstances and will draw on experience of what has successfully worked in many parts of the country. Primary Care Groups will develop over time, learning from existing arrangements and their own experience. There will be four options for the form that Primary Care Groups/Trust can 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

2. The responsibilities and therefore functions of Primary Care Groups will partly depend upon the choices made as to the level of Primary Care Group. However, each Primary Care Group must focus on the requirements of the whole of the community it represents. They will therefore need to be able to contribute to:

   - the identification of the needs for that community - what are the issues

   - the determination of objectives to meet those needs - how to address those issues

   - delivering those objectives - have we resolved those issues

3. A successful Primary Care Group must consequently:

   - contribute to the Health Improvement Programme on health and healthcare, thereby helping to ensure that the agreed HIP reflects the perspective of the local community, the experience of patients and the views of service providers, whilst reflecting national priorities

   - work in partnership with other agencies to secure the wider public health of the population; creating opportunities for working with a wide variety of associated professionals such as other FHS contractors (dentists, optometrists, and pharmacists), child protection services, non statutory and voluntary health and social welfare organisations, criminal justice agencies, housing and environmental health agencies, where collaborative working would improve the health of patients and communities

   - commission health services for their populations from within the framework of the Health Improvement Programme, ensuring quality and efficiency

- maintain financial control by managing the deployment of budgets devolved to them, including monitoring expenditure against indicative practice level budgets (Primary Care Groups at level 1 will be expected to take financial considerations into account in their advice to the Health Authority)

- monitor performance against the service agreements they (or initially the Health Authority) have with NHS Trusts

- develop primary care by joint working across practices; sharing skills; providing a forum for professional development, audit and peer review assuring quality and developing the new approach to clinical governance; and influencing the deployment of resources for general practice locally. Local Medical Committees will have a key role in supporting this process

- better integrate primary and community health services and work more closely with social services on both planning and delivery. Services such as child health or rehabilitation where responsibilities have been split within the health service and where liaison with Local Authorities is often poor, will particularly benefit

4. In undertaking these function, a Primary Care Group will need to be able to reach consensus amongst its constituents as to the priorities of the group. And as part of that, the group must be able to reflect the needs and priorities of the patients. It is therefore self evident that in considering questions about 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 and reflect the demands and priorities of the population which is to be encompassed.

ANNEX B

LIST OF NHS EXECUTIVE REGIONAL OFFICE Primary Care Group CONTACTS

Region		Contact	Telephone
Northern & Yorkshire	-	Mrs Sue Maltby John Snow House Durham University Science Park Durham DH1 3YG	0191-301-1444
North West	-	Ms Donna Sager 930-932 Birchwood Boulevard Millennium Park Warrington WA3 7QN	01925-704-203
Trent	-	Mr Andrew Leary Fulwood House Old Fulwood Road Sheffield S10 3TH	0114-263-0300
West Midlands	-	Mrs Marion Rogerson Bartholomew House 142 Hagley Road Birmingham B16 9PA	0121-224-4707
Anglia & Oxford	-	Mr Barry Thomas 6-12 Capital Drive Linford Wood Milton Keynes MK14 6QP	01908-844-483
North Thames	-	Mr Vince McCabe 40 Eastbourne Terrace London W2 3QR	0171-725-5300
South Thames	-	Ms Gail Pascoe 40 Eastbourne Terrace London W2 3QR	0171-725-2562
South & West	-	Mr Ian Bloxham Westward House Lime Kiln Close Stoke Gifford Bristol BS12 6SR	0117-984-1915

ANNEX C

PRIMARY CARE GROUPS: OUTLINE TIMETABLE

March Preliminary local discussions about Primary Care Groups. National consideration of and consultation (including workshops) on range of Primary Care Group development issues.

Easter Initial guidance on Primary Care Group formation and related issues, including:

- configuration:
  - population base
  - degree of flexibility on size and boundaries
  - governing arrangements
  - nurse involvement
  - links with social services
  - interrelationship with Primary Care Act, GP Commissioning Pilots and Health Authorities
- approval process:
  - who approves the Groups
  - criteria for approving configuration of Primary Care Groups
  - resolving local disagreements
  - local consultation
  - timetable for agreeing groups
  - role of Health Authorities and NHS Executive (Regional Offices)
- human resources aspects of establishing Primary Care Groups
- management costs:
  - transition to new management cost envelope

April - Aug Develop Guidance on:

- Nursing
  - process and mechanism for involving community nurses in Primary Care Groups
  - competencies and skills

- financial issues:
  - allocation arrangements and pace of change issues
  - incentive arrangements
  - risk management arrangements
  - flexibilities over use
  - prescribing issues
  - savings
  - management costs envelope
- accountability framework:
  - good practice guide on Primary Care Group governance, including involvement of the public
  - accountability arrangements between Health Authorities and Primary Care Groups
  - agreements between Primary Care Groups and NHS Trusts
- primary care development:
  - flexibilities
  - quality and clinical governance
  - primary/community care integration
- IM&T requirements

By 31 July 1998: Primary Care Groups agreed.

By September: Shadow Primary Care Groups to begin preparations for agreements with NHS Trusts from 1999/2000

Sept - Jan 1999

- General HR guidance on establishing Primary Care Groups/Trusts
- Clarify position on Primary Care Trusts functions; timing and arrangements for first wave (subject to timing of legislation)
- Criteria for determining entry levels (options i-iv)
- Primary Care Group allocations confirmed
- Detailed IM&T guidance for Primary Care Groups

April 1999

- New Primary Care Groups in place