THE CONCERNS OF FAMILY PRACTITIONER COMMITTEES

An Analysis of FPC Annual Programmes for 1985-86 and 1986-87

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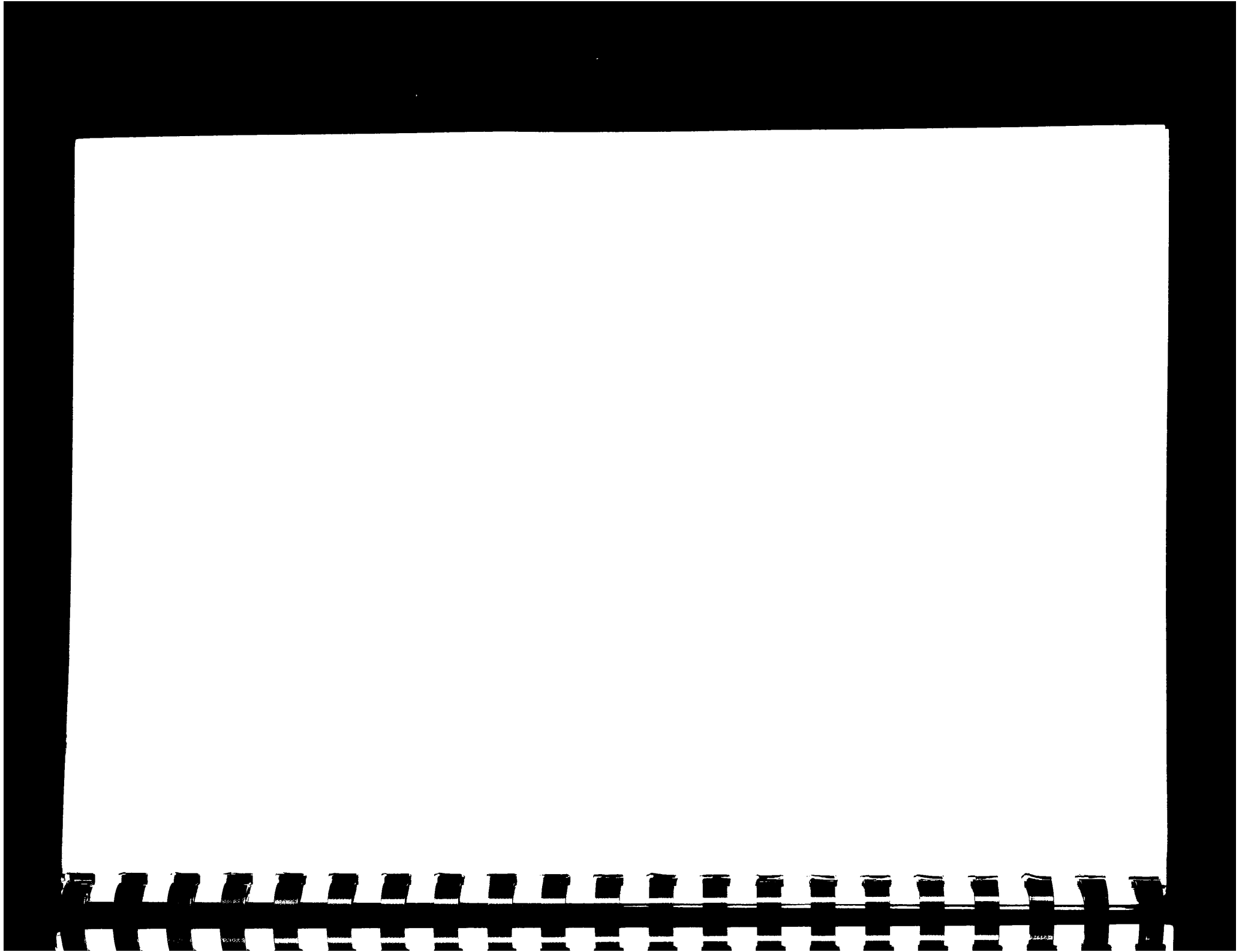
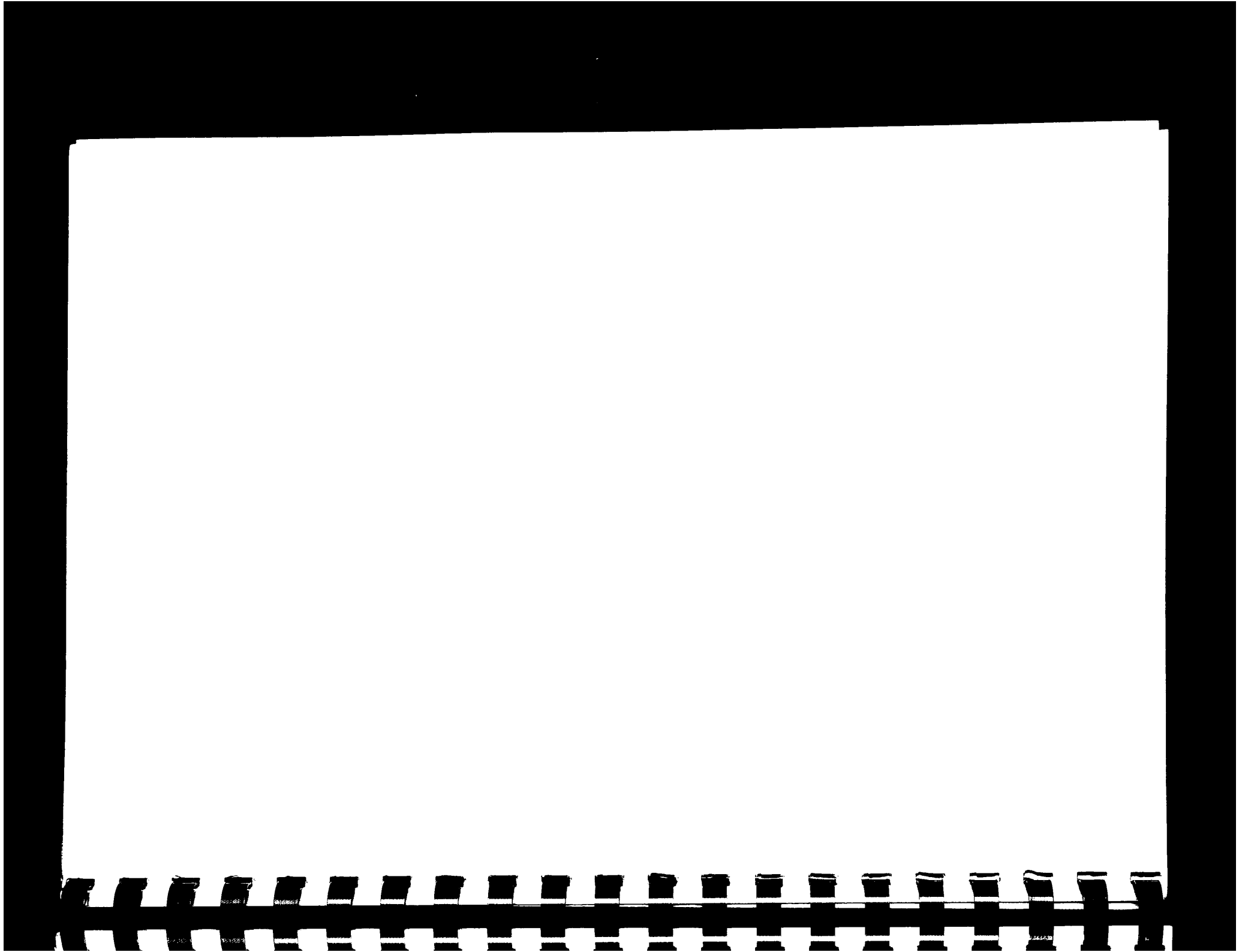


INTRODUCTION

The 90 English FPCs monitor, plan and partly administer the provision of services by four important groups of NHS practitioners: general practitioners, dentists, opticians and pharmacists. Since 1 April 1985 they have functioned as independent health authorities, directly accountable to the Secretary of State, forming a parallel administrative structure with the other health authorities. Between 1974 and 1982 they were under the control of AHAs and between 1982 and 1984 of DHAs. (Between 1946 and 1974 they occupied a similar position to now.)

The main responsibilities of FPCs are to regulate the services provided by the four groups of practitioners and to collaborate with the various other bodies or groupings which have an interest, as providers or consumers, of primary health care. Both functions include a planning role. FPCs have always been important as a source of planning information - helping maintain patient records and screening services for example - but independent status has given planning and collaboration major importance for them.

However, whereas the role, resources and responsibilities of DHAs for example are fairly well defined, this is not the case with FPCs. This is both because they are in the process of establishing their new organisational frameworks, and because the provision by the NHS of primary health care involves a number of district services and practitioners over which the committees have little direct control. The practitioners are independent contractors with the health service. Also, some services which are vital to primary health care, such as community health care and hospital provision, are the responsibility of the DHAs. Others are provided by LAs. Even so, FPCs must ensure that these services mesh with those which are their direct responsibility.



The main tasks of FPCs have been described in HN(FP)(81)12. They have manpower and personal roles in respect to the practitioners - interviewing potential new practitioners for vacancies, monitoring the use of deputies, ensuring contract terms are fulfilled, investigating complaints. They inspect medical practice premises and advise on the schemes through which they may be improved. They maintain many sorts of medical records. They monitor immunisation and screening and supply clinical and stationery items to contractors.

Among their planning responsibilities FPCs will plan services for example for new town developments and they form a channel of communication between the Minister of State and the professions and are required to provide statistics and returns to the DHSS.

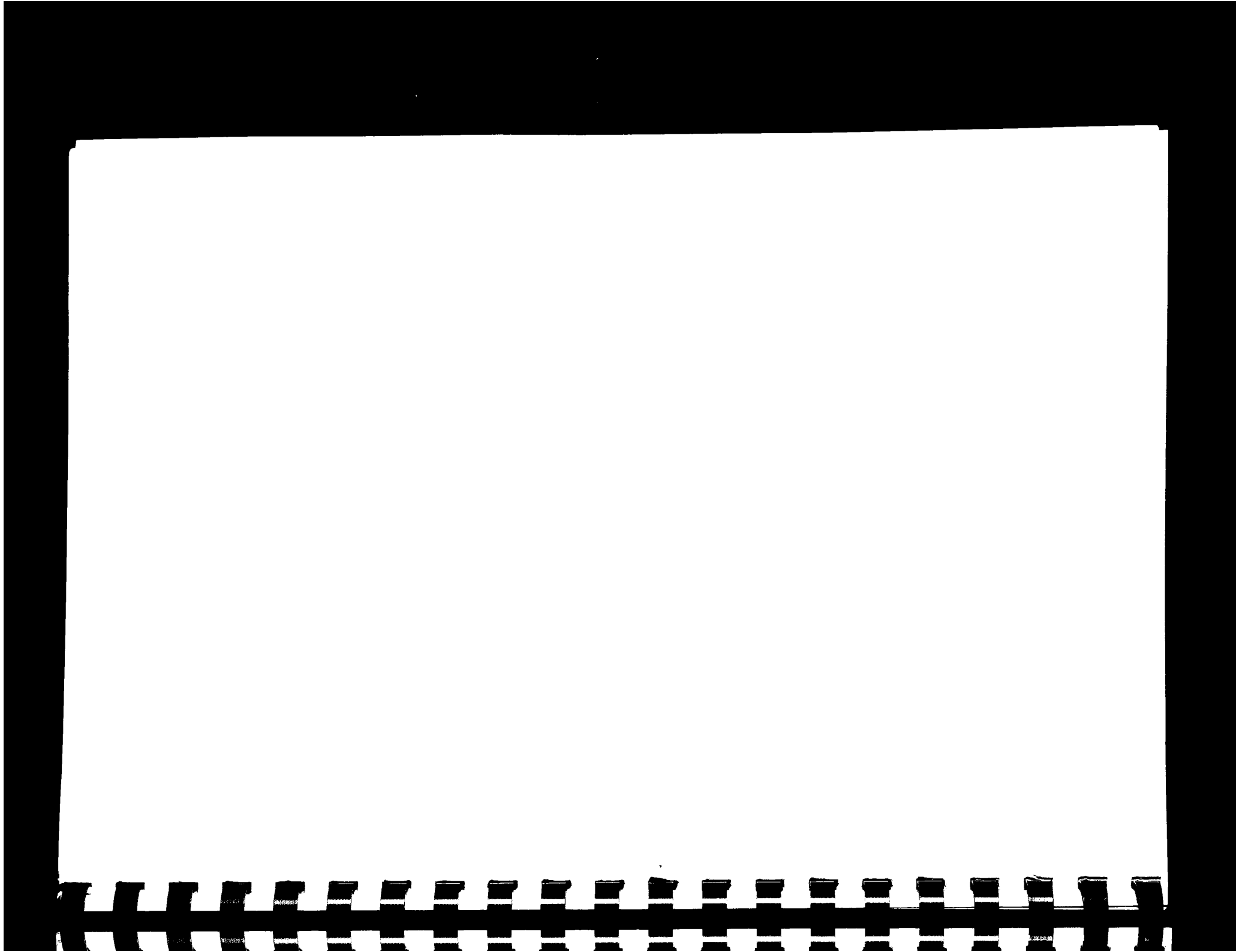
Among these returns are the annual programmes which form the basis of this study and which combine with five yearly profile and strategy statements, annual scrutinies and periodic performance reviews, to fulfil FPCs responsibility for accountability. The DHSS issued operational requirements, procedures and guidelines for 1985-86 in circular HC(FP)(85)10. This included the requirement to submit to the DHSS an annual programme, the structure for which was set out in an appendix to the circular. Programmes should give the FPC's proposals for two years ahead and, once the cycle is established, review progress made in the past year towards previously agreed objectives. The FPC's five year strategy should be 'agreed with the department and drawn up in consultation with local representative committees (LRCs), DHAs, local authorities and other interests' [(HN(FP)(84)37 on accountability arrangements)].

The King's Fund Institute agreed with the DHSS that it would undertake some preliminary analysis of the annual programmes for 1985-86 and 1986-87 of the 90 FPCs in England.

Three of the programmes due to be published in 1985 were unavailable and thirteen of those for 1986. Those available varied greatly in presentation and content. Some were carefully and attractively produced documents providing much useful information and comment. A few appeared to be hurriedly typed and duplicated and removed many of the topics which circulars had requested to be covered. The adequacy or otherwise of the information provided is covered in the section of this study on individual topics; again, there was great variation between the more thoughtful reports, the modest but adequate, and the perfunctory.

The FPC annual programmes contain information on a wide range of FPC concerns. covering FPC administration and the four family practitioner services: general medical services (GMS), pharmaceutical services, general ophthalmic services (GOS) and the general dental services (GDS).

Four topics which FPCs had been asked to report in their programmes for 1985-86 and 1986-87 were selected for more detailed study. For the programmes for 1985-86 we looked first at the general and central issue of objectives and priorities for the FPC and family practitioner services. Second, we chose, as an example of the concerns of general medical services, the topic of deputising services. For the programmes both for 1985-86 and 1986-87 we analysed their approach to the promotion of good GP premises, progress on collaboration with other administrative bodies and interest groups, and practices in relation to complaints.



Two main aspects of the 'objectives and priorities' sections of the annual programmes are examined. We assess, first, the FPCs' approaches to the formulation and presentation of objectives and priorities. Then we turn to the content of the objectives and identify some main trends in the objectives set. On the topic of deputising services we examine the FPCs' policies and procedures and consider their general attitudes to deputising services as expressed or implied in the annual programmes.

For the topic of GP premises, we examine FPCs' reaction to more detailed requirements for inspection and standards, their inspection policies, and their promotion of the various schemes designed to help GPs make improvements to their surgeries. On collaboration, we look at how FPCs intended to carry out their requirement to collaborate with health authorities; with community health councils (CHCs) and local representative committees (LRCs); and with other groups. We also examine some of the obstacles to effective collaboration. Finally, we review FPCs' general approach to the issue of complaints against practitioners and summarise the available data about the incidence and outcome of complaints.

A: FPC ANNUAL PROGRAMMES 1985-86

Summary

Objectives and priorities, and deputising services, were the topics selected for a preliminary analysis of the annual programmes for 1985-86 of the 90 family practitioner committees in England.

1. THE FORMULATION AND PRESENTATION OF OBJECTIVES AND PRIORITIES

Introduction

The setting of objectives is a crucial factor in FPCs' participation in NHS planning and in their direct accountability to the Secretary of State since they attained independent status in April 1985. In the annual programmes, however, the objectives were not always clearly formulated nor presented. Few FPCs gave priority order or timescales for their objectives and few had completed the consultation process. Only one-fifth of the annual programmes included intended methods of achieving the aims. Further guidance from the DHSS on setting objectives is suggested.

The most frequently stated objectives for general medical services concerned the standards of premises, distribution of GPs, collaboration with other agencies, computerisation and staffing. For the pharmaceutical services the most frequent objectives centred on distribution of pharmacies, the out of hours service, and oxygen services. The main objectives given for general ophthalmic services were adequate distribution, monitoring the effects of the 1985 legislation, and liaison. Three issues dominated the objectives for general dental services: distribution, emergency dental services, and collaboration. Main objectives for FPC administration focused on management,

staffing and personnel issues, efficient administration, collaboration, and computerisation.

The setting of objectives is a crucial factor in FPCs' participation in NHS planning and in their direct accountability to the Secretary of State.

In their annual programmes FPCs were asked to give their objectives and priorities for the general medical services, pharmaceutical services and general dental services, and to indicate whether consultations with the LRCs on these objectives were complete; they were also to state objectives and priorities for management, give proposals looking up to two years ahead and an action plan for 1985-6 and 1986-7 (HC(FP)(85)10). It was to be expected, however, that many FPCs would not have had the time or resources to formulate detailed objectives, nor to carry out the necessary consultation, in the six months between their change to independent status and the end of September 1985 when annual programmes were to be submitted. Several FPCs commented on the impossibility of the task within this timescale; for example 'In the first year of the operation of independent FPC it is not possible suddenly to produce well-worked strategies and information and this FPC is reluctant to publish any strategy before it has been properly thought out' (Camden and Islington FPC).

There were wide variations in the ways in which FPCs approached the task of stating their objectives and priorities. Camden and Islington FPC, having commented on the difficulties as above, went on to set limited, fundamental objectives on which more specific ones would be based. A few other FPCs presented coherent strategies, with ordered priorities, achievable within

specified timescales. Some FPCs gave lengthy lists of objectives covering many topics, while others gave minimal, vague objectives. A few did not state any objectives at all, either for an explicit reason such as lack of time or for no given reason. One FPC's sections headed 'objectives and priorities' consisted of blank spaces! The weaker annual programmes showed little understanding of what was expected and gave, under the heading of objectives, aims which were unclear or obscure, or aims concealed within the description of services, or which were not objectives at all.

Presentation of the Required Objectives.

Most FPCs presented some objectives on general medical, pharmaceutical, and general dental services, and on FPC administration, within the sections of the annual programmes on these topics. Objectives for general medical services were given most frequently (87 per cent of FPCs), while 79 per cent of FPCs gave objectives for pharmaceutical and general dental services, 75 per cent included objectives for administration, and 44 per cent for general ophthalmic services, although these were not required in the circular. Some FPCs also included action plans with their objectives within the relevant sections, or separately at the end of the document or elsewhere. A few FPCs did not state objectives separately within the sections but included all their objectives in an action plan and/or strategy statement or a general presentation of objectives. The most usual format (in 69 per cent of the annual programmes) was for objectives to be included within four or five of the main sections, those on ophthalmic services being the most frequently omitted. In almost one-third of the annual programmes the statement of the objectives required by the Department was incomplete.

In the better annual programmes objectives and priorities were clearly headed and presented, sometimes on separate pages, at the beginning or end of the relevant section. Some FPCs, for example Cheshire, Greenwich and Bexley, and Lancashire, also gave a summary of all their objectives at the beginning or end of the annual programmes. Where FPCs followed the sequence suggested by the circular and included objectives and priorities as second or third of a number of items of varying importance within a section, the objectives were sometimes difficult to find, particularly when they were not clearly headed. As objectives and priorities form an important part of the content of annual programmes, it is useful for the reader to be able easily to locate an FPC's objectives.

Priorities and Timescales

The question of priorities was rarely addressed in the annual programmes. Lancashire FPC gave its objectives in priority order for the family practitioner services (except ophthalmic) and administration, and summarised all its priorities at the beginning of the document. Bedfordshire FPC identified as top priority for the general medical services the computerisation of the register of female patients, and Dudley FPC gave first and second priority lists of objectives for family practitioner services. Birmingham FPC commented on its objectives for the various services that it was not possible to give priority order because 'many are ongoing items and/or inter-dependent upon other items on the list'.

Most annual programmes, however, did not include any mention of priority order for their objectives. This was not too serious an omission where a limited number of objectives had been identified and might all be assumed to be priorities, or where target dates were specified. Some FPCs however gave

long, wide-ranging lists of objectives, all of which might be very worth while, but included neither priority order nor target dates. In such cases it was clearly unrealistic to expect that all of these objectives could be achieved within the next two years or even in the foreseeable future, and the listing of objectives was less meaningful than it might have been.

Although the annual programme structure given in circular HC(FP)(85)10 includes in the management section proposals for the two years ahead, it does not specify any timescale for objectives for the family practitioner services. Consequently many FPCs did not give target dates for most objectives. Less than one-half of the FPCs gave dates for management objectives, just over one-third included dates for general medical services objectives and less than one-quarter gave target dates for any of the other objectives. A few annual programmes did set out clearly the year or years in which particular objectives were to be met. Bolton FPC for example had a section on 'FPC objectives and policies' for each service, for collaboration with the DHA and for administration; on each of these topics the objectives were followed by a section on 'proposed action' giving for each objective the year(s), resource implications and sources. Most FPCs did not include resource implications or costings with their objectives, although some gave detailed costings particularly for management targets, as required in the circular.

Consultation Process

Another requirement of circular HC(FP)(85)10 which was not always adequately met was the indication as to whether consultation on the objectives had taken place. Only one-half of the annual programmes mentioned consultation with any of the LRCs, the most frequently included being the local medical committee. The information given was usually that the consultation process was not yet

completed, although a few FPCs were able to report agreement with their objectives after consultation with LRCs and occasionally also other agencies. Some annual programmes included the LRCs' comments on the FPC's objectives or on the family practitioner services in general; in some cases LRC comments were given in lieu of FPC objectives. Consultation with, or agreement of, LRCs and other agencies on specific objectives such as GPs' surgery inspections, was sometimes mentioned. More generally, some annual programmes cited the practice of consulting LRCs on particular issues, rather than as part of the formal process of deciding objectives and priorities.

Further Information

FPCs were not required to show how their objectives might be met, and only one-fifth of the annual programmes included even a brief indication of the intended methods of achieving their aims. Such information, where it was included, was very useful. Calderdale FPC, for example, clearly presented each objective followed by a list of ways of meeting the objective. The annual programmes did not always distinguish objectives from methods. For example, 'routine inspection of surgery premises' was often given as an objective, when this might more accurately be presented as a way of achieving the objective of 'ensuring high standards of surgery premises'.

Some of the more informative annual programmes, for example those of Norfolk and Lancashire FPCs, included an outline of the background to particular objectives and priorities, indicating the reasons for choosing these objectives, or the current state of progress towards them. Concise background information of this type, placing the objectives and priorities in context, was useful in helping the reader to form an opinion about whether or not the objectives were appropriate and realistic.

This brief review of FPCs' approaches to the formulation and presentation of objectives and priorities has shown that many of the 1985 annual programmes' sections on objectives had some useful features, but few included all the required information. Further guidance from the Department might encourage all FPCs to set and present objectives in an appropriate form for planning and accountability purposes. The following points could be included in such guidance:

* Objectives should be clearly presented and easily located within the annual programme.
* A limited number of main objectives is preferable to a long list of possible objectives.
* Comment should be given on the priority order of objectives.
* For each objective FPCs should include target dates, costings and planned methods of achieving the objectives.
* FPCs should indicate whether the formal consultation process has been completed for a set of objectives.
* Concise background information on the objectives selected could be presented with the objectives, or cross-referenced if included elsewhere in the document.

CONTENT OF THE OBJECTIVES STATED

The annual programmes of 87 FPCs on the four family practitioner services and FPC administration inevitably included a large number of individual objectives. The intention of this summary is to identify the main trends and areas of concern in these objectives rather than to give a detailed analysis. Objectives for the family practitioner services could be divided into three

main categories: (i) availability of service, (ii) service provision, and (iii) administration. Management objectives were categorised as (i) collaboration and planning, (ii) management and administration, and (iii) computerisation and new technology. There was some overlap of content between the services and management objectives; for example, cervical cytology call and recall schemes appeared both in the general medical and management sections.

General Medical Services

The objectives for GMS tended, not surprisingly, to reflect some of the main current interests of the DHSS and the subjects of recent circulars and other publications. Those which appeared most frequently concerned the standards of premises and equipment (mentioned by over two-thirds of the FPCs); distribution and accessibility of GPs (over one-half of the FPCs); collaboration and liaison with other agencies; of computerisation and records (over two-fifths of the FPCs); and staffing, including ancillary workers and the attachment of primary care workers (over one-third of the FPCs). Several FPCs commented that the implications of the awaited Green Paper on Primary Care Services would be taken into consideration in formulating future objectives.

(i) In the main category of <u>availability of service</u>, objectives on the distribution and accessibility of GPs included reviewing medical practice committee areas, reviewing the provision of branch surgeries and rationalising areas of practice, monitoring manpower requirements and community needs, and ensuring accessibility in terms of surgery hours, telephone contact and access for people with disabilities. The other main cluster of objectives in this category concerned information for the public, for example through revised

medical lists or practice leaflets. Birmingham FPC for example aimed 'To investigate ways of giving greater and more effective publicity to the information contained in the Committee's Medical List with a view to enabling patients to make as informed a choice as possible about their family doctor'. Objectives on services for special groups such as homeless people, or promoting patients' choice of type of practice or women doctors, featured less frequently.

(ii) Turning to service provision, the main concern was about the standard of surgery premises. This item was included in the operational requirements for the year and has been the subject of several recent communications from the DHSS; FPC objectives included inspection programmes, the uptake of higher improvement grants in the inner city, and the purchase or standards of health centre premises. The next main cluster of objectives was on computerisation and record keeping, including general practice involvement in cervical cytology call or recall schemes, and the provision of age/sex registers for general practices. Staffing objectives formed a third trend; FPCs aimed to encourage the employment of ancillary staff and to promote the primary health care team concept by attachment of community nursing and other staff, and sometimes by improving premises to accommodate such staff. One example stated:

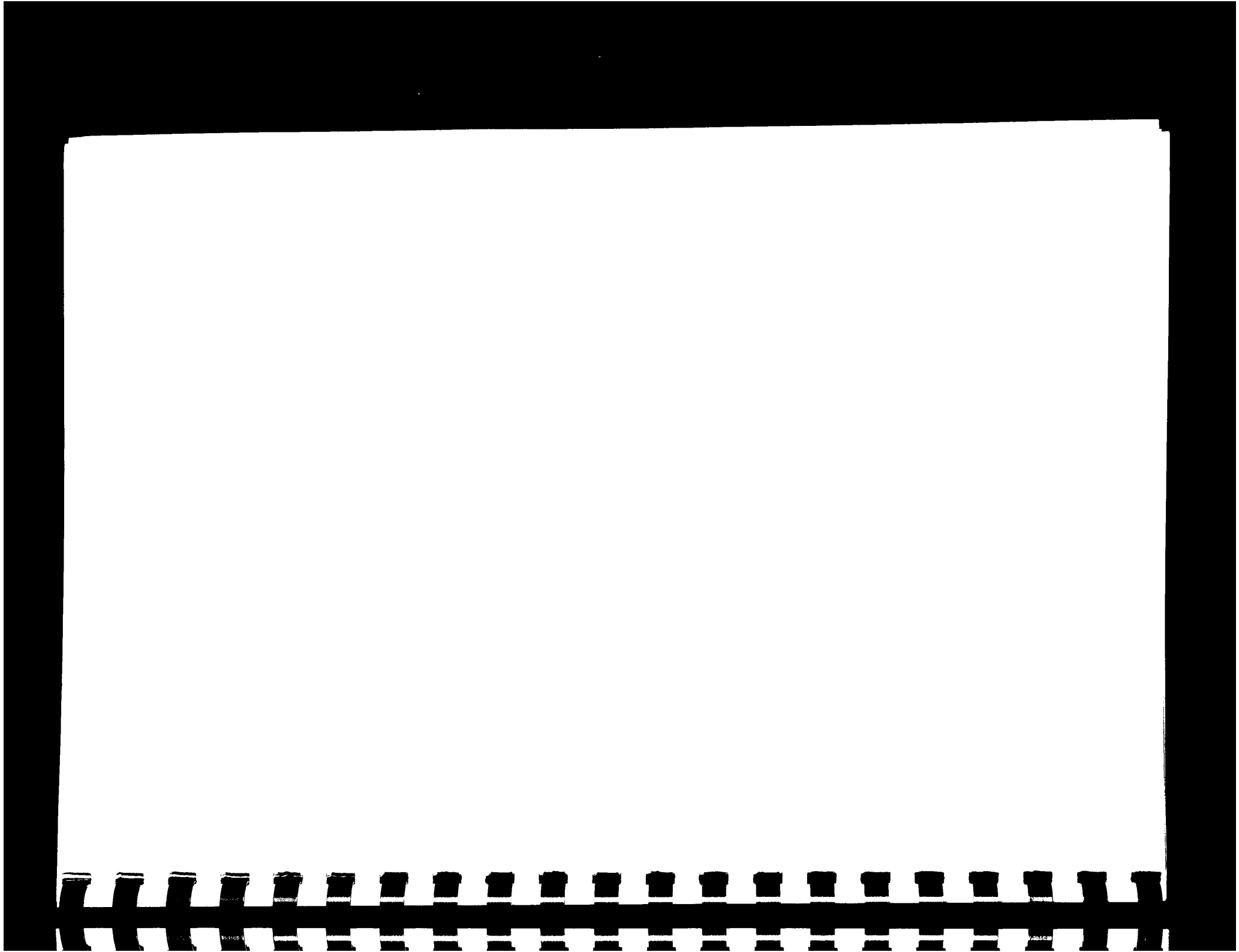
> 'The FPC's objective is to persuade as many doctors as possible to upgrade their surgery accommodation through the improvement grant and cost related rent schemes. By doing this the primary health care team concept of doctors, district nurses, social workers and midwives working closely together for the benefit of patients in greatly improved practice, or indeed, purpose built accommodation, can be achieved' (Barking and Havering FPC).

Less frequently stated objectives focused on out of hours arrangements and deputising services, training, promoting standards of care in general, and extending the role of the GP in preventive medicine, screening and health promotion. For example: 'The FPC with the support of the LMC supports DHA proposals for general practitioners to carry out a greater proportion of Well Women Services and vaccination and immunisation procedures and would wish to see this objective achieved during the period of the plan' (Coventry FPC).

(iii) Where administration of GMS was concerned, the main objectives centred on collaboration and liaison with other agencies, including collaboration with the district health authority (DHA) on providing primary care services, liaison with health and local authorities, general practitioners (GPs), hospitals, community health councils (CHCs) and health education units. Norfolk FPC, on its objective of collaboration with health authorities, states that 'The Committee, through its officers initially, will continue to discuss with representatives of the three District Health Authorities in Norfolk, ways of achieving a closer working relationship between general practice and the community health services in order to promote the concept of unified primary health care'. Other objectives were improved information, for example through computerised registers or by circulating information to GPs and other agencies; and effectiveness and efficiency, including practice audit and new technology.

Pharmaceutical Services

During the period when the 1985 annual programmes were being compiled, the DHSS and the pharmaceutical services negotiating committee were discussing a new contract for pharmacists' NHS work. After a settlement in May, the new



contract was announced early in September 1985. This included arrangements for a better distribution of pharmacies, more support for essential small pharmacies in sparsely populated areas and improved procedures regarding costs and remuneration. Several FPCs commented that they were awaiting the new contract or that they would take this into consideration when implementing their objectives. In October 1985, however, it was announced that the new contract could not be introduced under current legislation, and that its introduction might be delayed for two or three years.

For the pharmaceutical services, the most frequent objectives concerned adequate distribution and accessibility of pharmacies (mentioned by over one-half of the FPCs), the out of hours service (over one-third of FPCs) and oxygen services (over one-quarter of FPCs).

(i) Objectives in the availability of service category were almost all about the distribution and accessibility of the service, for example: 'Subject to the provisions of the new contract proposals, to review, in consultation with the Local Pharmaceutical Committee, the distribution of pharmacies within the area and identify areas where availability of pharmaceutical services is below the standard which the public might reasonably expect' (St. Helens and Knowsley FPC). A much smaller number of FPCs gave objectives on the provision of information to the public, for example by updating lists of pharmacists providing out of hours services, and publicity campaigns in pharmacies and GP surgeries.

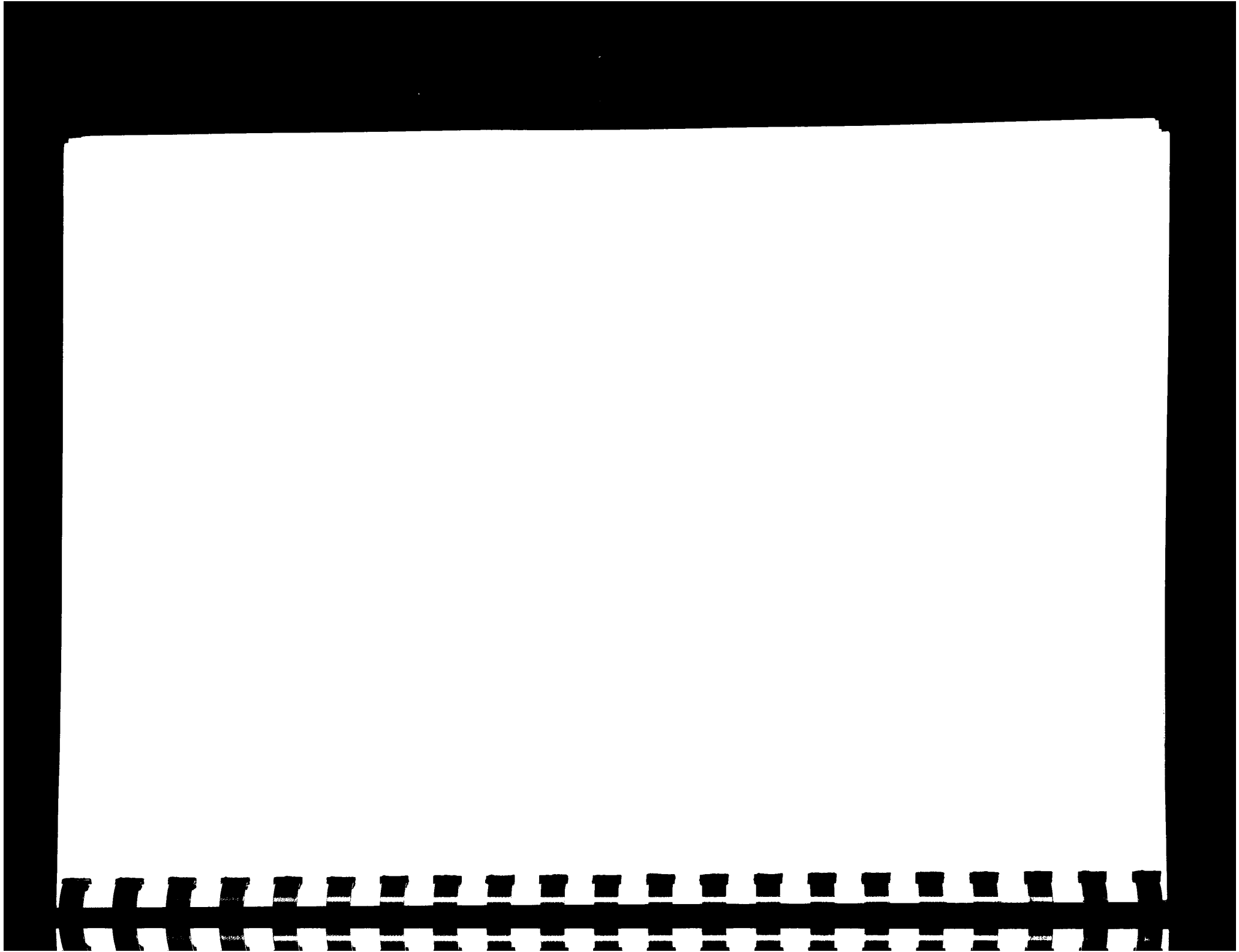
(ii) Most of the objectives for the pharmaceutical services concerned service provision, particularly the out of hours service and oxygen services. On out of hours services, objectives included reviewing these services, encouraging

the maintenance of a voluntary out of hours service, and reviewing urgent dispensing arrangements; for example: 'To review the operation of the hours of service rota provision, in the light of changes which are expected to follow on the introduction of the new contract, and closure compensation arrangements' (Wirral FPC). Objectives for the oxygen services mentioned the new oxygen concentrators introduced in 1985 and included reviewing the oxygen therapy service and monitoring holdings of equipment, for example: 'It is proposed to circulate contractors who provide oxygen therapy services with a view to increasing the number of contractors in the list who have expressed their willingness to provide oxygen therapy services in emergencies outside normal hours' (Gateshead FPC). Less frequently mentioned objectives were encouraging high standards of service or premises, and health education or promotion as part of the pharmacist's role.

(iii) There were a number of different objectives on the <u>administration</u> of pharmaceutical services, all mentioned by less than one-fifth of FPCs. Apart from general objectives on implementing the new system, and liaison with hospital pharmaceutical services and other agencies, the main specific proposal was for the collection of unwanted drugs. Barnsley FPC, for example, aimed to 'organise periodic local drug drop schemes to collect unwanted or unused drugs and medicines'.

General Ophthalmic Services

Fewer objectives were given for general ophthalmic than for the other services, partly because FPCs were not asked to include these objectives, and partly because the reduction in GOS dispensing since new regulations were introduced in April 1985 had meant a reduced workload for FPCs as far as GOS



were concerned. The main objectives stated (each by less than one-fifth of FPCs) were adequate distribution and accessibility, monitoring the effects of the 1985 legislation, and liaison with other agencies.

(i) On the availability of services most objectives concerned distribution and accessibility, for example to 'ensure that the distribution and availability of ophthalmic services is adequate to the needs of the community' (Barnsley FPC). A small number of FPCs included objectives on services for special groups, such as domiciliary visiting of the housebound, and information to the public about the services available.

(ii) The few objectives on service provision included promoting high standards of premises, equipment and care, and screening for diabetes or glaucoma. Nottinghamshire FPC's strategic statement for 1985-95 gave as an objective for GOS: 'The FPC will seek to collaborate with the Local Optical Committee in carrying out inspections of premises with the aim of identifying and promoting methods of good practice among other opticians'. One of Barnsley FPC's aims was to 'Consider the early detection of diabetes in patients presenting themselves for eye tests'.

(iii) One focus of the objectives for the administration of GOS was on liaison between the GOS and hospital eye service or other agencies including those representing consumers' views. Calderdale FPC, for example, proposed 'To check on the improvement in liaison and cooperation following the recent monitoring of diabetics meeting between the LOC, LMC and Consultant Ophthalmologists and to monitor and encourage its development'. The other main objective was to monitor the effects of the new regulations introduced in April 1985. Some concern was expressed about the new system and its possible

harmful effects for patients. Birmingham FPC aimed 'To seek for the return of a full GOS for all patients or at least, the maintenance of the provision as it stands now (October 1985), viz: full provision for children, deprived groups and complex lens patients of both new spectacles and particularly for children, the replacement or repair of spectacles'.

General Dental Services

Three main issues dominated the objectives for the GDS: adequate distribution and accessibility, and emergency dental services (each given by over one-half of the FPCs) and collaboration with the DHA (mentioned by over one-third of FPCs). Responsibility for the emergency dental service was transferred to FPCs in April 1985 and a DHSS circular on the subject had been issued in March 1985. It was thus to be expected that the emergency dental service would be a major feature of the FPC objectives for the general dental services.

(i) The main focus of objectives on the availability of service was on adequate distribution and accessibility of the service, including provision in under-provided areas, the identification of shortfalls, and ensuring availability of NHS services. The provision of services for special groups, and information for the public were the other main objectives in this category. The special groups mentioned were usually elderly, handicapped or housebound people; the objectives included domiciliary services by general dental practitioners using portable equipment, for example: 'To establish a list of those general dental practitioners who will undertake NHS treatment for the handicapped and the elderly and provide domiciliary care for the housebound and to circulate this list to the relevant homes etc' (Merton, Sutton and Wandsworth FPC). Objectives on publicising information included that on the dental list, on NHS services available, the emergency services,

and exemptions from charges. For example, Birmingham FPC aimed 'To explore more effective ways of publicising the information contained in the Committee's Dental List for patients' benefit'.

(ii) In the service provision category, emergency dental services were the main concern; the objectives were to review or evaluate the need for these services. Derbyshire FPC planned a pilot scheme: 'The results showing use of the services will be analysed at the completion of several months to determine whether or not it should be continued and, if so, whether other local dental practitioners should be involved'.

Encouraging health education or dental health promotion through the GDS was a less frequently mentioned aim, for example: 'To improve health education facilities in the area - by encouraging the increased use of dental surgeries as points of contact for health education' (Hillingdon FPC). Other objectives in this category included encouraging high standards of premises and of care, and the provision of special services such as orthodontic treatment, and preventive dentistry.

(iii) Objectives for the administration of GDS centred on collaboration and liaison with the DHA and other agencies on service provision, information and planning. Ensuring a suitable balance of dental services between GDS and community dental services featured frequently in these objectives, for example: 'To assess with the District Health Authority and Local Dental Committee the balance between community and general dental services to ensure that the services are complementary and cost effective' (St. Helens and Knowsley FPC). The other main cluster of management objectives concerned efficiency, cost effectiveness, and charges, including monitoring the effects

of increased charges on the take-up of services, and monitoring instances of very high earning by dentists.

FPC Management

Since FPCs had recently had a change in status, it was not surprising that their main objectives concerned management, staffing and personnel issues (mentioned by nearly three-fifths of the FPCs), and efficient administration (almost one-half of the FPCs.) In expressing their management objectives for 1985-6 FPCs took up the objectives suggested in FPC operational requirements: 'to continue to discharge their responsibilities to the community and family practitioners as smoothly and efficiently as possible and, as far as lies within their power, to ensure that all resources are used effectively and economically' (HC(FP)(85)10).

The other most frequently mentioned objectives focused on the subjects of two recent reports. Nearly one-half of the FPCs mentioned collaboration and liaison, and two-fifths gave computerisation of the register as their objectives. The Joint Working Group on Collaboration between FPCs and DHAs, and the Arthur Andersen report on FPS administration and the use of computers, were both published in 1984.

(i) In the category of collaboration and planning, the main objectives concerned collaboration and liaison between the FPC, DHA and other agencies. Objectives were to adhere to the principles of the Joint Working Group on Collaboration, to review links at officer and member levels and with family practitioners, and liaison with CHCs and health education units. Kingston and Richmond FPC for example listed a range of such aims:

1. To improve and extend relationships with District Health Authorities, Community Health Councils and Local Representative Committees.

2. To develop a more active role at both member and officer level, in planning of services, at practitioner and community level.

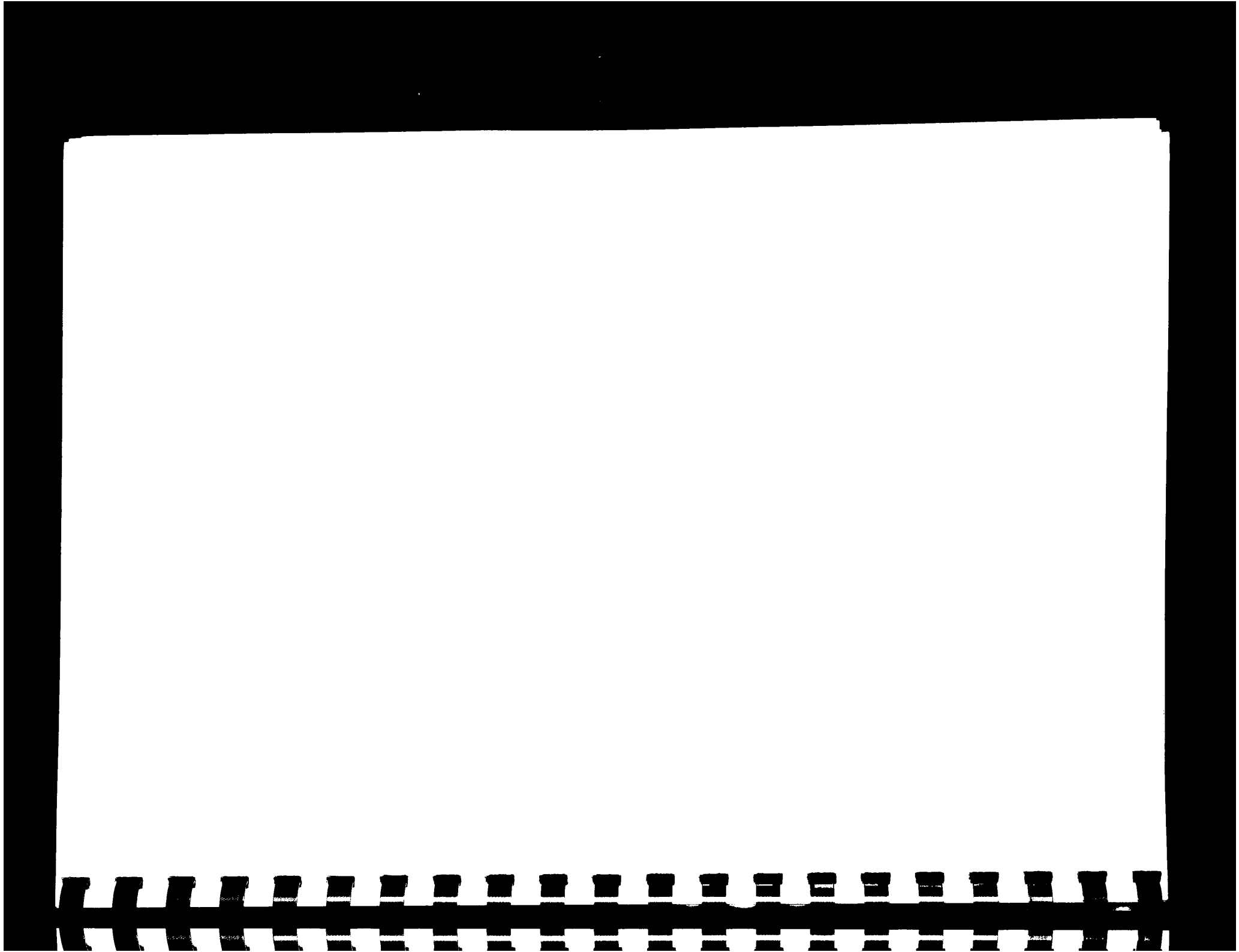
3. To ensure that the FPC makes a valid contribution to planning proposals put forward by the Health Authorities.

4. To participate in discussions on the development of Primary Health Care Services, and the promotion of health education.

5. To increase the effectiveness of the FPC's contribution to Joint Consultative Committees and Joint Care Planning Teams.

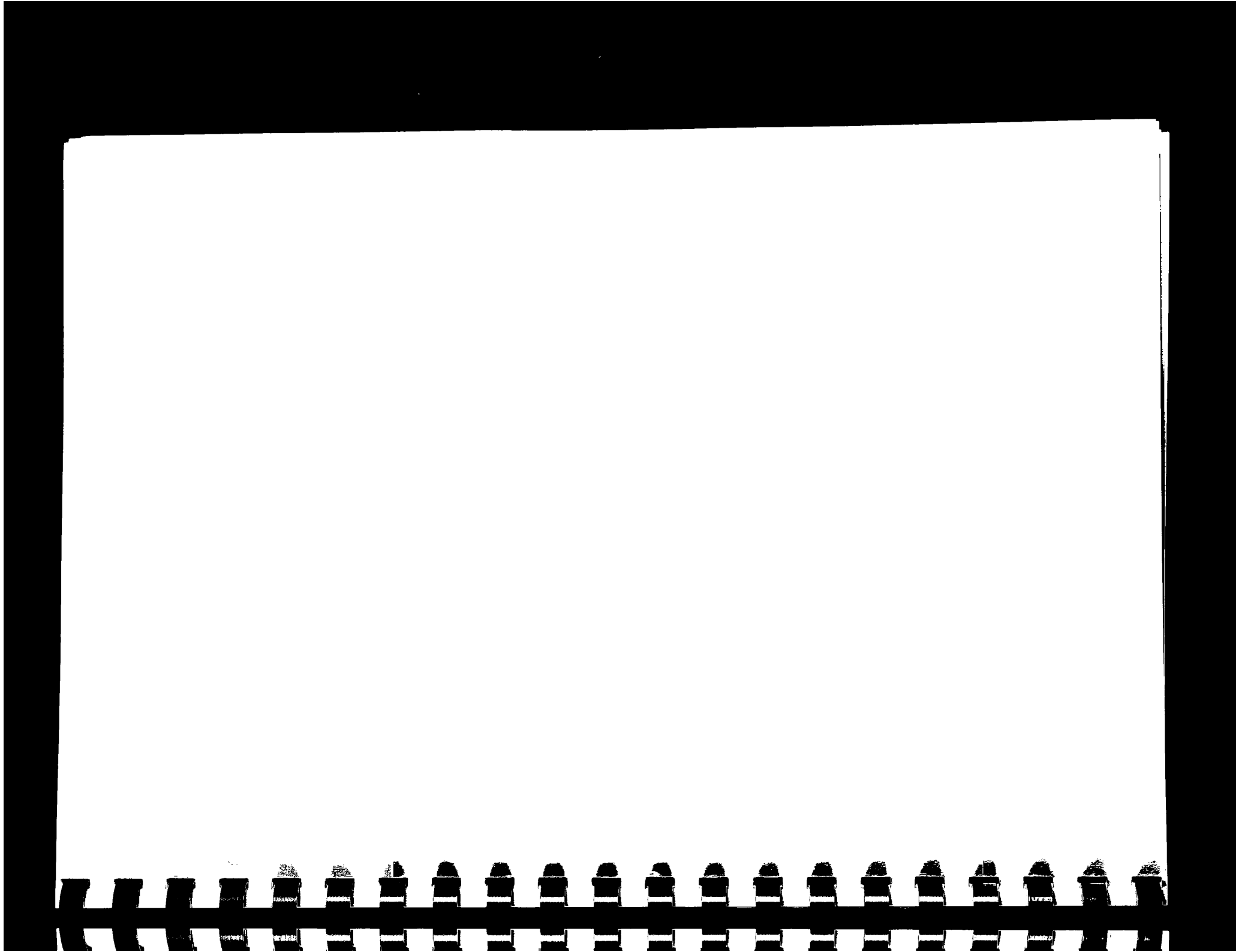
The next most frequent objective in this category was the dissemination of information on FPC functions, through publicity or training, to FPC members, other agencies and the public. Planning objectives included compiling the annual programme and strategy, responding to consultative papers, and collecting information, for example by surveys, on which to base plans.

(ii) The largest group of objectives for the FPC were those on <u>management and administration</u>. The management structure, staffing and personnel matters were the principal concerns of the recently independent FPCs seeking to match staff to their new roles, for example: 'A further objective will be to review the gradings of posts in the light of the considerably increased responsibilities of the Committee's staff, arising from the additional duties placed on the committee by the Department of Health and Social Security' (Oxfordshire FPC).



Efficient administration was the next main aim, as suggested by the circular quoted above; objectives included providing a supportive service to contractors and improving services to patients. Linked to these were objectives on the use of performance indicators and audit, and staff training. FPC premises and stores, and the handling of complaints were the subjects of the other aims in this category, for example: 'To establish an informal complaints procedure for general medical services and investigate whether such a procedure would be an effective method of dealing with complaints relating to the other professions' (Rotherham FPC).

(iii) Computerisation and new technology was the third main category of FPC objectives, with computerisation of the register of GP patients the most frequently given. For example, Cheshire FPC stated: 'The major objective and first priority for the FPC is to strive to obtain the necessary funding for the computerisation of the Committee's register of patients. The bulk of the FPC's aims for the future depend on first achieving this objective. This embraces issues ranging from improvement in information given to other authorities and the general public to the restructuring of the Committee's staffing establishment'. Computerisation of the register of female patients was usually planned as an initial aim, and this was linked to another objective, cervical cytology recall or call schemes. The use of computers, and new technology in general, were also fairly frequent objectives; the computerisation of financial or payments systems was a further specific aim. Stockport FPC for example, aimed 'To consider and develop the use of new technology within budgets and ensure that staff are prepared for the introduction of full computerised systems when these are available'.



Comment

The principal objectives and priorities stated by FPCs tended, predictably, to reflect topical issues and the current concerns of the DHSS, in particular those included in the operational requirements for the year, or the subjects of recent circulars and reports. Collaboration, for example, was a major theme of the objectives for all the family practitioner services and for management. There was also a tendency for FPCs to select as their objectives items which were unlikely to be controversial, such as adequate distribution (a major objective for all four services), rather than those concerned more directly with standards of care, such as reviewing the use of deputising services, a topic which we analyse in detail below.

2. DEPUTISING SERVICES

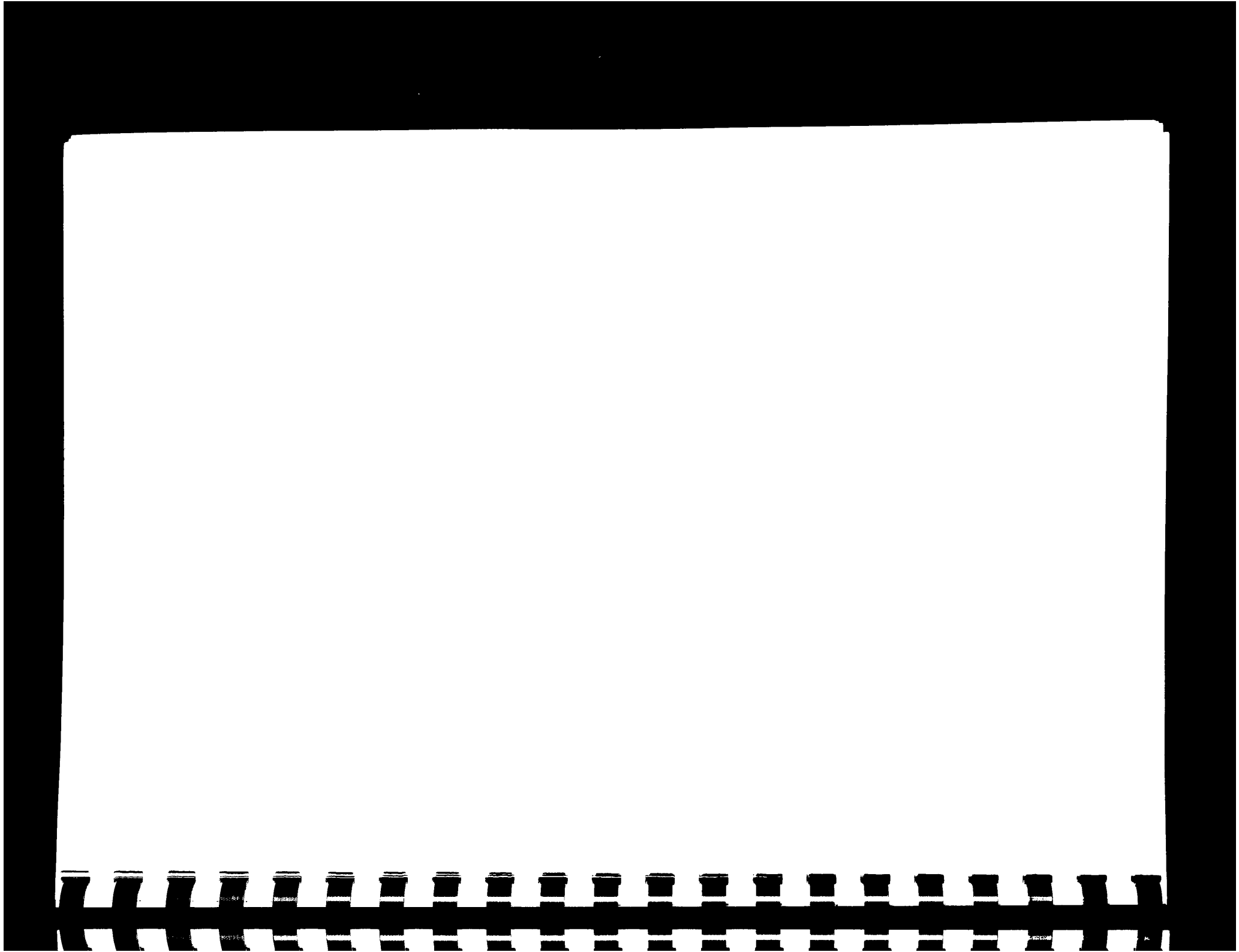
Introduction

Sixty-nine FPCs had commercial deputising services operating in their areas. Many FPCs stated their policy on limiting use of deputising services by giving the average permitted number of visits per 1000 patients per month, without indicating the principles underlying this policy. As required by circular HC(FP)(84)2, most FPCs had appointed a Deputising Services Sub-Committee, but only 27 had appointed liaison officers. Less than one-half of the FPCs indicated the methods by which they monitored the service, for example by visiting the deputising services or interviewing prospective deputies. One-third of the FPCs gave no information on how compliance on level of use was ensured; the most frequent method was signed statements from doctors. Attention was focused by FPCs on limiting the use of deputising services rather than monitoring standards.

In many of these first annual programmes there were inadequacies in the process of defining and presenting objectives and priorities. Perhaps inevitably, the objectives stated reflected the current concerns of the DHSS. FPCs might have taken more part in proactive planning, and might have been expected to take a wider view on issues such as deputising services. The development of the planning role of FPCs might be expected in future years as FPCs' new management structures are established.

In May 1984 the DHSS issued a circular on 'General Practitioner Deputising Services' which 'includes fresh guidance on the need to ensure that deputising services are of a satisfactory standard, that the extent of their use is reasonable in the circumstances and that arrangements are regularly reviewed. It transfers to FPCs direct responsibility for monitoring the standards of the deputising services' (HC(FP)(84)2, paragraph 2). The circular includes specific suggestions as to how this responsibility might be discharged. The analysis of the content of the FPCs' annual programmes on the topic of deputising services examines the extent to which FPCs report on their implementation of such suggestions on policy and procedures.

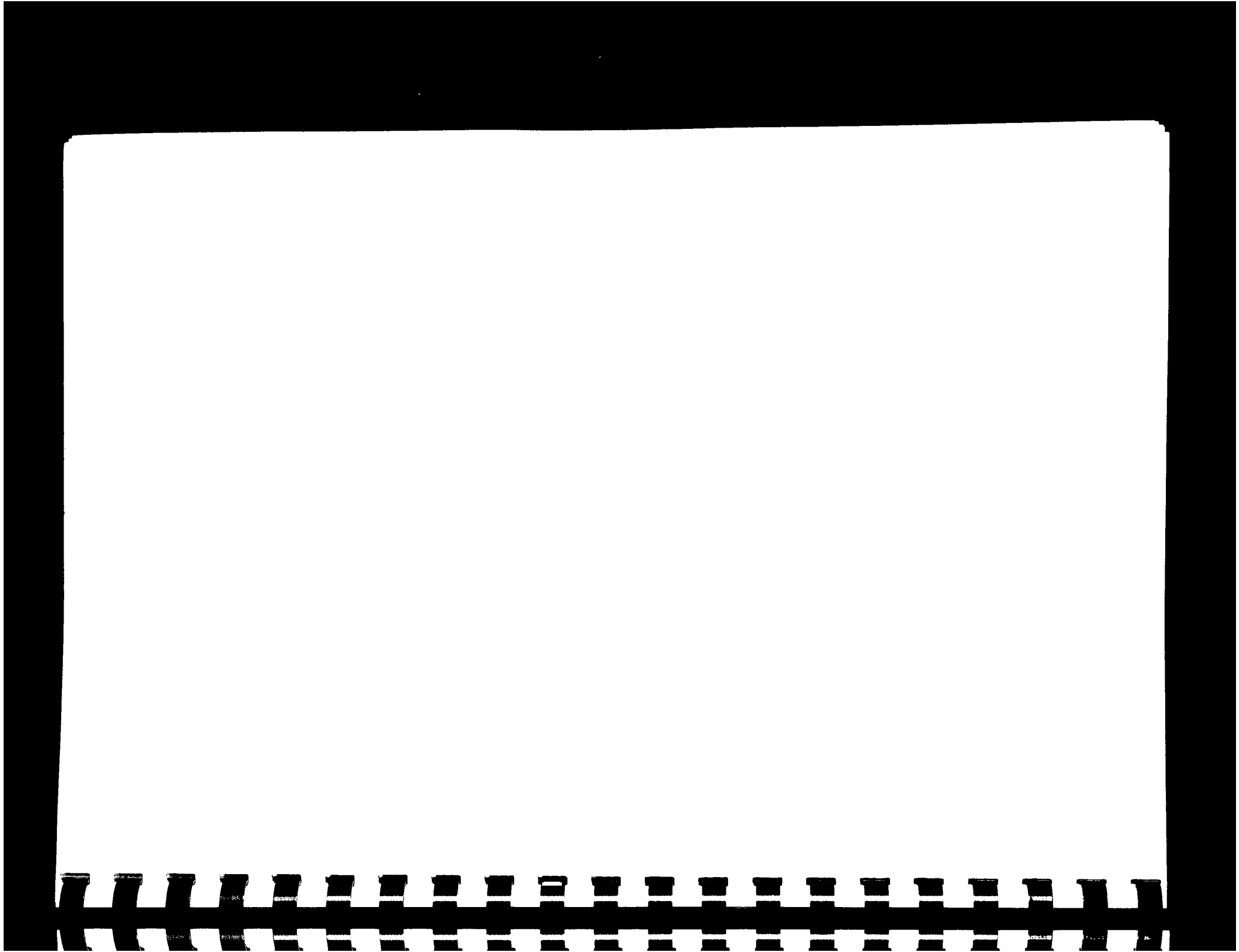
Deputising services operated in most of the FPC areas. Eleven FPCs from rural counties reported that no commercial deputising services operated in their area. There was no information on deputising services in the Cambridgeshire FPC annual programme. Bolton FPC mentioned a 'non commercial cooperative arrangement run by and for GPs'. Buckinghamshire, North Yorkshire, Warwickshire and West Sussex FPCs reported that deputising services were used by very few practices. The main analysis is thus based on the 69 FPCs in whose areas commercial deputising services operated, with some information from the four counties where use of deputising services was minimal.



Policy on Deputising Services

The information on deputising services policy which FPCs were asked to provide in their 1985-6 annual programmes was: 'What policy has been formulated and made known on consents to use, including the terms in which extent of use is expressed and the nature of the limitation' (HC(FP)(85)10, Annex A). They were also asked specifically for the 'Number of consents to use deputising services' and the 'principles governing these consents'. In fact many FPCs chose to state their policy very briefly by specifying the maximum level of usage of deputising services, giving neither the reasons for selecting the particular level of usage, nor the principles on which this policy was based. The DHSS recognised that the information given was inadequate and again asked that in the 1986-7 annual programmes FPCs give their 'general policy on consents and the principles underlying this' (HC(FP)(86)2).

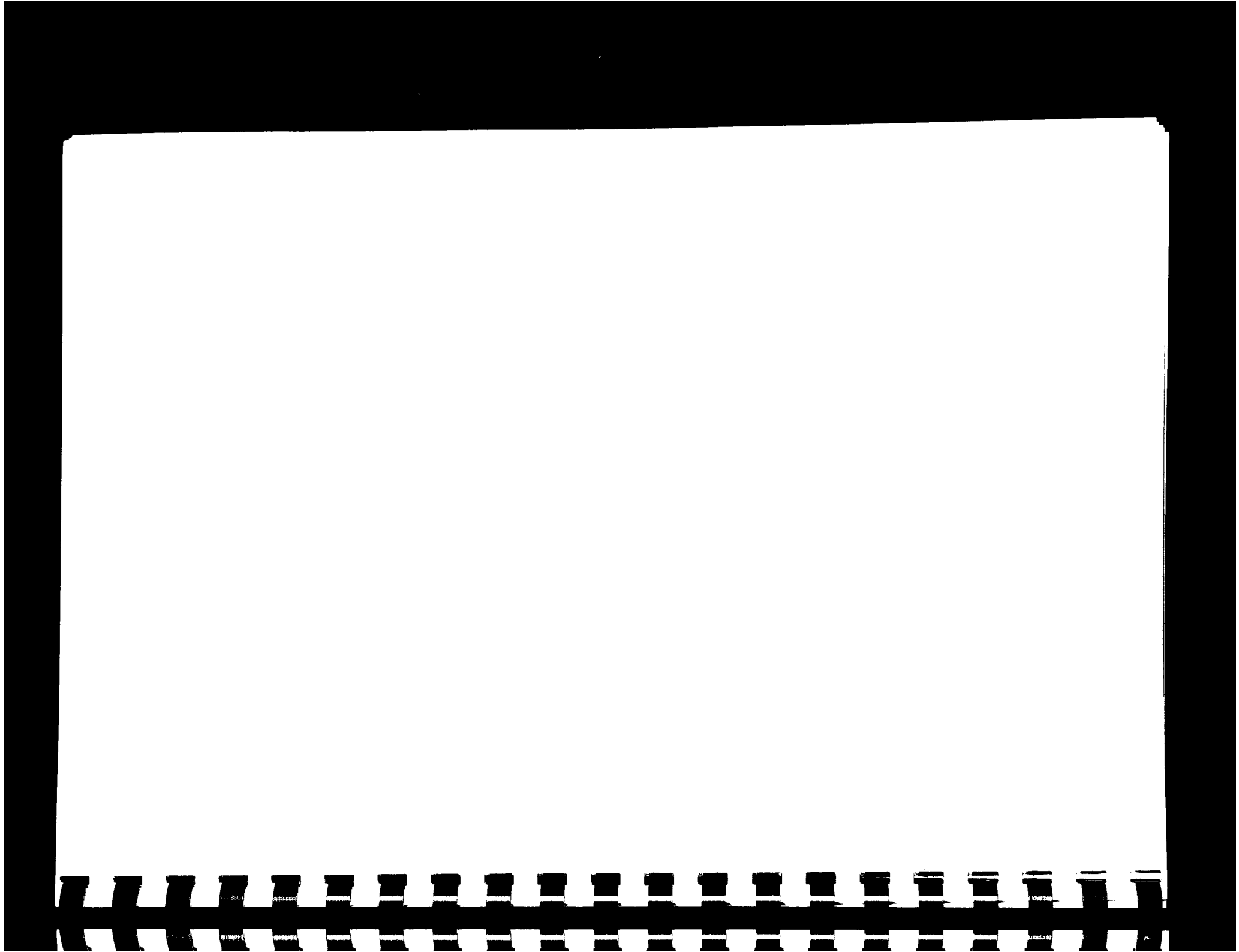
In the 1985-6 annual programmes 36 of the 69 FPCs mentioned as their policy that deputising services should not care for a GP's patients every night and weekend, which is stipulated in circular HC(FP)(84)2. Apart from this and their specific statement of the limitations on consents, only 21 FPCs gave any indication of the general principles informing their policy. The principle most frequently mentioned, by ten of these FPCs, was to ensure that deputising services maintained satisfactory standards. For example, 'The Committee continues to strive to maintain the highest possible standards of its deputising services, as illustrated by its continued insistence on requirements in excess of those stipulated in DHSS Circular HC(FP)(84)2' (Birmingham FPC); and 'The Committee's aim is to ensure that out of hours care of patients is of no less a standard than that provided in hours' (Wigan FPC). Seven FPCs mentioned compliance with the Circular or with its Code of Practice in Annex 2.



Strict control and monitoring of the use of deputising services were cited as the policy of five FPCs, for example: 'The Committee will be prepared to withdraw and review approvals if the appropriate assurances are not received, and the undertakings given conformed with' (Lancashire FPC). This and one other FPC were concerned with the competence and efficient management of the deputising services: 'The Committee supports the concept of efficiently organised and managed deputising services particularly in inner city areas to ensure that prompt and efficient care is always available' (Brent and Harrow FPC). Four FPCs mentioned that in deciding on the level of usage of deputising services they took account of the demographic and other characteristics of the area, for example: 'This general policy, which will be reviewed periodically, takes into account the demographic, social, environmental and epidemiological factors of City and East London which is generally considered an unattractive inner city area' (City and East London FPC).

Only four FPCs specifically included in their policy service or information for the patients, for example: the Committee is 'anxious to ensure that all patients are aware of the arrangements for out of hours services within their own practice and the use and availability of deputising services' (South Tyneside FPC).

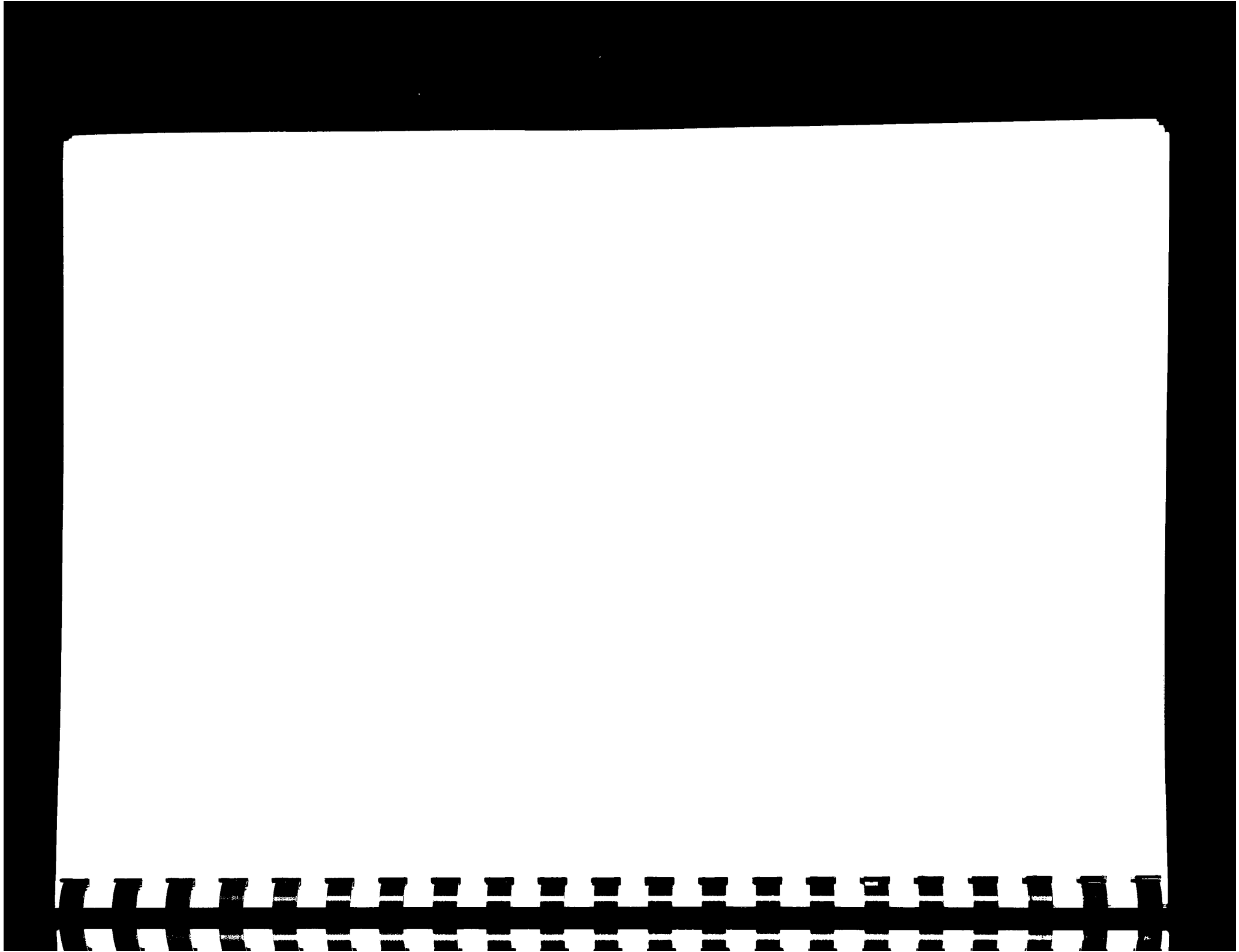
Although other FPCs may have had similar policies, these were not stated. All however indicated the limitations imposed on the use of deputising services. The most common method, used by 56 FPCs, was to state the average permitted number of visits by the deputising services per 1000 patients per month, based either on individual GPs' lists or per practice. The number of visits allowed



per month ranged from 8 to 25 with a median of 15; the most frequent number was 12 per thousand patients (17 FPCs). Five other FPCs gave the number of visits without specifying for how many patients, for example 25 per doctor, whereas two had different levels for different practices, ranging from 12 to 20 per 1000 in Humberside, and 10 per 1000 for single and two handed doctors but 5 per 1000 for practices of three or more in Merton, Sutton and Wandsworth. Manchester FPC allowed, in addition to 12 visits per 1000, two for a male GP aged over 60, two for a female GP and two for inner city practices. In addition to the number of visits, Essex FPC specified a maximum of four nights and alternate weekends, and several FPCs stated the hours during which deputising services could be used.

The other FPCs used different methods of setting limitations, or were reviewing the policy. Walsall GPs were required to provide a personal service one night per week and one weekend in eight. In Wigan GPs were to indicate their estimate of intended use. Only two used another main method suggested in the Circular, to give a percentage of out of hours time during which deputising services may be used: Kirklees FPC's policy was that for at least 20 per cent of out of hours time deputising services should not be used, and Calderdale FPC specified a maximum 50 per cent use. Liverpool FPC did not consider any of the methods of limitation in the Circular to be satisfactory: 'The Committee considered in great detail the area of "consents to use" and felt that it was not possible to effectively monitor use by a "lucky dip" method of numbers of calls per 1000 patients'. Instead, they agreed to exercise 'a strict monitoring role within the terms of the Circular'.

Several FPCs stated that the level of usage was a provisional one, to be reviewed after a trial period. Most said that in special circumstances

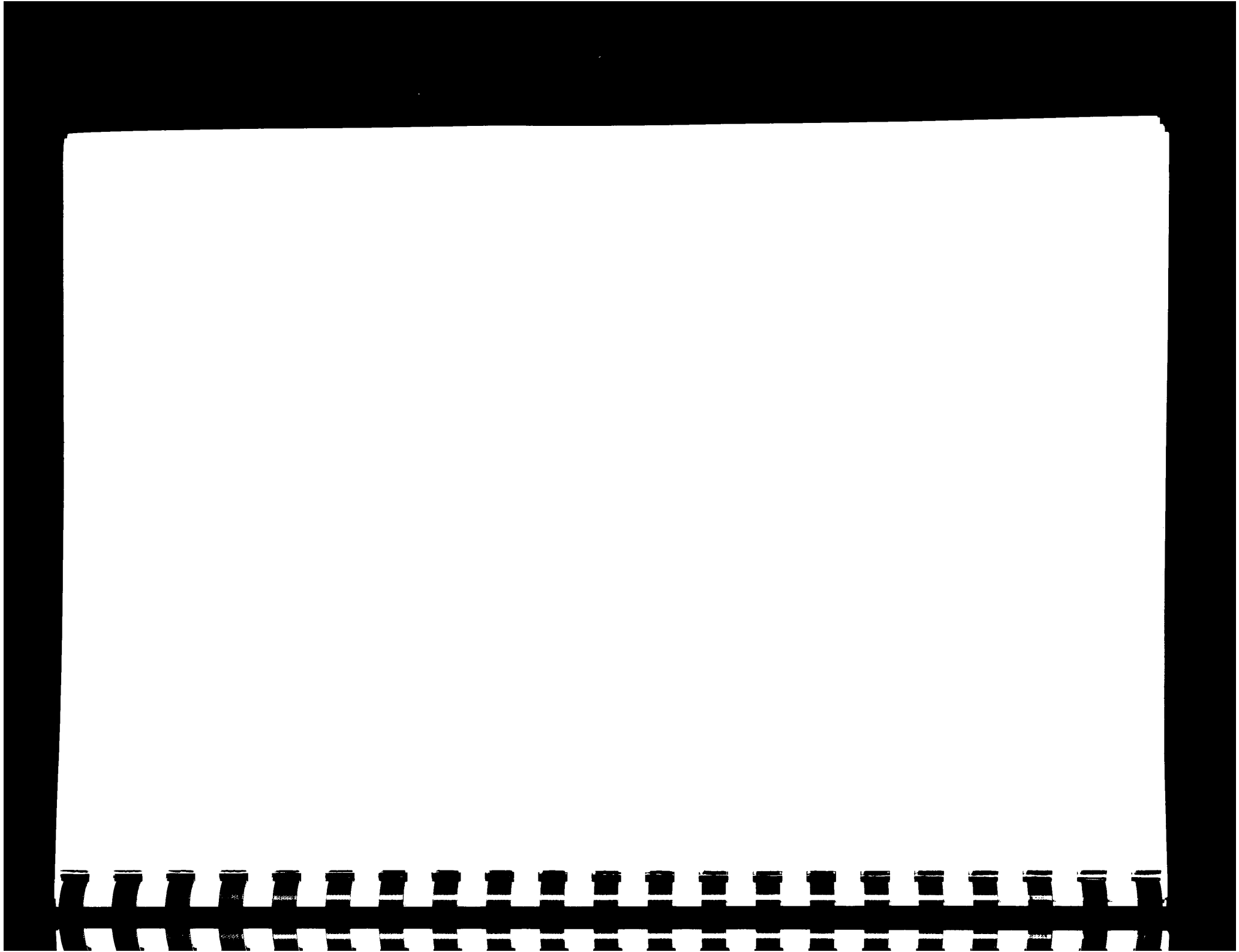


doctors could apply for the level to be increased. Few FPCs, however, gave any indication of the actual level of use. The level of usage expressed in number of visits per 1000 patients did not vary by type of area; one might have expected higher levels in urban areas but there was no consistent pattern.

Monitoring Level of Use and Standards

Turning to the arrangements made by FPCs for monitoring the level of use and standards of deputising services, the information given in the 1985-6 annual programmes was again very limited. FPCs were asked to say whether they had appointed a Deputising Services Sub-Committee (DSSC) and a liaison officer, as required by the circular on deputising services (HC(FP)(84)2), which specified that the liaison officer should be medically qualified. Sixty-three FPCs had appointed a DSSC, including Shropshire where the sub-committee was to meet once an application to set up a deputising service was received. Eight of these FPCs did not mention the DSSC (listed under Committees) in their section on deputising services, however, although this sub-committee has a major role in monitoring the services. Three FPCs made no mention of a DSSC. North Yorkshire, Warwickshire and West Sussex FPCs considered a DSSC unnecessary because of the low use of deputising services. Four FPCs had joint DSSCs with neighbouring FPCs, as did 24 of the FPCs which also had their own DSSC. The joint DSSC was responsible for monitoring deputising services which covered a wider area than that of a single FPC.

Liaison officers had been appointed by 27 FPCs to be the point of contact between the FPC and a deputising service. Gateshead FPC had not appointed a liaison officer as the liaison officer for the joint DSSC was a member of its own DSSC, and Camden and Islington FPC had not appointed one because the joint



DSSCs had their own liaison officers. Bradford and Leeds FPCs had not been able to appoint liaison officers as there was no payment for this post. Coventry FPC, although it had a liaison officer, 'strongly supports the need for liaison officers to be adequately remunerated'. Three FPCs gave no reason for not appointing a liaison officer, while the remaining 39 FPCs made no mention at all of liaison officers.

Less than one-half of the FPCs gave even the briefest indication of the methods by which the DSSC monitored deputising services and five gave some information on the role of the liaison officer, for example that the liaison officer had 'completed visits and submitted reports' and that the services had 'agreed that the liaison officer should have ready access to premises and records' (Lancashire FPC). Several FPCs mentioned monitoring by the DSSC within the terms of the Circular.

More specifically, a method of monitoring mentioned by eight FPCs was visits to the deputising services by DSSC members, for example: 'Two visits are planned to each deputising service annually, one being unannounced' (Solihull FPC). Five FPCs carried out reviews of the operation of deputising services, and two had investigated the deputising services thoroughly before approving their use, for example: 'Members of the Sub-Committee visited the premises of all the Deputising Services and interviewed the Directors. Their services have only been accepted after undertakings have been received regarding the acceptability of the service available. These undertakings are in line with the matters defined in Annex B of HC(FP)(84)2 and relate to competence, sufficiency, continuity of care, supporting staff, transport, priority of and response to calls, records and the procedures for dealing with complaints' (Lancashire FPC). These listed topics, which are covered in the Code of

Practice, are rarely mentioned in the annual programmes' sections on deputising services.

Interviewing prospective deputies was another method by which DSSCs could promote satisfactory standards of service; this was mentioned by nine FPCs, for example: 'The Sub-Committee have also agreed to establish an interviewing panel which will be involved in the appointment of deputies with regard being given to their relevant experience and, in the case of doctors in contract with the FPC, their ability to continue to provide the necessary level of general medical services within their own practices' (Barnsley FPC). Four FPCs mentioned paying attention to complaints and another four made periodic or random checks on the level of use. Other ways of monitoring cited were discussion with deputising service managers (Brent and Harrow FPC), monitoring statistical information (Bromley FPC), receiving reports on efficiency and staffing (Hillingdon FPC), assessing the quality of the deputising service (Humberside FPC) and undertaking surveys of the incidence of use (Kingston and Richmond FPC).

It is impossible to ascertain from the 1985-6 annual programmes whether other FPCs also used any of these methods of monitoring; for this reason the DHSS asks for 1986-7 annual programmes to include information on 'how deputising services are monitored (including the role played by the liaison officer)' (HC(FP)(85)10).

Procedures for Ensuring Compliance

The remaining information which FPCs were asked to provide on deputising services was the action taken under paragraph 13 of the Circular on deputising services. This paragraph states that 'FPCs should check no less frequently

than annually that consents are being properly observed. This should be done by seeking information from the deputising service, with the doctor's agreement or FPCs may rely on a signed statement by the doctor' (HC(FP)(84)2).

Seventeen FPCs mentioned that consents were reviewed annually and another 'periodically'. The signed statement from the doctor (28 FPCs) was used more often than seeking information from the deputising service (13 FPCs); five of these FPCs used both methods. Doctors were usually required to submit a signed statement, annually or quarterly, that they had not exceeded their permitted use of deputising services. Alternatively, or additionally, deputising services would provide the FPC or doctors with details of the use of the service by GPs, for example: 'The Sub-Committee has made arrangements for the Deputising Service to provide subscribing doctors with details of their use of the service and for doctors to pass that information to the FPS administrator when the service is being reviewed' (Avon FPC).

Twenty-three FPCs gave no information on how compliance on level of use was ensured, two because the procedure was under review. Fifteen cited other criteria or procedures instead of, or in addition to, statements from doctors or information from deputising services. Some of these were variations on the signed statement method, for example: 'Each practice shall give a written undertaking to the FPC to provide details of the number of visits carried out on their behalf by the deputising service each month' (South Tyneside FPC) or the Committee was 'to enter into individual written agreements with doctors on the basis of use' (Barnsley FPC). Four FPCs stipulated conditions about practice arrangements to ensure that patients could contact a doctor at all times, that the deputising service could contact the GP or that standby

doctors would be available, for example: 'Each group of practices who have rota arrangements together or between themselves shall at all times have a standby practitioner for call out in the event of the service becoming overloaded' (Durham FPC). Kirklees FPC had arranged to provide the deputising service with details of the number of patients on GP lists.

Cheshire FPC provided as an appendix to the annual programme its form 'Application to use a deputising service' which sets out very clearly its detailed criteria and could be cited as an example of good practice.

Attitudes to Deputising Services

There had been adverse publicity in 1983 about deputising services and some very disturbing cases had been reported. On 26 July 1983 the then Minister, Kenneth Clarke, wrote to all FPCs in the light of this publicity and asked them to review the arrangements for deputising. The circular on deputising services was issued the following year. Although it is unlikely that such problems with deputising services have ceased to exist, little concern was expressed in the FPCs' annual programmes about the standards of services, even in the areas where the publicised problems had arisen. In the 1985-6 annual programmes FPCs were asked to make 'any comments on particular services provided' (HC(FP)(85)10), but few gave such information.

Where comments were made on services, however, they almost invariably expressed satisfaction. Thirteen FPCs stated that they found the deputising services satisfactory, for example that they were 'operating quite correctly and efficiently. The doctors, FPC and CHCs were all in agreement that these services were of great value to the community and should be allowed to continue in their present form' (Hampshire FPC). Kirklees FPC was satisfied

because a majority of the deputies were GPs on the FPC list which 'guarantees that most deputies will be experienced general practitioners rather than "moonlighting" hospital doctors earning a little pin money'. Liverpool FPC was 'extremely impressed by the service provided particularly in relation to the checks and safeguards built into the operational procedures'.

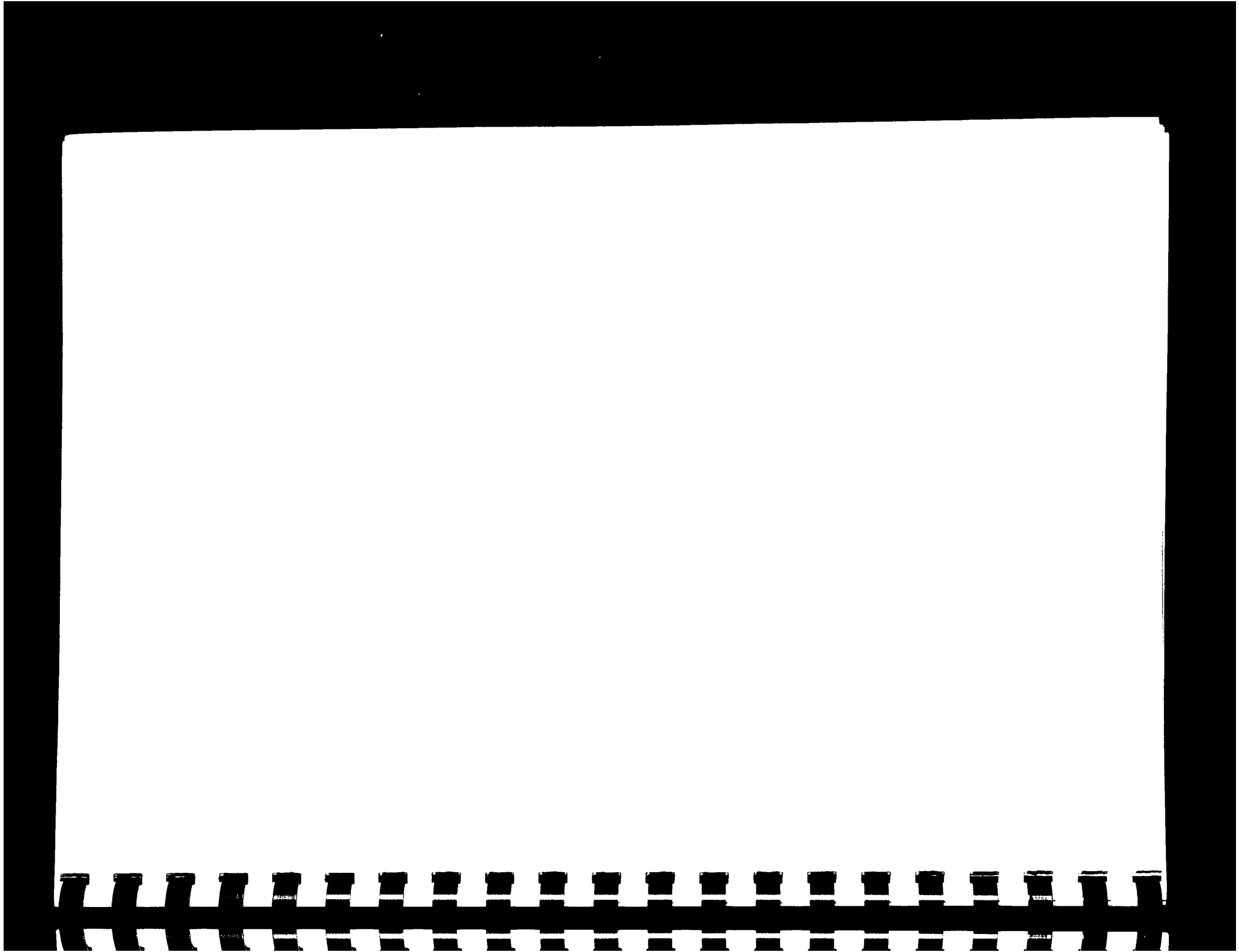
In contrast, only one FPC (Kirklees) mentioned difficulties, that the head office of the deputising service was based in Leeds and the service would not operate in some outlying rural areas 'much to the chagrin of the doctors working there', a problem for the doctors rather than for patients. Some FPCs based their confidence in the service on lack of complaints, but none mentioned any research into patients' experiences or opinions of the services, and few spoke of consultation with the CHC about deputising services.

Satisfaction with the services was implicit in the reports of four other FPCs, but the remaining Committees gave no indication of their opinions of the standards of service, confining their reports to administrative matters.

Attitudes to deputising services may also be assessed from the concern stated by FPCs about their responsibility in respect of deputising services. Some FPCs made this explicit in their policy or procedures, whereas from the entries of most FPCs we could only infer, from the information given, that they were concerned about certain aspects of their duties. Attention was focused by FPCs on limiting the use of deputising services. Five FPCs expressed concern about this, for example: 'The Committee takes its responsibilities in connection with monitoring and controlling the use of deputising services extremely seriously' (Birmingham FPC). Almost all the other FPCs implied by their procedures that they were anxious to limit use.

Monitoring standards of service received less attention: ten FPCs expressed concern, there was implied concern by 25 others but one-half of the FPCs did not mention standards. Dorset FPC, for example, was anxious to ascertain the quality and competence of the deputising service before agreeing to its use and made 'exhaustive enquiries' into manning levels, 'arrangements to deal with unexpected surges in demand' and ensuring that 'calls are dealt with promptly and efficiently'.

The main groups with an interest in deputising services are the patients, GPs, and the FPC. Where concern about any of these interests was strongly expressed in the annual programmes, this was mainly about the FPCs' problems in meeting their responsibilities, mentioned by four FPCs. Two of these felt strongly about the need for payment for liaison officers, while the other two were worried about the administrative burden. Hampshire FPC had staff shortages which meant the 'sheer impossibility of tackling the work involved' in monitoring deputising services. Bromley FPC was worried about the stress on the administration because a large deputising service was located in its area, which is the smallest London FPC area. GPs' need for relief from 24 hour cover was often mentioned in the introduction to deputising services sections of the annual programmes and some specific difficulties, such as for women doctors on night calls, were cited. Sunderland was considered a high risk area for out of hours services, and GPs' need for relief was seen as important there. As shown above, however, the interests of patients rarely featured in FPCs' annual programmes' sections on deputising services: four expressed concern for patients and in four others there was some implicit concern.



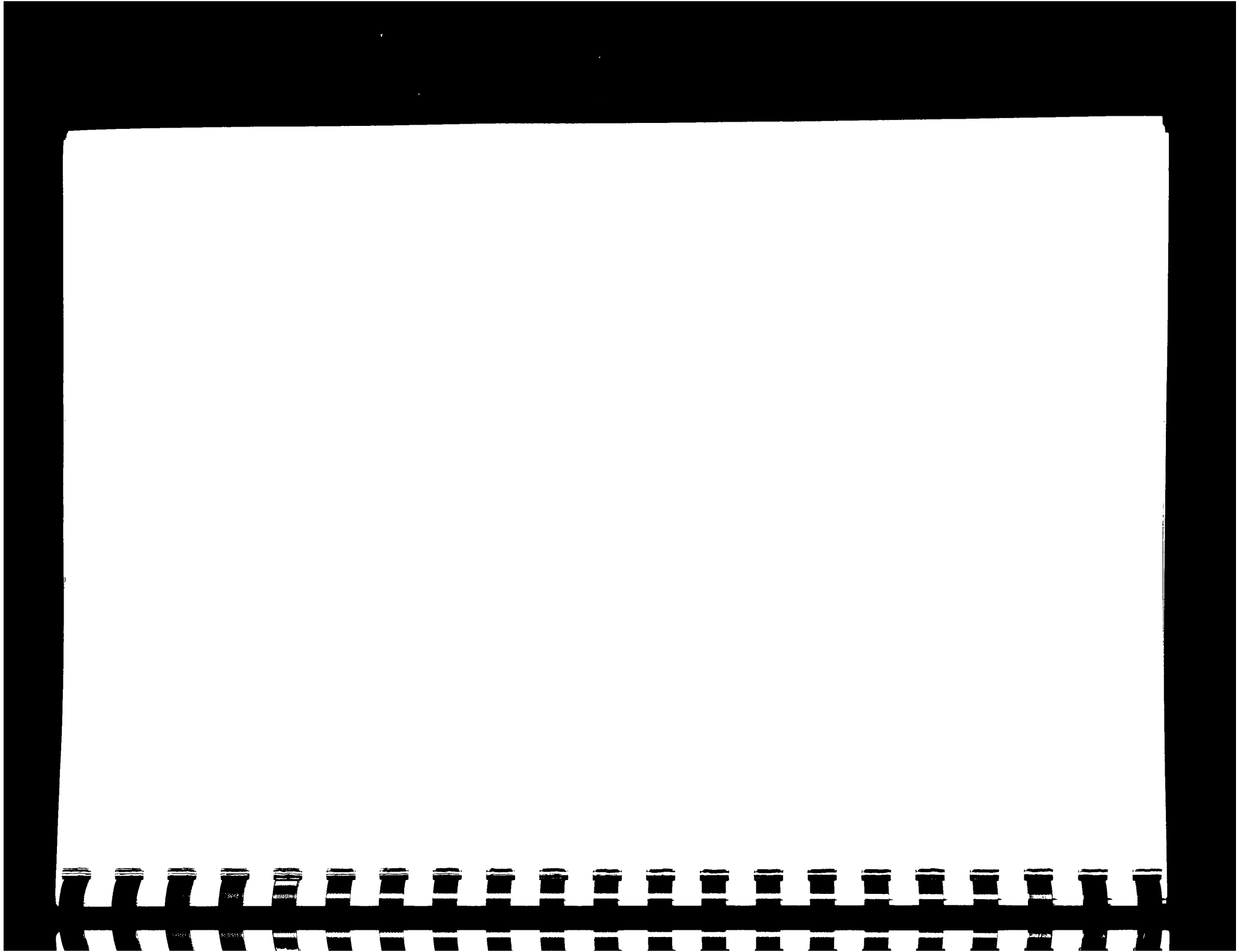
Comment

Deputising services are used in most FPC areas. Their use is an important issue with implications for doctors, patients and the FPC. It may also affect hospital accident and emergency departments whose workload may increase where out of hours general medical services are unsatisfactory. The requirements and Code of Practice included in Circular HC(FP)(84)2 would, if implemented, provide to some extent the assurances of reliable and satisfactory services which GPs, patients and the FPC should expect.

Most FPC annual programmes, however, gave little indication of how far and in what way the circular was being implemented. Although a minority of FPCs were conscientious in stating the principles underlying their criteria and gave details of their monitoring procedures, the issue of deputising services did not appear from the annual programmes to be given the attention it warrants. The DHSS requirements on the content of these annual programmes on deputising services were on the whole met summarily if at all, and to the letter rather than the spirit, as the DHSS recognises: 'Overall the information was insufficient to allow firm conclusions to be drawn about how the arrangements were working' (HC(FP)(86)2).

CONCLUSION

Our identification of main trends in the content of FPCs' objectives inevitably drew little attention to the minority of objectives which were innovative and sought to promote change in service provision, collaboration, or the dissemination of information. Although some FPCs did propose such objectives, however, the overall impression remains that some FPCs might have taken more part in proactive planning rather than reacting to other



authorities' plans or adhering to traditional roles. In their new role as planning authorities FPCs might have been expected to take a wider view on issues such as deputising services, or to initiate some research into the level of satisfaction with such services, but their main preoccupation as reflected in their entries on deputising services in the 1985-6 annual programmes, seems to have been with fulfilling their administrative responsibilities. The development of the planning role might be expected in future years as FPCs' new management structures are established and staff become adjusted to, or are trained for, their new roles.

Some FPCs gave interesting and realistic sets of objectives agreed with local representatives, and included target dates and methods of achieving these objectives. It is clear, however, that in many of these first annual programmes there were inadequacies in the process of defining and presenting objectives and priorities. We have suggested above some points on which guidance could be given to assist FPCs in stating their objectives and priorities in a more helpful way for planning and accountability purposes. It should be stressed, however, that the formulation of the objectives themselves is the responsibility of the FPC in consultation with LRCs and other agencies, and in recognition of local needs, identified by knowledge of the area and research where appropriate.

It might be necessary in future annual programmes for the information required by the DHSS to be more directly focused on the setting of objectives and priorities so that FPCs might concentrate on this crucial aspect of their planning role. This is recognised in the operational requirements for 1986-87 where it is stated that much of the detailed information in the first annual programmes need not be repeated but should be updated (HC(FP)(86)2). The

circular also asks for 'quantified targets and dates' for the achievement of objectives to be included in the 1986-87 annual programmes.

One might expect that in the 1986-87 annual programmes FPCs will report that consultation on their objectives has been completed. Where in the 1985-86 annual programmes FPCs commented on the lack of time available for deciding objectives, it is also to be expected that objectives have now been set. FPCs are also required by the DHSS, to update their 1985-86 objectives and report on achievements to date. Our analysis of the 1986-87 annual programmes will consider the extent to which these expectations have been met.

B. FPC PROGRAMMES FOR 1985-86 AND 1986-87

Summary

In analysing the FPCs' annual programme for 1985-86 and 1986-87, three topics were selected, on all of which the FPCs had specifically been asked to report; GP premises, collaboration and complaints. While many of the committees seemed to be broadly satisfied with their existing system for monitoring (and improving where possible) surgery provision, their new status from 1 April 1985 and new statutory demands for collaboration meant in every case that new arrangements had to be made in this latter area. On the topic of complaints, we outline the attitude of FPCs to dealing with them, and as far as the limited comparability of the data in the reports allows, the incidence and outcome of complaints is analysed.

3. GP PREMISES

Introduction

Even in the area of GP premises, there were changed requirements which gave a new impetus to many FPCs' activities in monitoring them. HN(FP)(84)42 of December 1984 set out revised minimum standards for surgery premises, gave advice on improvements, visiting, and sanctions, and provided a standardised form for a progress report to be completed by 31 March 1986.

Similar information was to be provided by FPCs in their 1985 reports: HC(FP)(85)10 of April 1985 gave an outline of the information required, by September 1985, in these. FPCs were 'asked to indicate in their programme

arrangements for satisfying themselves as to the quality of general practitioner premises, for example, inspection programmes and follow-up arrangements where these are applicable'.

An Appendix to the Circular gave a more detailed framework for the information required, as follows:

3.8 Premises: Number of cost rent schemes and Value.
Number of improvement grants and value.

3.9 Eligibility, and any bids for higher improvement grants under Inner City partnership provisions.

3.12 Premises:

i. Response to revised minimum standards monitoring request, if completed.

ii. Inspection programme

iii. Details of existing premises: health centres;
owner occupied surgeries;
rented surgeries.

iv. Branch surgeries - number and location.

FPCs were also asked to provide a commentary on the supply and distribution of branch surgeries relative to need.

The 1986 annual programmes, required by 31 May, specified a number of areas in relation to premises in which information - mainly updating the 1985 reports - was required. FPCs were asked to describe

- 'progress (since 30 June 1985 - the key date in 1985 programme) with programme of premises visits and targets to be achieved in 1986-87 or
- programme for visits if not previously defined - with target areas and data commencing in 1986-87;
- eligibility and any bids for higher improvement grants under Inner City partnerships provisions;
- changes in premises since 30 June 1985 in respect of health centres, owner occupied and rented surgeries and branch surgeries'.

They were also asked to describe 'changes in distribution of practitioners from position reported in 1985 Annual Programme'.

Of the 90 FPCs in England, information on premises was available from 86 in their 1985 annual reports and 72 in 1986. Only 18 FPCs gave all the information asked for in 1985 and many preferred to give it in a different form to that set out in the guidance. This creates difficulties in comparing FPCs and years. Nil or negative reports were often not made, most frequently in the case of eligibility for higher improvement grants. Those FPCs which did not cover the inner-city areas to which these grants apply very often ignored this question, perhaps thinking the response was self-evident. Some detailed grants received, but not bids made. Other FPCs provided relatively full information on the distribution of premises, for example, but no figures which could be used for comparison. The opposite pattern was shown by those reports which provided complete data but no flesh on the bones. The most useful reports were those which provided all the data asked for, in the suggested form, and supplemented them with other figures, explanation, and argument arising from their own experience.

Up to 1985 FPCs would inspect premises when a new doctor joined the Medical List and when thought necessary in connection with the schemes for reimbursement of rent or rates and improvement of premises which they administered. Many FPCs, especially in areas well provided with good quality surgery premises, were reluctant to add a systematic inspection programme to these visits. There were two main reasons for this: the time and expense involved and apparent wish to avoid acting in a 'policing' role. Buckinghamshire FPC, for example, provided no information on inspections or improvement grants in its 1985 programme, noting however that 'the standard of practice accommodation ... is generally high'. In 1986 it reported 'it is with some reluctance that a routine visiting programme to all practice premises is to be carried out to comply with the Department of Health and Social Security instructions'. A comprehensive list of premises with in most cases the dates of the latest visit was appended. Another FPC's response in 1985 was 'await for further guidance on a more positive role' (Wiltshire).

FPCs took the view, which in the circumstances is clearly correct, that the 'carrot' of grants for improvements and advice and encouragement is more effective than the (in any case limited) 'stick' available to them. They frequently made a point of stressing their cordial relationships with their local medical committees and most of them emphasised that they already provided help and encouragement to improve premises. Visits had usually been in this context and were described as such and not as 'inspections'.

At the same time, the more detailed criteria of acceptable surgery standards given in HN(FP)(84)42 were often welcomed and the reminder in that Notice of

FPCs' powers to withhold reimbursement of rent and rates, in the event of a practitioner refusing to make necessary improvements within a reasonable time, was often echoed. (The further but rare sanction in such a case is a hearing before the FPC medical service committee.) It was only occasionally, however, that much dissatisfaction was registered with the standards of premises and in only one reported case in the 1985 or 1986 reports were rent and rates reimbursements in fact withheld. (There were three reported cases in one FPCs' area - Enfield and Haringey, see below - of these payments being abated and two other FPCs reported each having given notice to one practice that failing improvements to premises payments would be stopped.)

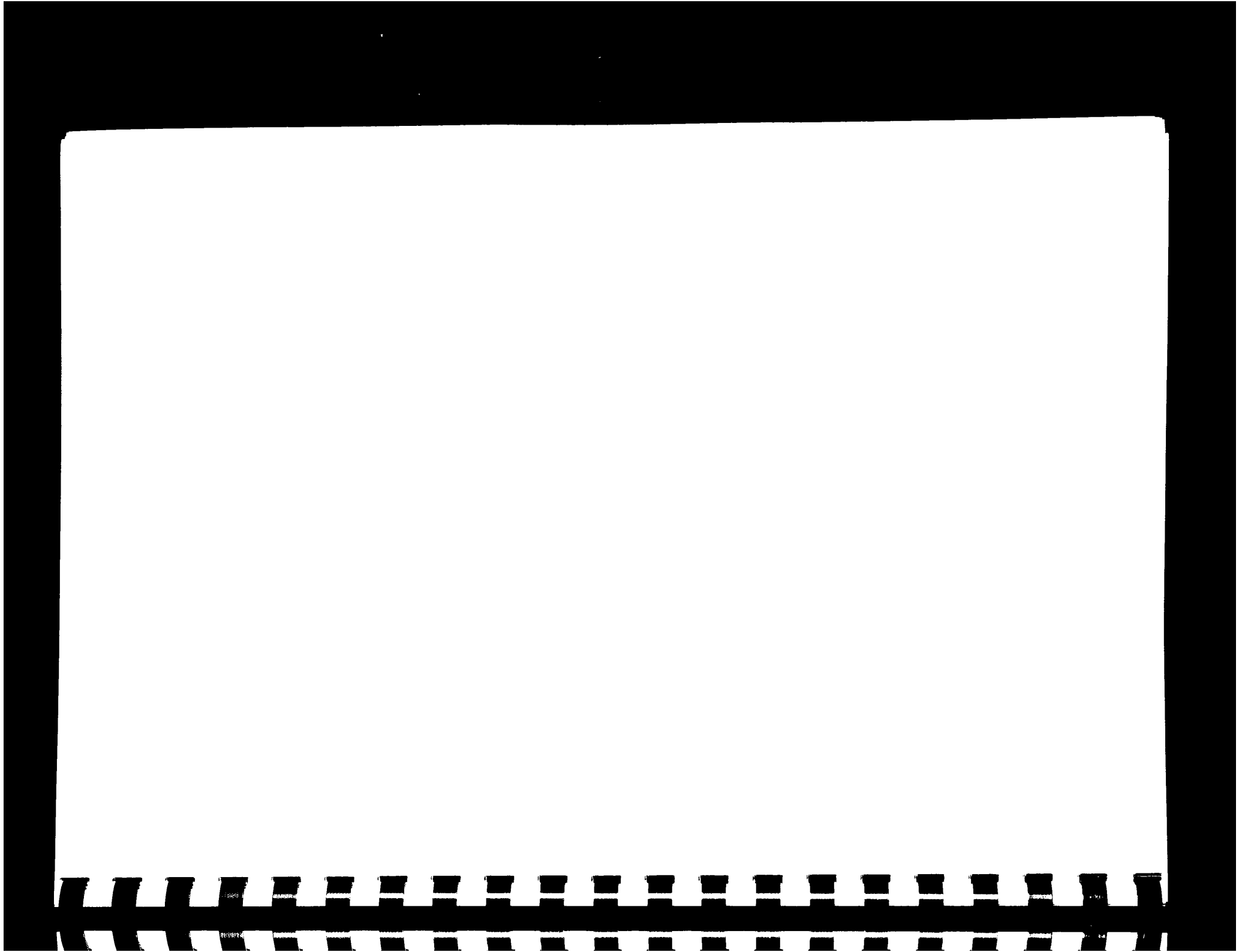
FPCs therefore rely primarily on the professionalism and goodwill of doctors and various financial incentives to enhance the stock of premises.

Policy on Surgery Visits

As mentioned, many FPCs were broadly satisfied with their arrangements for monitoring surgery premises. In the 1985 reports many merely stated that they had a programme of visits, without giving details of who did the visiting, the pattern and timescale of visits, and the criteria used. A number of committees had not been able to formulate a response to the revised minimum standards monitoring request issued in December 1984. However, some of the briefer reports were still able to give a reaction to the request and the salient points of the programme of visits planned. Enfield and Haringey, for example, noted that before the circular visits were undertaken in connection with the rent and rates scheme, cost rents and improvement grants and on receipt of complaints. It was now intended, in consultation with the LMC 'as a matter of priority to begin a programme of routine visits to practice

premises as described in Health Notice HN(FP)(84)42'. The visiting team was to comprise members and officers of the FPC and members of the LMC and the intention was to visit all the premises within a year. (This was one of the more ambitious timescales, and the 1986 report showed that of the 98 main surgery premises only 28 had been visited for the purposes of determining whether the minimum standards had been met. Of these, seventeen needed improvement and in three cases the visiting team recommended that rent and rates payments be abated. It was intended to complete the programme and produce a full report in time for the 1987 annual programme.) As with most of the committees, the stated purpose was positive: 'The purpose of the new programme of visits is, as before, to advise doctors on how they can improve their premises and take advantage, where appropriate, of the various schemes open to them'. Another committee (Derby) went further in its 1986 programme to state specifically that the aim was '... not to penalise doctors for sub-standard accommodation'. Only one committee (Kirklees) reported 'friction' between the FPC and 'one or two' practices, on the subject of access for handicapped people. Hillingdon's 1986 report was unique in including a discussion on how to achieve 'patient satisfaction' in this area.

By 1986 most FPCs had a programme for systematic visits. Sixty-one of the 72 FPCs reporting on premises in that year's programme either reported progress (or lack of progress) in a previously established programme of visits, although this figure includes a few which had no routine planned programme. Six either had no complete plans or had made no start on visits. Five did not comment on their policy or progress as regards visits in 1986, although two of these had defined a programme in 1985.



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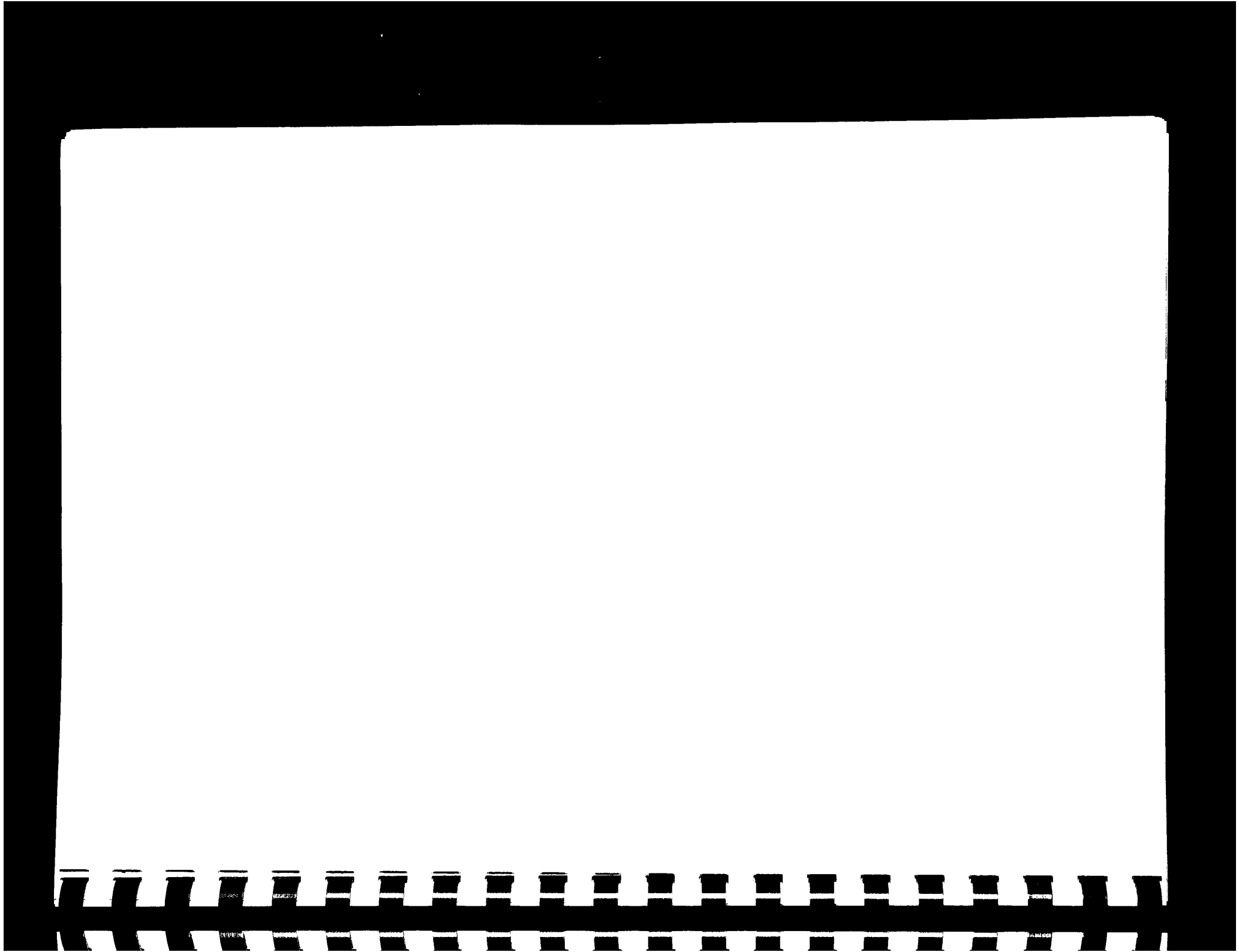
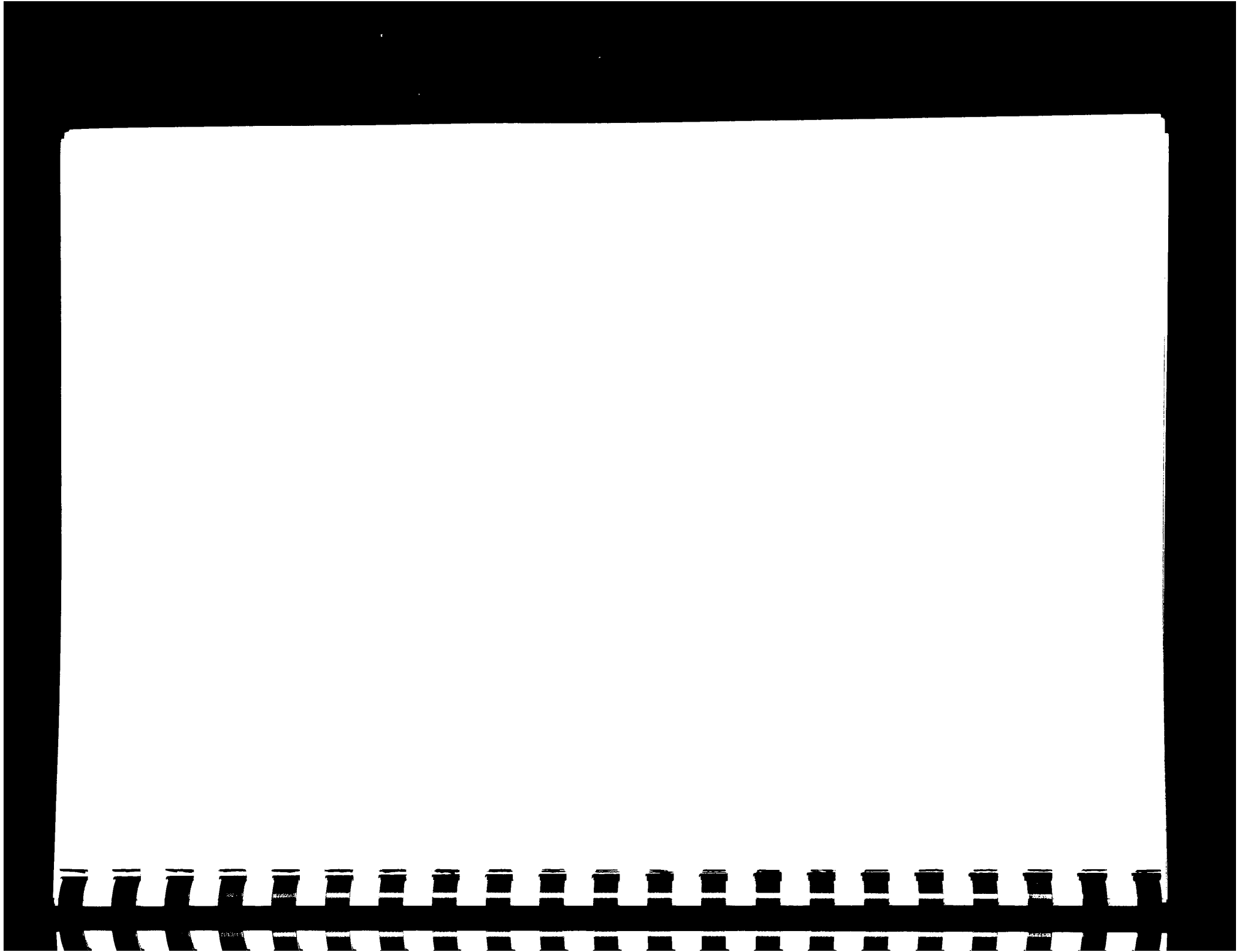


The 'reluctance' of one FPC to start a programme of visits has already been noted. Other FPCs covering large rural areas were experiencing problems in completing their programmes. Somerset reported 'Due to the large rural area, the distances to be covered within the county, and the limited resources available as no increase in cash limits has yet been notified to undertake this responsibility, it will take at least 3 years to complete the programme'. Suffolk was suspending its programme for some months in 1986 'due to lack of staff resources'. Other FPCs were confident of the standard of premises in their area, without apparently needing specific visits, while being prepared to begin a programme of visits. One had in 1986 'no programme, as such' but proposed that 'a programme involving one visit each month be established so that all premises will be visited over a four year period'. They were not to be formal 'inspections': 'it is to be emphasised that these visits would not be concerned solely with the standard of practice accommodation, but would be seen as an opportunity for matters of mutual interest to be discussed in an informal setting' (Doncaster). One FPC had made no visits to monitor surgery standards but stated an objective for 1986/87 arising out of the DHSS performance review 'To resume by September, 1986, a planned programme of visits to surgery premises with a view to completion by end of March, 1987'. The two Sussex FPCs had no programme. 'As no additional funds were forthcoming to provide for the routine inspections of doctors' surgeries, no programme has been defined' (E. Sussex). 'Unfortunately, due to pressures in many other directions, the planned programme for surgery visiting was not commenced during 1985/86' (W. Sussex). However, the West Sussex FPC was to have an officer seconded from a DHA, one of whose tasks would be 'to draw up the programmes for visiting and make the necessary arrangements'.



Standards of Premises

While not specifically asked to comment on the results of their surgery visits, many FPCs did. As might be expected, there was wide variation in the proportions of premises found not to meet the revised minimum standards. In the City and East London area more than half of the 31 visited needed improvement. Even when premises were not seriously deficient visits often resulted in some action: installation of screens or fire extinguishers for example, up to applications for improvement grants. Ealing, Hammersmith and Hounslow FPC had made 17 visits by 1986 and 'most' had resulted in proposals for action. Five out of the nine surgeries visited in Solihull were unsatisfactory in some way (two of them in minor ways). Shropshire FPC reported thirteen visits and a 'very high' standard, with no surgeries with a standard so low that withholding rent and rate reimbursements would be considered. Improvements were suggested by some doctors and supported by the visitors. Sanctions were only very rarely used - or even threatened. One FPC reported a good general standard: 'in only <u>one</u> case has the Committee had to inform a practice that reimbursement of rent and rates would cease after due notice. The position in that practice has now been resolved to the satisfaction of the Committee' (Sefton). Greenwich FPC was the only one in 1986 or 1987 to report actually withholding rent and rates - in a single case, and in this case too, it was hoped, the situation would be resolved successfully.

Composition of Visiting Teams: timescales and criteria

For their 1985 programmes, FPCs were asked for details of their inspection programme but the details required were not specified. It is therefore

perhaps not suprising that it is difficult to assess from the annual programmes exactly how committees planned to monitor premises, for example who was to inspect, over what timescale, what criteria they were to use and what were to be their targets.

The most common composition of inspecting groups specified was one lay member of the FPC, one senior FPC officer and a member of the LMC. There were however several other similar combinations given, almost always of three people, one of whom was an LMC member. Camden FPC, partly in order to speed the process, proposed to have several teams, each including the Liaison Officer. No timescale was given, in an otherwise full report. Brent and Harrow FPC had a full time liaison officer dealing with surgery improvements. Derbyshire FPC planned a two-stage approach: an initial visit by an FPC officer, followed, if the premises appeared sub-standard, by a formal inspection by FPC and LMC representatives. These examples are somewhat exceptional in diverging from what appeared to be the most common response to the new guidelines which was to expand the existing system of visits while adopting the revised minimum standards. Several FPCs reproduced the salient points of the latter in their programmes to show the criteria by which their visiting teams were operating. One of the more comprehensive descriptions of proceedures and criteria is that given in Trafford FPC's Annual Programme.

As can be seen from the extracts from the DHSS guidelines quoted at the beginning of this section, FPCs were asked in somewhat more specific terms in 1986 than in 1985 to define their inspection programmes with reference to 'target areas and dates'.

The response to this request shows, as mentioned earlier, that only six of the FPCs in which reports were available in 1986 did not have, or had not begun, programme of visits. On the whole, FPCs had found extra efforts on this area worthwhile; they kept the FPC in better touch with GPs and they resulted in many improvements. The 1986 programmes were more detailed in this area both because of the more specific request for information and increased activity.

Improvements to Surgery Premises

FPCs saw visits to premises, though time-consuming, as valuable, not least because they gave an opportunity for FPC members and officers to meet GPs in person and to make sure they were aware of the help available to improve their surgery accommodation. Doctors' practice rent and rates expenses are reimbursed whatever their tenure type: if they own their premises a notional rent payment is made. In addition to this there are two main sources of finance administered through FPCs which are intended specifically to raise the standard of premises: the cost rent scheme and improvement grants. FPCs were asked to report the number and value of these schemes in their areas in their 1985 programmes, as well as the areas eligibility for higher improvement grants under the inner city partnership provisions, and any bids under them. The latter information was also required in the 1986 programme. Two grant schemes apply mainly to inner-city areas. HN(FP)(83)36 announced temporary higher improvement grants (up to 60 per cent) for GP premises. HN(FP)(84)14 announced a temporary scheme to encourage group practice in inner cities: doctors joining together were eligible for an incentive payment of not more than £4000 per doctor.

Forty-one of the 86 FPCs whose 1985 reports on premises were available provided the data requested on these three schemes. One FPC (Cambridgeshire) provided a detailed description of the principles of the cost rent and improvement grant schemes, but no statistics on their uptake. Some committees gave the number of such schemes in operation, but no indication of their value. Others covered the topics fully but chose not to use the suggested detailed headings.

Some £80m is spent annually on improving surgery premises (Cmnd 9771, 1986) and it is clear that the two major improvement schemes are seen by FPCs as the principal way in which they are able to influence and improve surgery provision. It is unfortunate that so few statistics were provided in 1985 and that they were not requested (apart from those for inner-city grants) in 1986.

Information on Existing Premises

Turning to the information provided on existing premises, 57 of the FPCs gave the details asked for in 1985, while some others gave all the details except for the location of branch surgeries. Most provided this in list or table form, while a few provided maps, which were useful in showing distribution at a glance, but - unless supplemented by tables - were less useful for numerical or year-by-year comparison. For 1986 only changes from these base statistics were required. Thirty-eight FPCs listed changes or gave 1986 figures along with those for 1985. One of these reported no change. Some of the eighteen areas which provided no figures presumably did so because there was no change: it would be useful to know. Fourteen FPCs gave the 1986 position only. The best format was that (for example Humberside FPC's terse but complete report)

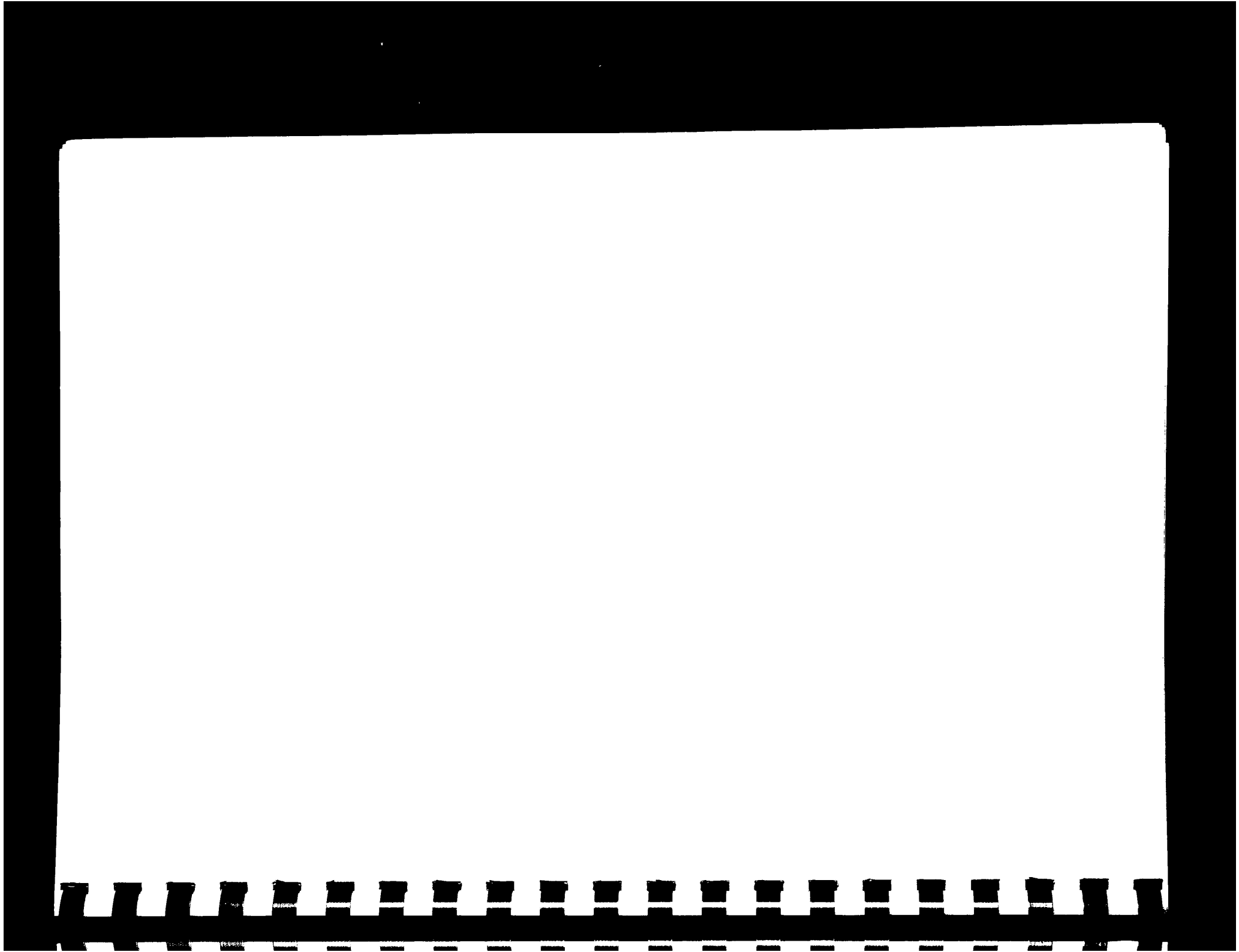
which gave the figures for 1985 alongside those for 1986 and showed the changes.

Branch Surgery Policy

When a vacancy for a GP arises or there is an application to close a branch surgery or request - from doctors or public - to open a new one, FPCs have an important role in assessing the need for surgery provision in various localities. In 1985 they were asked to state their general policy on branch surgeries. Those FPCs which responded generally expressed caution about providing too many branch surgeries, particularly in urban areas. Both Kirklees and Hereford and Worcester, for example, drew attention to the costs - to both doctor and FPC - of maintaining branches and the waste of the doctors' time in travelling; the former FPC mentioned the problem of patients' medical records being at the wrong surgery at the wrong time, while the latter felt that 'whilst branch surgeries do in many instances provide a useful service, good medical practice can best be carried out at properly equipped and staffed main surgeries ...' West Sussex FPC recognised these caveats and in principle supported group practice and the concentration of resources, but stressed that branch surgeries were 'a vital service for members of the rural population without private transport'. A survey of the location of rural branch surgeries was planned for the next year. One new branch had opened in the previous year and approval in principal had been given for two more in growing urban areas.

Comment

FPCs regarded ensuring the standard of GPs premises as one of their most important functions. It is the area where they can be of the most obvious



assistance to GPs in improving their service. However, it is perhaps as well that FPCs seem to have no great reservations about the standard of GPs' premises on the whole, since with their limited resources they may well find other of their functions more urgent than the time-consuming regular inspection of all premises in their areas. One FPC mentioned the advantage of having a qualified architect on its inspecting team: this suggests that given the resources and expertise FPCs could perhaps with advantage provide a more comprehensive service to GPs and patients in the area of surgery accommodation than their present role of administering and explaining the grant and incentive schemes.

The annual programmes themselves varied enormously in the quality and quantity of the information they provided. While FPCs will not want to have extra administrative burdens placed on them for no good reason, it would be worth the effort to ensure that in particular the statistical information requested is presented in a standard form and as far as possible completely and accurately. This might aid both local and national planning.

4. COLLABORATION

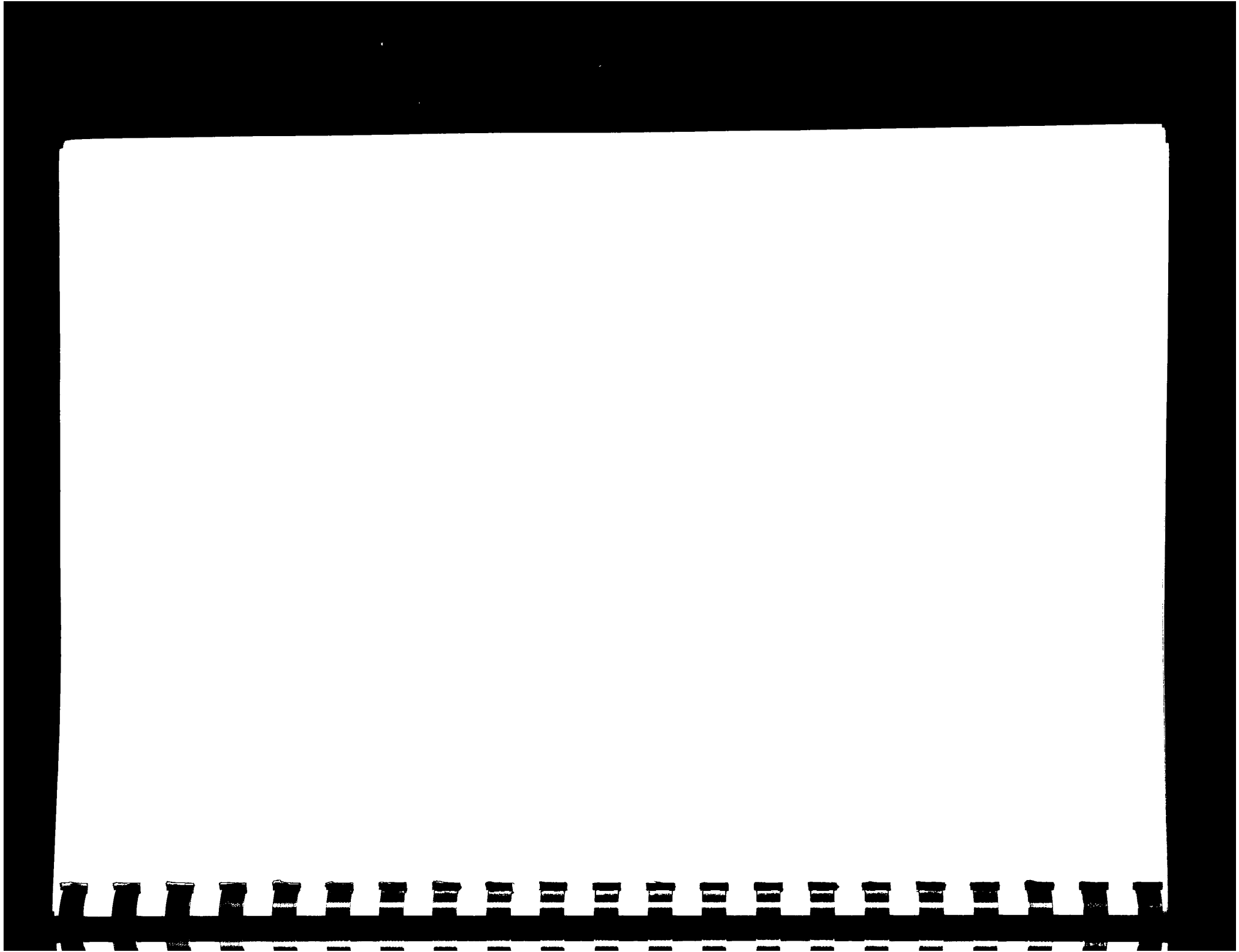
Introduction

In their annual programmes for 1985, the FPCs were asked by the DHSS to report 'the stage reached in establishing arrangements at local level to secure collaboration with health and local authorities and other bodies' (HC(FP)(85)10). The Operational Requirements and Guidelines 1986-87 noted that the 1985 programmes had shown 'considerable progress in establishing mechanisms and contacts', and asked FPCs again 'to give a high priority to

collaboration with health and local authorities, to consult CHCs, and to report progress in their 1986-1987 Annual Programmes. Reference should be made particularly to planning activities and to initiatives in respect of individual services'. FPCs were asked 'to identify in health authority strategic plans those proposals affecting the FPS and to discuss their implications with the associated health authority'. Their 1986 Annual Programmes were to state 'formal and informal arrangements for collaboration with health and local authorities, local representative committees and CHCs' and 'collaborative issues with health authorities (e.g. service provisions of mutual concern, planning, health provision and education)' (HC(FP)(86)2).

FPCs appeared keen to carry out their responsibilities in regard to planning and collaboration. There were three main obstacles to this - the number of agencies to which they related (Hampshire in 1986 reported that there were 19 Councils and authorities to deal with); manpower restrictions coupled with pressures on time from other areas; and FPCs' limited powers. In addition, many FPCs mentioned - both in 1985 and 1986 - that the Griffiths reorganisation of health authority management would delay the establishment of links.

From April 1985 FPCs had a number of new rights and duties in regard to collaboration, and their first year of independent status was partly taken up with implementing these in practice. For example, they now had to provide representatives to their local JCCs, and the NHS Community Health Councils Regulations 1985 formally entitled CHCs to consultation by FPCs about strategic plans and changes in services. FPCs and CHCs were to meet at least annually.



Of the 90 FPCs, 1985 reports were available for 87, although four of these had no information on collaboration. In 1986, 67 reports were available, of which three failed to provide details on collaboration. FPCs liaise or collaborate with many different agencies or groups: district health authorities, community health councils, local representative committees, local authorities, voluntary bodies, the media and the public, and of course the DHSS. Few of the committees mentioned all these groups in their sections in their annual programmes on collaboration.

Joint Planning and Liaison with Health Authorities

Liaison with health authorities dominated FPCs' concerns in this area, although most programmes mentioned several agencies or bodies. Barnsley FPC, for example, specifically stated it did not 'regard collaboration as being solely a two way process with the health authority'. It mentioned the local authority, voluntary sector, and CHC as bodies with which it was 'keen to strengthen links'.

Such links could be of several kinds - informal, formal, or fortuitous for example. The latter category might include the many reported copies of cross-membership of committees - unformalised links which were highly valued. Of the formal links, among the most important were participation in JCCs and JCPTs. The usual pattern of representation was for the chairman of the FPC to be on the JCC (sometimes with another FPC member) and the administrator to be on the JCPT. DHAs also have formal representation on FPCs.

A degree of frustration was evident regarding participation in joint planning and the JCCs. FPCs have few funds with which to plan or influence planning and their members found their roles in JCCs to be correspondingly restricted. Norfolk FPC commented in 1986 as follows:

> 'A year's experience of involvement in joint planning forums has revealed a widely differing approach in the three JCCs operating in the county, and a general feeling that the allocation of joint finance funds is sometimes given too high a priority to the detriment of true planning. To that extent the Joint Planning Working Group's report "Progress in Partnership" has been welcomed. FPC involvement has so far been minimal, a situation which members regard with some degree of frustration, and ways in which the Committee's role can be strengthened are being investigated' (1986, p.14).

Suffolk FPC in 1986 also regretted JCCs lack of resources:

> 'The involvement of the FPC in joint planning is considered to be important but the lack of resources for administrative support of JCCs and the training of new members devalues the effective contribution members can make'.

Hertfordshire FPC (1986) also regretted the emphasis on joint finance money in joint planning, but suggested FPCs should themselves have a budget:

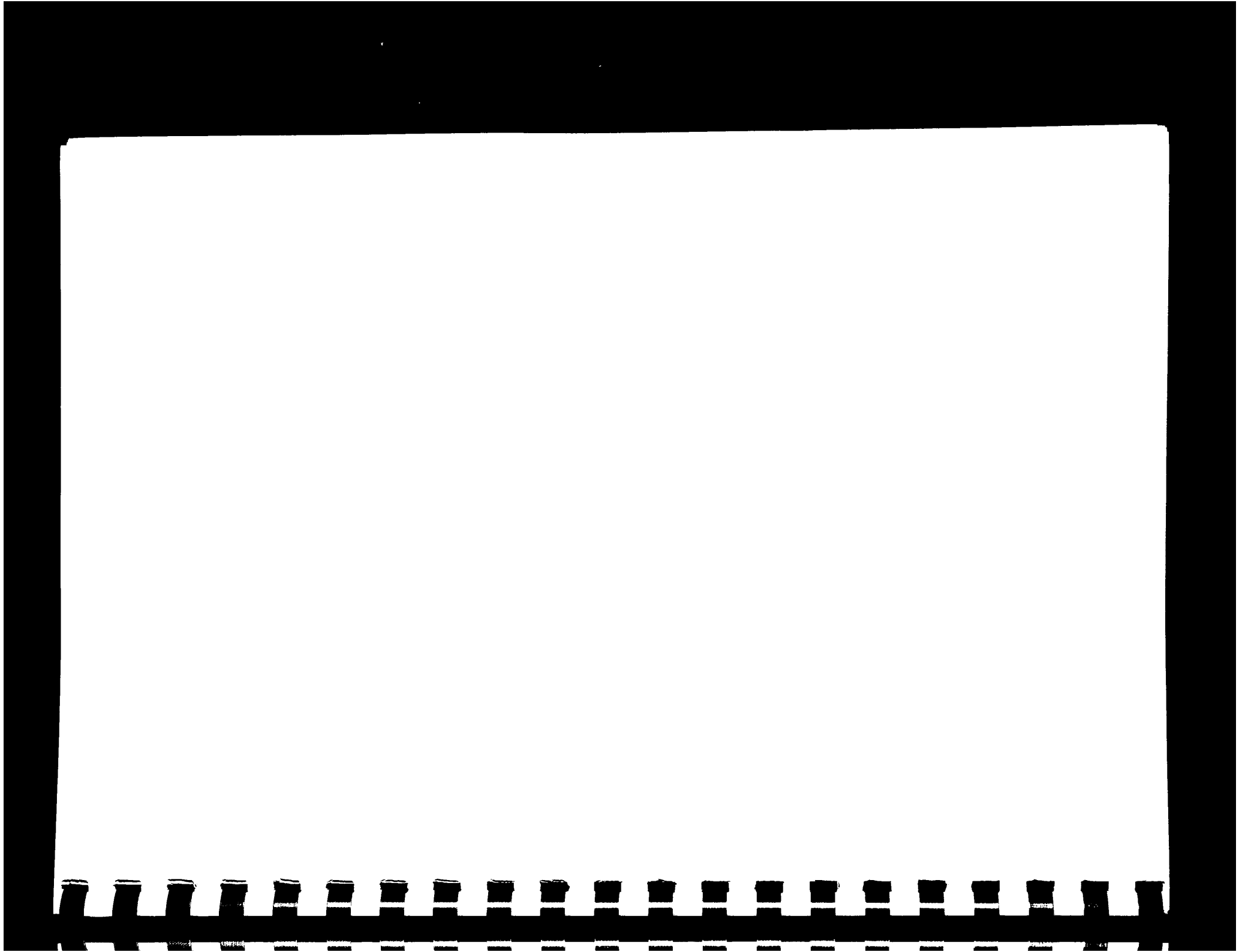
> 'This Committee hopes that the future will see Joint Planning concentrating on making the best use of all resources and moving away

from past pre-occupation with the allocation of joint financing monies. However, as a new autonomous body, it is felt that some consideration should be given towards providing FPCs with a budget to allow some contribution to be made for specific schemes'.

The same annual programme criticises the draft guidance of joint planning and collaboration for the 'very low profile' FPCs are given in it and for failing to 'make clear that FPCs with no development funds of their own, are in fact eligible for joint finance'. The former criticism was also made in Lancashire's programme for 1986 which also voiced doubts as to whether FPCs resources were adequate to support the increased role which the Circular gave to joint planning. Joint Finance had however been obtained by the Committee through the JCC for an 'Evaluation and Development Officer in the areas of Mental Illness and Mental Handicap', following DHSS confirmation that FPCs were eligible for such funds.

Most FPCs appeared to have satisfactory informal contact with health authorities, and occasionally the feeling was articulated that this could be preferable to formal meetings.

Traditionally, good officer relationships have existed informally between the FPC and local Health Authority staff and it is hoped that these will be fostered and strengthened further following the appointment of the Planning/Liaison Officer since it is felt that such links form the cornerstone of successful inter-Authority collaboration. It is hoped that in the future, the Administrator and Planning/Liaison Officer will be able to arrange more regular contact



than at present with Community Administrators, Community Unit Management Groups and Planning Officers, although it is felt at this stage to be neither desirable nor practical to seek to hold meetings with these people simply for the sake of so doing.

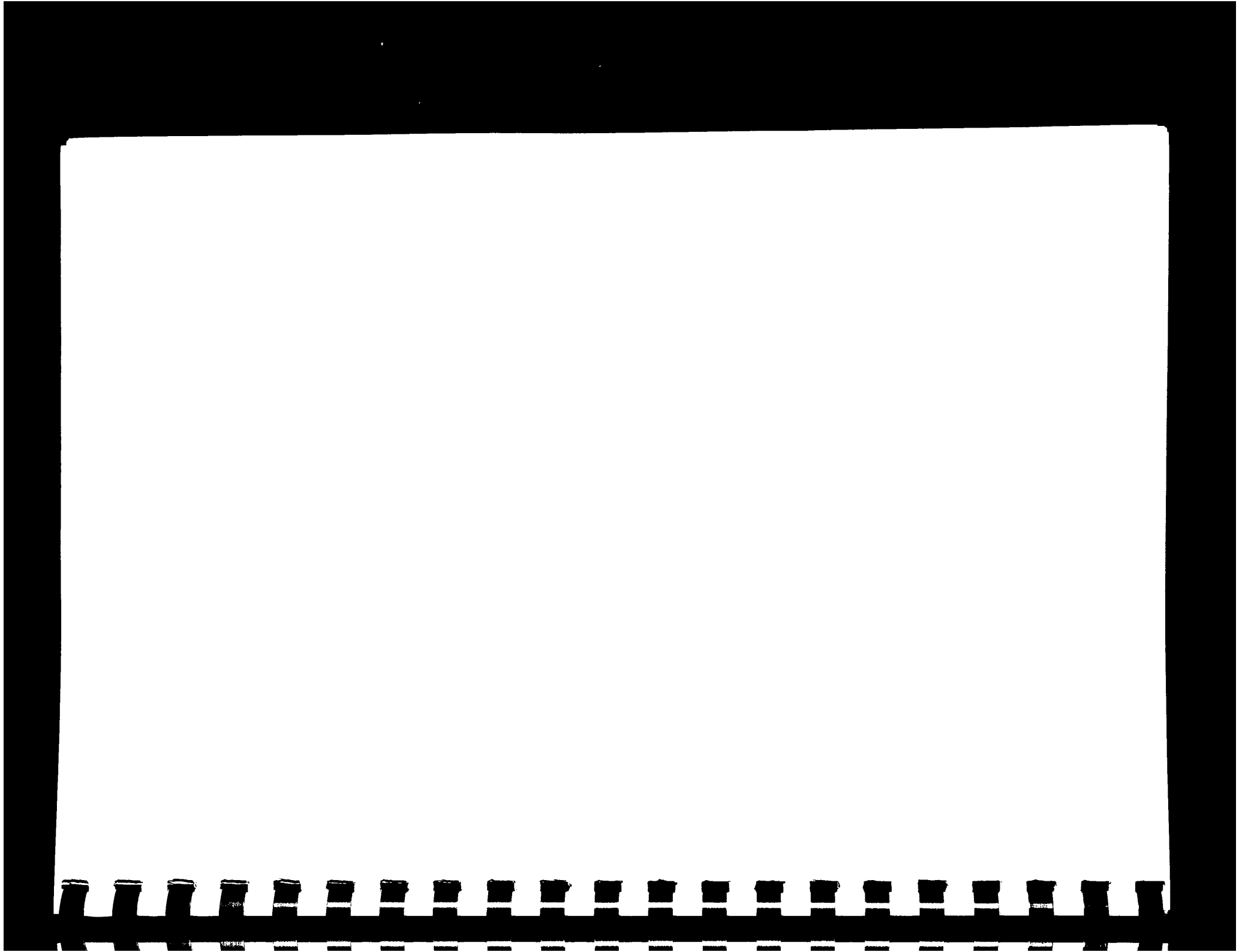
The benefits which flow from effective cross-membership of FPC/DHA members are very much appreciated by the FPC and it was felt that in the period following the DHA's reorganisation in 1982, up to 31st March 1985, valuable links were built up to the advantage of all concerned (Birmingham FPC, 1985, p.29)

'Considerable discussion during 1985 has taken place on collaborative arrangements and the consensus of view as to how collaboration should work reveals a strong preference to keep the need for co-operation at as informal a level as possible, with frequent contact between officials within the operational management tiers and an avoidance of routine formal meetings' (Humberside FPC, 1986, p.2).

Humerside FPC planned to create several small groups of members, one to liaise with each of the four DHAs within its area. Other FPCs, such as Birmingham, had created or planned to create a liaison/planning officer, although only a small minority mentioned this.

Liaison with CHCs and LRCs

After joint planning through JCC and JCPT representation, and collaboration with DHAs, liaison with CHCs was the next most discussed item in FPCs' reports on collaboration. Most FPCs had by 1986 met formally with their local CHCs,



as they were required to do, at least annually, from 1985. There were few reports of friction with CHCs, but equally instances of true collaboration were very much the exception. Few FPCs in their first year since reorganisation seem to have been able to give much systematic consideration to what services were wanted (rather than how well they were provided). Northamptonshire was one which intended to do this:

> 'The Committee, with the co-operation of the local Community Health Council wish to collect information from surveys about family practitioner services in Northamptonshire and act upon the information received. The surveys will provide information on what the public expect from family practitioner services, what is actually provided and what should be provided. The CHC have agreed to carry out the surveys and the FPC will analyse the results in consultation with the CHCs and the local Professional Representative Committees. The Committee will agree with the two CHCs the topic and form of the proposed consumer surveys by January 1987' (1986, p.8)

Northumberland FPC had praise for two of its local CHC's initiatives (independent of the FPC) to encourage public awareness of health services offered as well as noting 'it has been most helpful in assisting the Family Practitioner Committee on matters relating to pharmacists' hours of service, dealing with the proposed closure of two branch surgeries and with interim arrangements following the removal of a doctor from the FPC's list'.

Relationships with LRCs were also said to be good and although 'FPC interests and the interests of the relevant profession do not always correspond'

(Kirklees, 1986) this fact was not dwelt upon. Dudley FPC reported in 1986 'excellent' relations with its LRC 'all the more important in view of events elsewhere and indications of some friction between the professions and the new FPC.'. These events and friction did not show up in the FPCs annual programmes, perhaps understandably.

Collaboration with Other Bodies

Many FPCs, in the context of collaborative issues and FPCs' new role, regretted the low public awareness of their purpose or indeed existence. Liaison with the media was therefore frequently added as an extra category to that with DHAs, LAs, CHCs and LRCs. FPC officers had met editors; minutes and agenda for FPC meetings (the 'open' part of them) were often circulated to local media; and there were several reported instances of officers giving talks to local school or other organisations. A few FPCs had appointed press officers. Trafford FPC was preparing (in 1986) a series of articles on FPC activities for local newspapers:

> 'The intention behind this is to promote public awareness of the work of the committee. Some of the topics to be covered will include the work of the FPC, publicity for pre-payment certificates, the patient's right to choose where contraceptive and maternity services are concerned, how to change doctor, the need to notify change of address, publicity for pregnancy testing services offered by pharmacists and the procedure for making complaints against a practitioner (1986, p.9)

There were few mentions of liaison with voluntary organisations; again Trafford FPC (1986) provided one of these:

'To date co-operation with voluntary organisations has largely been restricted to the mailing of promotional material for them. One significant breakthrough has, however, been achieved. The Committee has successfully co-operated with the Health Authority, the Local Dental Committee and the Local Pharmaceutical Committee to widen the scope of a voluntary organisation called "Tramcars". This will enable patients who are usually housebound because of disability, age or transport problems to be transported to suitable dental and ophthalmic surgeries for treatment. This will improve the availability and the quality of the service to these patients' (p.9).

In the context of a 1986 programme which acknowledges a long way still to go in establishing collaboration, Dudley FPC mentioned, despite personnel and time restrictions, one successful instance of collaboration with an organisation involved with drug abuse.

Voluntary bodies are also represented on JCCs, where there will be opportunities for FPC members to liaise with them.

Few FPCs specifically mentioned collaboration with local authorities outside the context of JCPTs and JCCs. Berkshire FPC in 1985 criticised the DHSS Joint Working Group Report (April 1984) for not encouraging LA collaboration.

The full section on collaboration in Trafford's 1986 programme, quoted from above, also included a section on collaboration with the DHSS, the only report

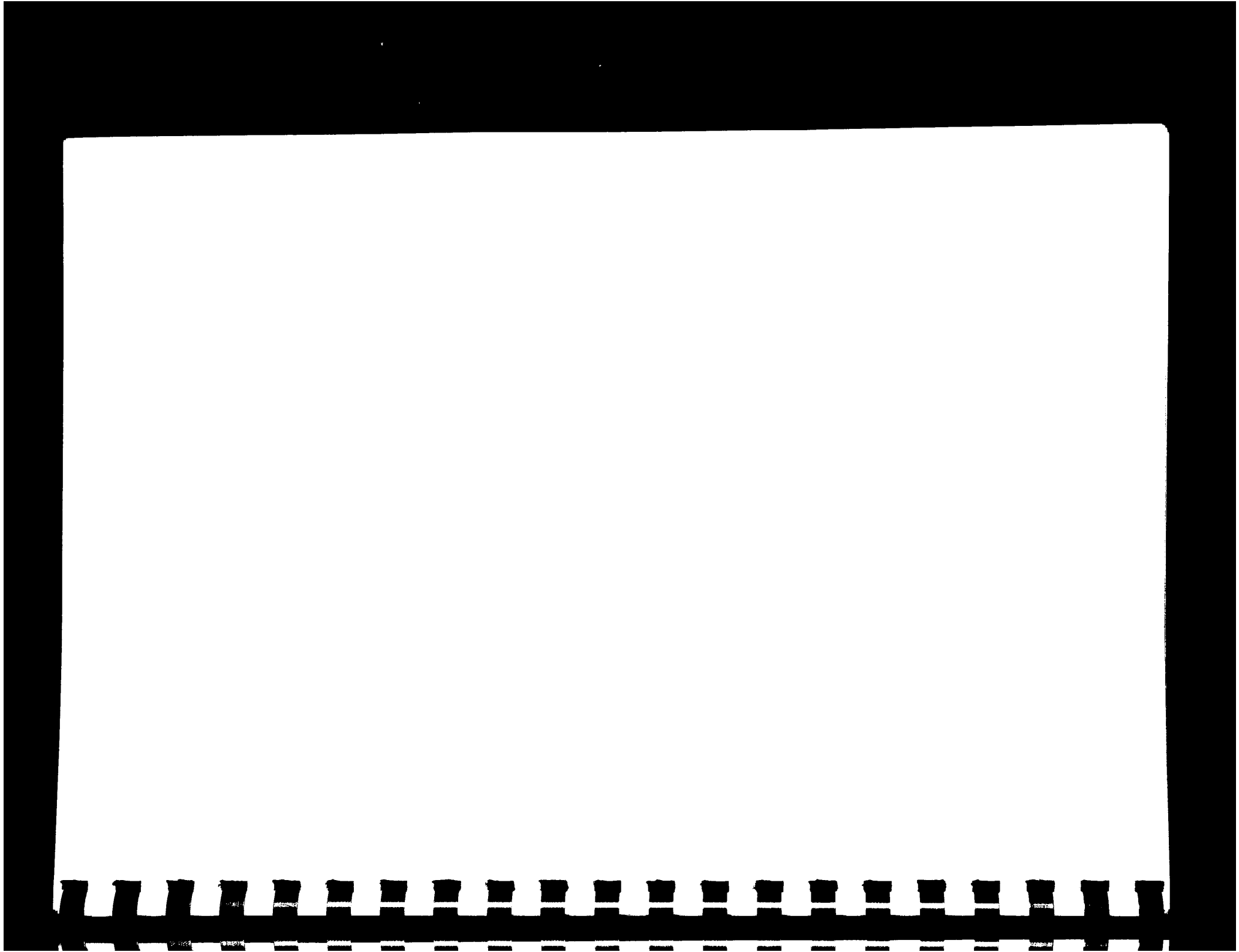
to do so: despite praise for DHSS-organised training courses for FPC members, the motivation for the section was clearly 'a great deal of frustration on the part of members' at what was seen as an attempt to 'control the Committee's day-to-day activities centrally'.

Obstacles to Achieving Collaboration

The difficulties facing FPCs in taking up their new responsibilities and opportunities in joint planning to provide better primary health care will be clear from the foregoing discussion. A useful brief analysis of what FPCs could aim for and what the restraints on planning are is provided in Wigan FPC's 1986 programme; three main constraints are identified:

'1. The fact that FPS are provided by practitioners who provide services to the NHS on a contract basis means that the approach to planning by FPC's [sic] must differ to that of health authorities, but the themes of planning apply i.e., establishing baseline provision; identifying local needs, opportunities and constraints; determining aims and policies and deciding (in consultation with other bodies) how these might be achieved; introducing and implementing proposals; and periodically reviewing progress.

2. FPC's [sic] cannot require contractors to do things that are not part of their contractual obligations, and the Committee's approach also has to take into account the fact that the Medical Practices Committee (MPC) and in certain cases, individual practitioners take decisions which can affect the provision of services within their area.



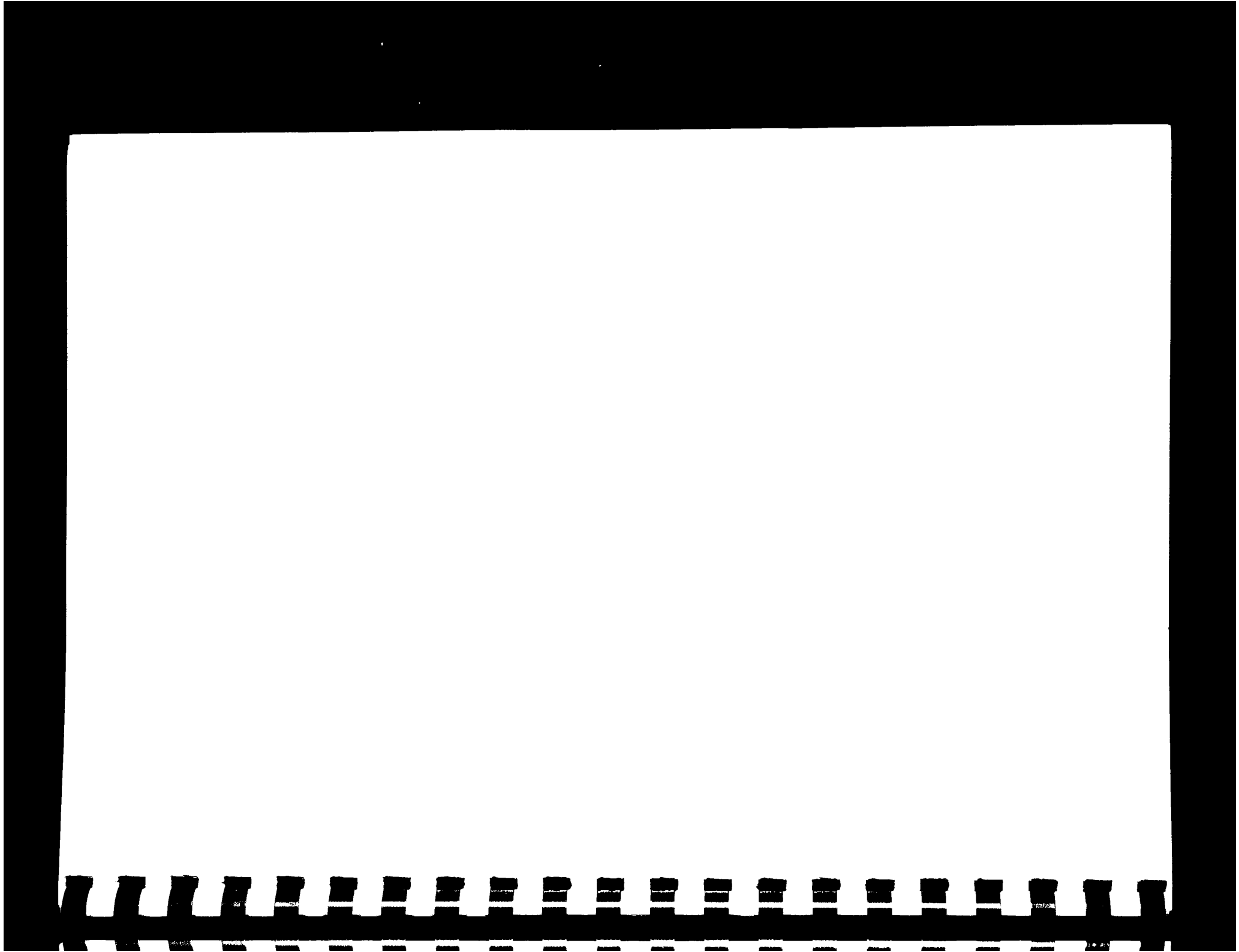
3. The FPC has not received an increase in its staff establishment to undertake its new responsibilities as an independent organisation, and officers are being required to undertake additional duties including planning and collaboration activities. The administrative time that can be devoted to these activities is therefore limited, but hopefully with both computerisation and also a review of the middle management structure it is hoped that in future extra input can be directed to these important FPCfunctions.'

(The first paragraph quoted paraphrases the NHSTA guide for FPC members by Barnard and Word (1985) p.24.)

Collaborative Issues and Instances of Successful Collaboration

The 1986-87 Operational Requirements and Guidelines asked FPCs to note in their 1986 programmes collaborative issues with health authorities. Most FPCs responded to this request and many instances of successful collaboration were described. Almost all FPCs which did respond mentioned cervical cytology call and recall schemes. Information systems generally were another important area. Schemes for the safe disposal of clinical waste, plans to reduce overlap of family planning provision, health promotion and education, and community care arrangements were initiatives mentioned by several FPCs.

Manchester FPC provided one of the most wide-ranging and detailed reports of such issues, including sections on child health, maternity, homeless people and travelling families, dental provision, alcohol-related problems, two pilot screening schemes (for 'well-men' and elderly people), family planning and

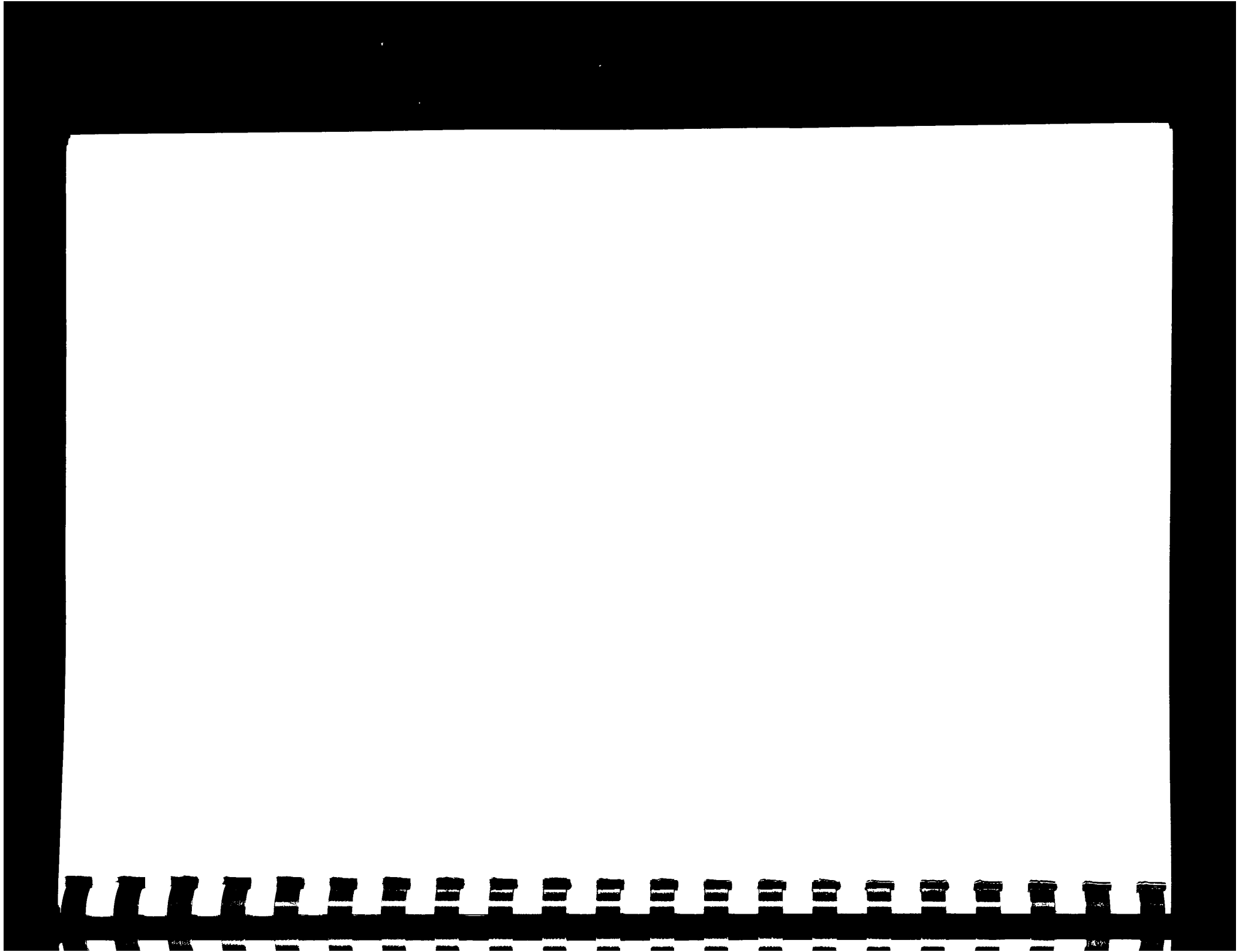


immunisation/vaccination, diabetes, general psychiatry, and elderly - especially elderly mentally infirm-people.

Comment

As the previous section indicates, there is a great number of areas where FPC planning and collaboration with other health care agencies could have a significant impact on the provision of effective primary care. However, they are time consuming processes, which take time to bear fruit. Frustration was a recurrent theme of the annual programmes. In some cases this was against what was perceived to be cumbersome administrative machinery and the requirement to be seen to be collaborating with other agencies as much as merely collaborating effectively but informally. As mentioned, several FPCs regretted their lack of resources - both in terms of manpower and in terms of resources to allocate to FPS and therefore to influence provision. Interestingly, few specifically regretted their lack of any executive power over the independent contractors - it may be this was seen as a 'fact of life' for FPCs, and in any case their programmes were not perhaps a proper forum for discussion about this.

Perhaps the most interesting and comprehensive annual programme from the point of view of collaboration was Nottinghamshire's 1986 report. Programmes are inteded to be a two-year view into the future as well as a current review. Surprisingly few of them mentioned timescales consistently, perhaps unwilling to set time targets when so many aspects of FPC administration were in flux. The Nottinghamshire format was to state aims on various items, indicate whether action was to be taken in 1986-87 or 1987-88 and for each item give a progress report/comment. The objectives were summarised as 'developing

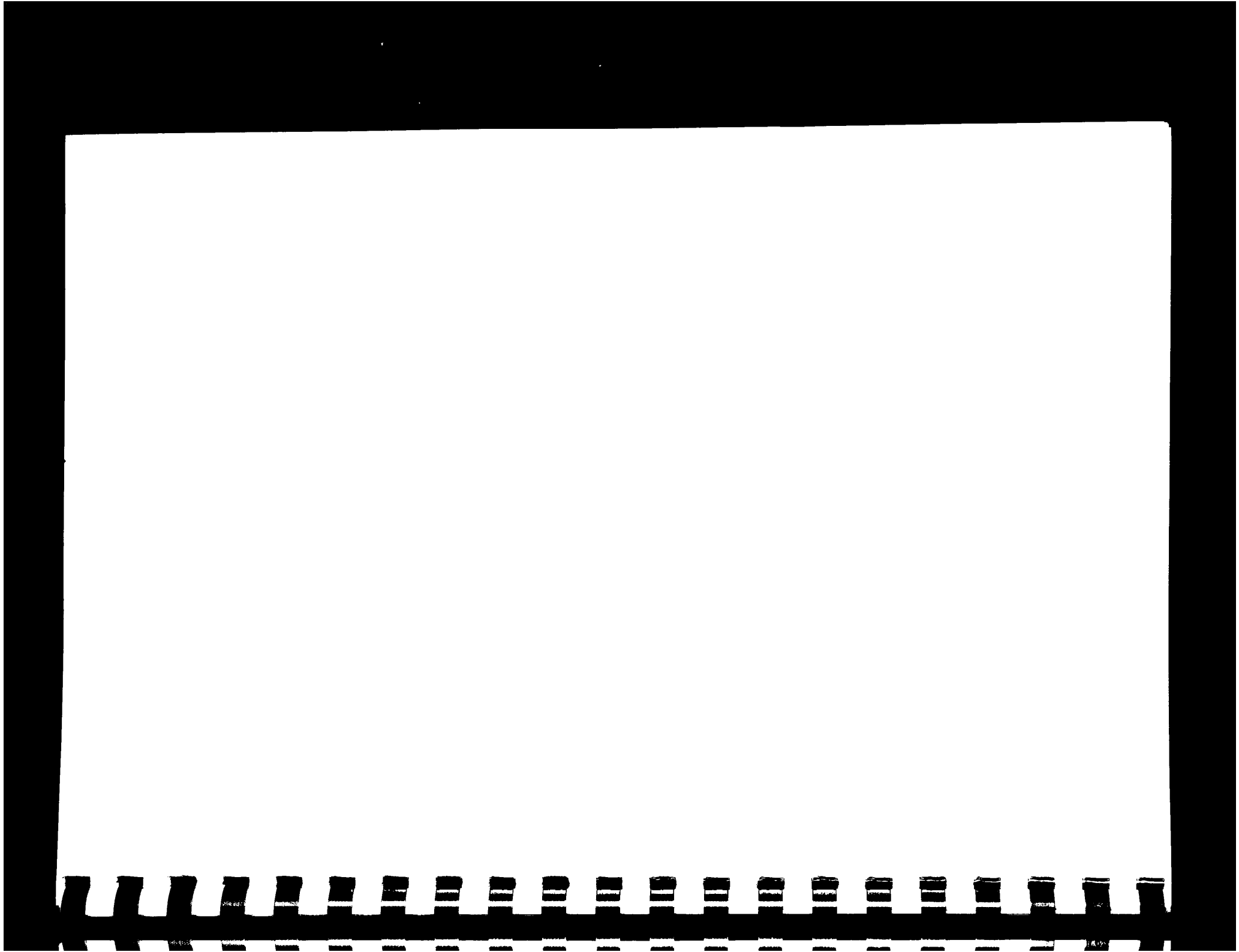


comprehensive information on services available and required, eliminating unnecessary duplication of services, and improving the effectiveness of service delivery'. FPCs may well consider that good planning and collaboration may mean them taking a leading role (as Nottinghamshire appears to be doing) in seeking information to consumer requirements from FPS and the impact of policies in other areas of health care which affect FPS most closely. The types of information FPCs already deal with - patient registers, details of surgeries and pharmacies and the distribution of practitioners, call and recall schemes, and so on - will become increasingly valuable in planning and may, in the context of the national intention to give the consumer of primary health care greater choice and information, give the FPCs a more equal role in planning terms with those agencies with which they collaborate.

5. COMPLAINTS

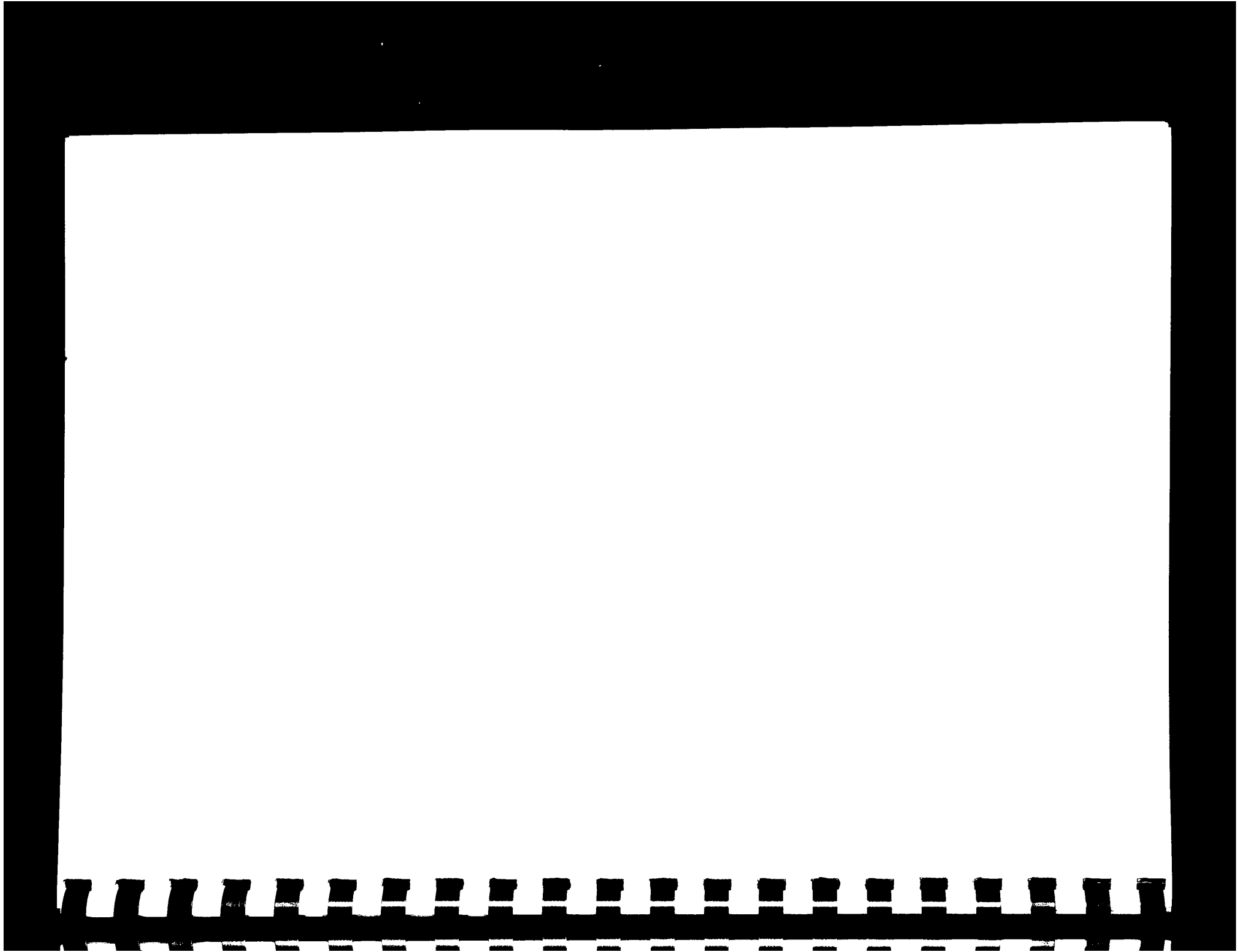
Introduction

The current statutory procedure for complaints against family practitioners is given in the National Health Service (Service Committees and Tribunals) Regulations 1974. Under this procedure service committees (one for each family practitioner service) decide, in some cases at a formal hearing, whether or not practitioners have complied with their terms of service. The service committee makes recommendations to the FPC and the FPC's decision is then eventually confirmed or amended by the Secretary of State, sometimes following an appeal by the complainant or practitioner.



Patients are not always aware of this procedure nor of the fact that complaints may usually only be made about matters concerning practitioners' terms of service. Initially the patient must approach the FPC, sometimes with the help of the CHC or other agency. In some cases FPC officers explain to patients that a complaint cannot be considered under the regulations. Patients often do not wish to make a formal complaint but to bring their dissatisfaction to the attention of the authorities. Comments made by patients to the FPC may be intended as complaints but not regarded as such by the FPC. Many complaints or problems are dealt with informally either under informal procedures for complaints about general medical services, or by correspondence or discussion between FPC officers, complainant and practitioner. Thus the definition of a 'complaint' is not always clear, and only a minority of those complaints or general problems which reach the FPC are brought to a service committee.

It is widely considered that the present complaints procedure is not adequately accessible to patients. As part of its review of primary care services, the DHSS issued a consultation document, Family Practitioner Services Complaints Investigation Procedures (August 1986). This proposed changes including rewriting the regulations in simpler language, accepting oral complaints, reappointing service committee members annually, and extending the time limit during which complaints may be made from 8 weeks after the incident to 13 weeks. Further proposals were that FPCs should make decisions rather than recommendations, and that all FPCs should use informal conciliation procedures for all family practitioner services.



In their annual programmes for 1985 and 1986, some FPCs commented on the operation of the complaints procedures whereas others presented statistics on the incidence of complaints without any further explanation. The DHSS operational requirements and guidelines given in circulars HC(FP)(85)10 and HC(FP)(86)2 asked FPCs to submit in their annual programmes statistics on the incidence, investigation and outcome of formal and informal complaints. One of the topics specified by the DHSS for inclusion in the 1986 annual programmes was complaints; FPCs were asked to report on complaints as a basis for discussion in performance reviews and scrutinies [HC(FP)(86)2].

The extent to which FPCs' annual programmes for 1985-6 and 1986-7 met the requirements of the DHSS on complaints reports, statistics and other specific information requested is considered below. The analysis is based on 86 annual programmes for 1985-6 and the 71 available for 1986-7. Some of the 1986-7 documents had not been received by the DHSS at the time of this analysis.

FPCs' general comments on the procedures.

Only a minority of FPCs, in their annual programmes for 1985 or 1986, commented on the complaints investigation process or attempted to set their complaints statistics in the context of FPC's role in dealing with enquiries or complaints about family practitioner services. Just over one-quarter of FPCs commented on the formal procedure in their first annual programme and even fewer did so in 1986. Although most FPCs used informal procedures of some kind, only just over one-third described or commented on these in either of their annual programmes. Even when specifically asked to report on complaints in 1986, only 55 per cent of FPCs gave any information other than statistical data which, when presented in isolation, have little meaning for

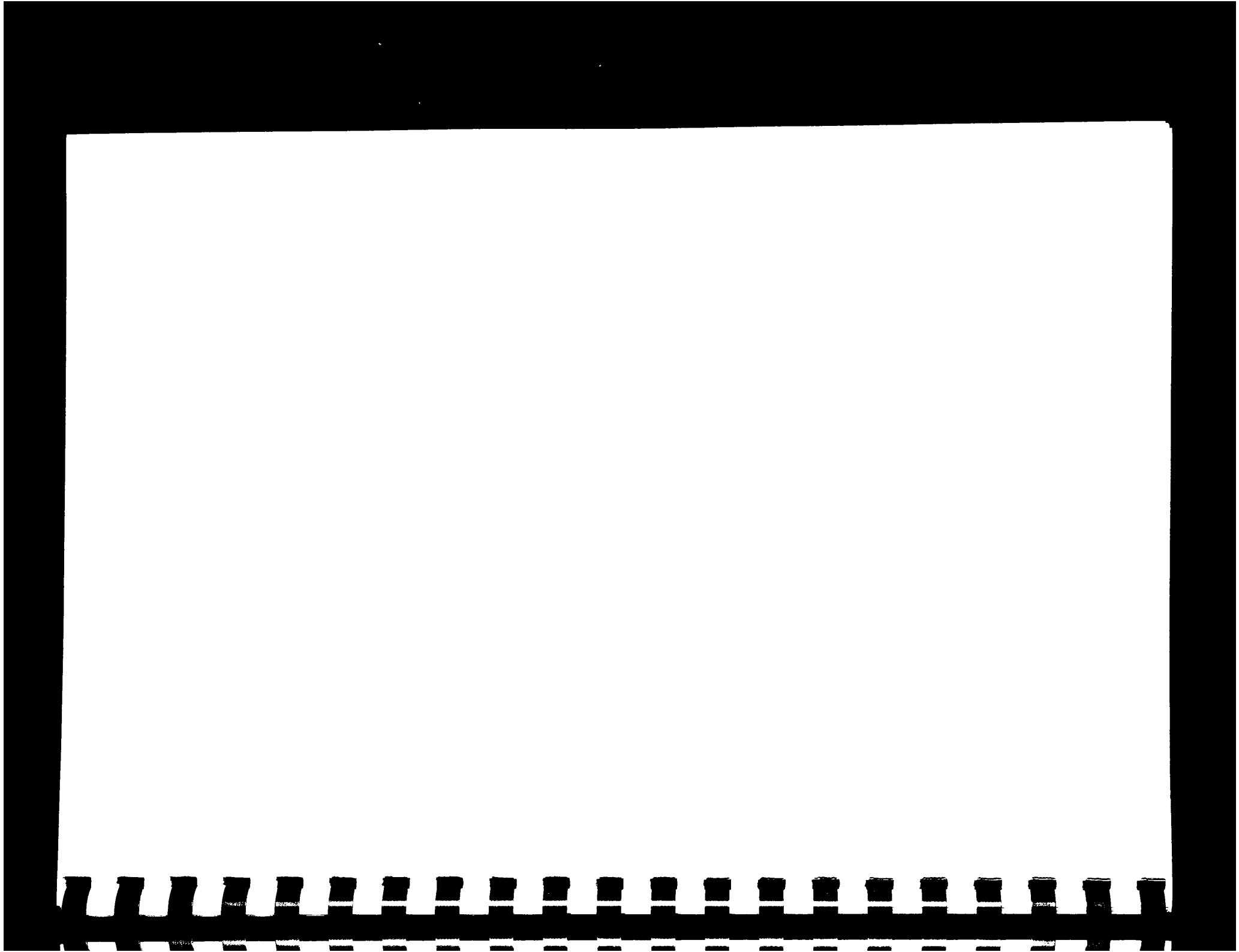
the reader. Several of the 1986 annual programmes, however, included useful sections on complaints, giving comment and statistical data for all the services.

A few FPCs described the formal complaints procedure in detail, or more simply as did Cambridgeshire FPC (1985):

> 'There is a statutory procedure for investigating complaints that doctors, chemists or opticians have failed to carry out the obligations set out in their contracts with the FPC.
>
> Complaints which prima facie allege that a contractor has not provided the service or otherwise complied with his contract may be investigated by a service committee comprising of a lay chairman and vice-chairman, three other lay members and three members of the appropriate profession to which the claim relates.'

Barking FPC gave, in 1986, a description of the formal and informal procedures including flowcharts showing clearly the different stages involved.

Comments in the 1985 annual programmes on the formal procedure included items now under review in the DHSS (1986) consultation document, for example that the time limit for submitting complaints was too short, or that deputy chairmen should be allowed to attend the service committee when not chairing it. Other FPCs stated that their procedures had been reviewed or revised, for example to make them more easily understood:



'Members of the public and practitioners do find the procedure difficult to understand at times and are occasionally not prepared for or accustomed to the requirements of presenting their own cases. In an effort to explain matters more clearly, standard letters are being revised and the leaflet produced by DHSS is being used. A Management Services study of complaints has been commissioned and undertaken.' (Ealing, Hammersmith and Hounslow FPC, 1985)

Examples of frequent subjects of complaint were given by a few FPCs such as Surrey (1985) where the most common complaints on medical services 'concern reluctance to make a home visit or an alleged failure to provide appropriate treatment', whereas for dental services they concerned 'unsatisfactory dentures or crowns...[or] the provision of private treatment when the patient felt or understood that this should have been done under the National Health Service agreements'. FPCs also commented on the complaints received which did not concern practitioners' terms of service but rather their attitude or poor communication. Such complaints were often resolved informally by officers. Several FPCs mentioned their policy to promote informal procedures.

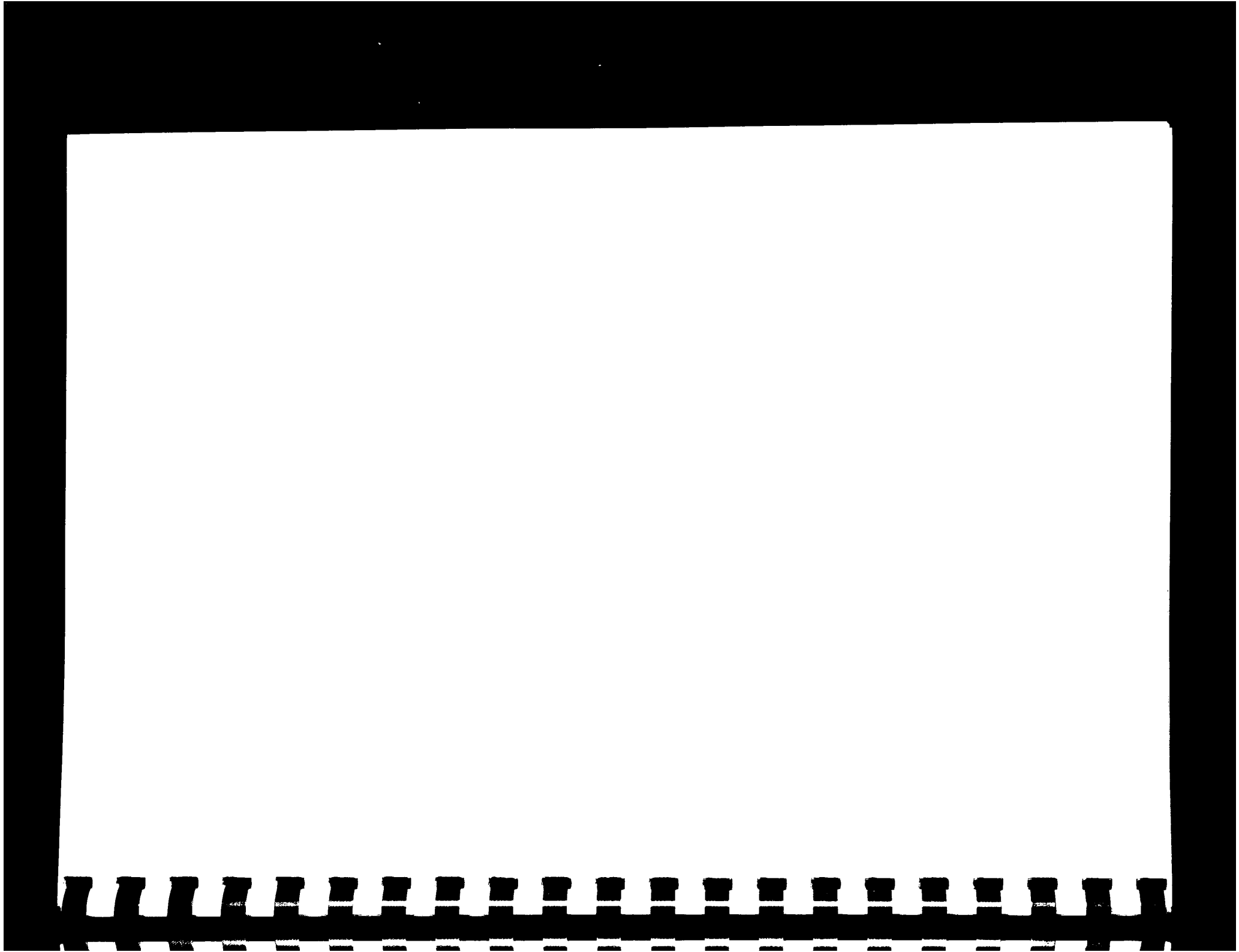
There is a nationally agreed informal procedure for handling complaints about general medical services which has been operated voluntarily by some FPCs for a number of years. Where this was mentioned in annual programmes, about one-half of FPCs said that they found this procedure valuable, whereas the others stated that they did not use the agreed informal procedure although some resolved minor complaints by discussion or correspondence. Six FPCs were

now reconsidering a previous decision against informal procedures and intended to set them up for medical complaints. Leicestershire FPC, for example, reported in 1986 that:

> 'The Committee does not operate a structured informal complaints procedure of the type which has been commended by the DHSS...The Committee has previously taken the view that its formal procedures worked well, and that more minor complaints could most effectively be dealt with by its officers, when the complainant was happy to accept informal reconciliation.
>
> In March 1986 it was decided that a review of the Committee's views on this subject should be undertaken, following which it was decided that the Local Medical Committee should be invited to give its views on the possible introduction of a structured informal procedure'.

Denture Conciliation Committees were mentioned by a few FPCs, but other methods of handling dental complaints informally were more common. Bedfordshire FPC (1985) claimed that:

> 'While a Denture Conciliation Committee has not been appointed, the Committee is perhaps justifiably proud of its success in resolving dental cases without causing the distress and inconvenience to patients and practitioners which sometimes arise under the service committee procedure. Such attempts at reconciliation are carried out with the full agreement of the



patients and with their having been made aware that they can opt to have the matter investigated formally at any stage'.

Informal methods of investigating complaints on pharmaceutical or ophthalmic services were also used, for example, by Birmingham FPC:

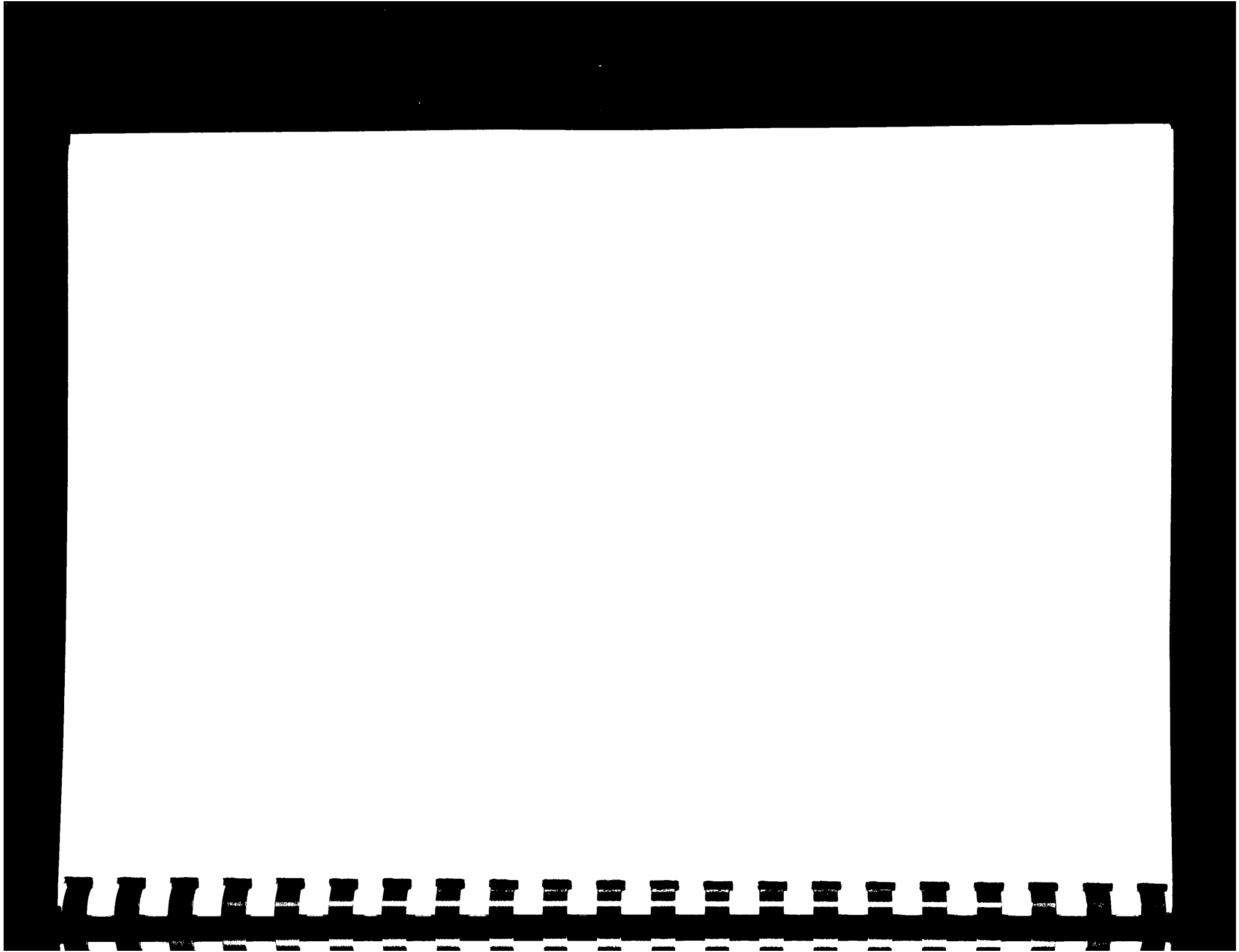
'Wherever possible, the Committee endeavours to resolve ophthalmic grievances informally by officers intervening to secure amicable agreements prior to formal proceedings.'

In describing informal procedures FPCs gave brief accounts of those involved and of their role, for example:

'This Committee also uses the recognised Informal Procedure for medical complaints whereby 1 doctor and 1 lay member meet the complainant and respondent with a view to resolving the problem'. (Wigan FPC, 1985)

'...since 1968 the Committee has adopted the policy of appointing a Lay Conciliator and a Medical member to be available to visit complainants in their own homes to discuss their complaints and this arrangement has been found to be extremely useful in attempting to resolve complaints without resort to the formal Service Committee procedure'. (Sunderland FPC, 1986)

North Yorkshire FPC (1986) also had a 'pre-informal procedure whereby either the Administrator or his deputy visits the patient or doctor concerned with a



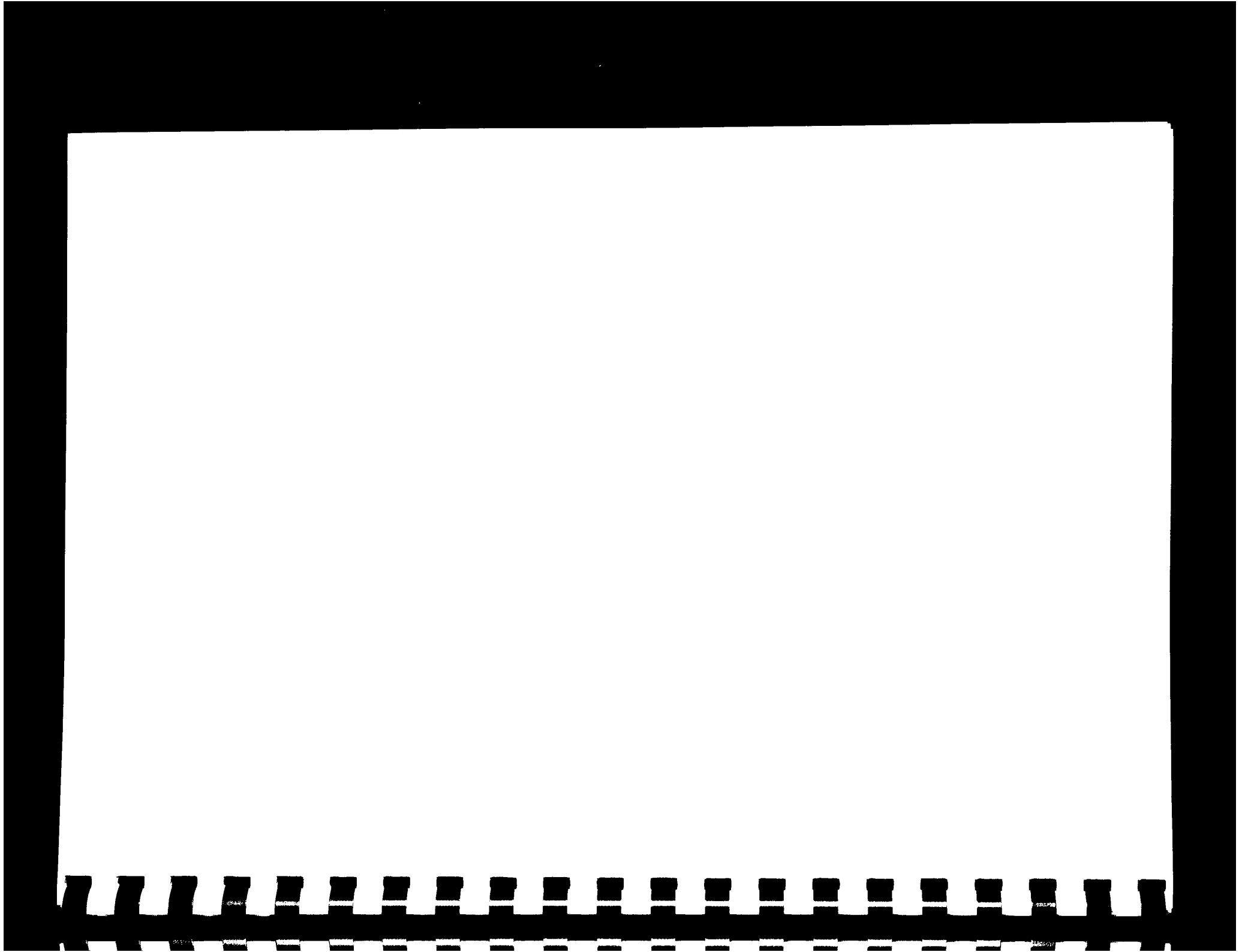
view to fully discussing the implications of the case and resolving any misunderstandings, or where an exchange of correspondence satisfactorily resolves the problem'.

Most FPCs describing informal procedures stressed patients' rights to opt for the formal procedure at any stage. The main aim given for informal procedures was to establish reconciliation between patient and practitioner; for example Barnsley FPC (1985) stated that:

> 'The aim of such a procedure is to invite the complainant and respondent to the FPC offices at a meeting chaired by a lay member in the hope that a reconciliation, or at least an understanding of events concerning the matters raised, can be reached'.

As shown by our analysis of the FPC annual programmes' content on **objectives and priorities**, improvement of the complaints procedure was not given high priority. Less than one-fifth of FPCs included the topic of complaints in their objectives or action plans. The most frequently mentioned objective on complaints was to review the formal and/or informal procedures. Avon FPC's action plan (1985) included:

> 'to study (by 31 March 1986) the operation of its complaints procedure and to assess its effectiveness and fairness, paying particular regard to the place for interviews in the informal procedures and also the low incidence of formal investigations'.



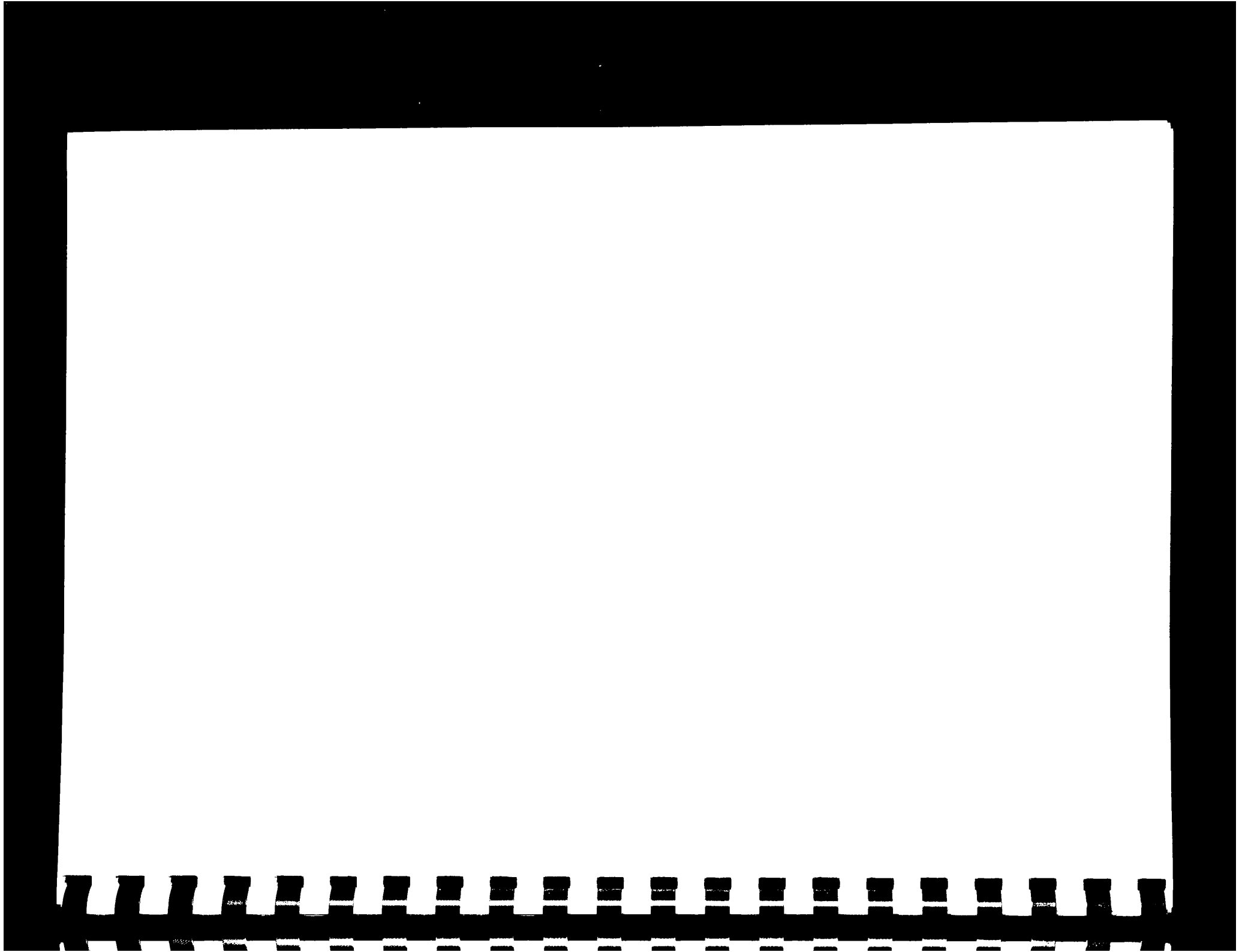
The next most frequent category concerned plans to improve the recording, monitoring and analysis of different types of formal, informal or pre-informal complaints and their outcomes. Cheshire FPC (1985) for example planned to 'compile a register of all complaints received in order to highlight the types of complaint which recur. The register will be presented to the members at each Committee Meeting'.

FPCs also aimed to minimise delays in handling complaints. In its 1986 progress report on 1985 objectives, Cornwall and Isles of Scilly FPC stated that:

> 'The processing of complaints against practitioners and contractors to ensure that the procedures followed do not result in unacceptable delays is scrutinised monthly by the Finance and General Purposes Sub-Committee'.

The revision or review of information leaflets and standard letters for patients was the other main objective mentioned, for example by West Sussex FPC (1986):

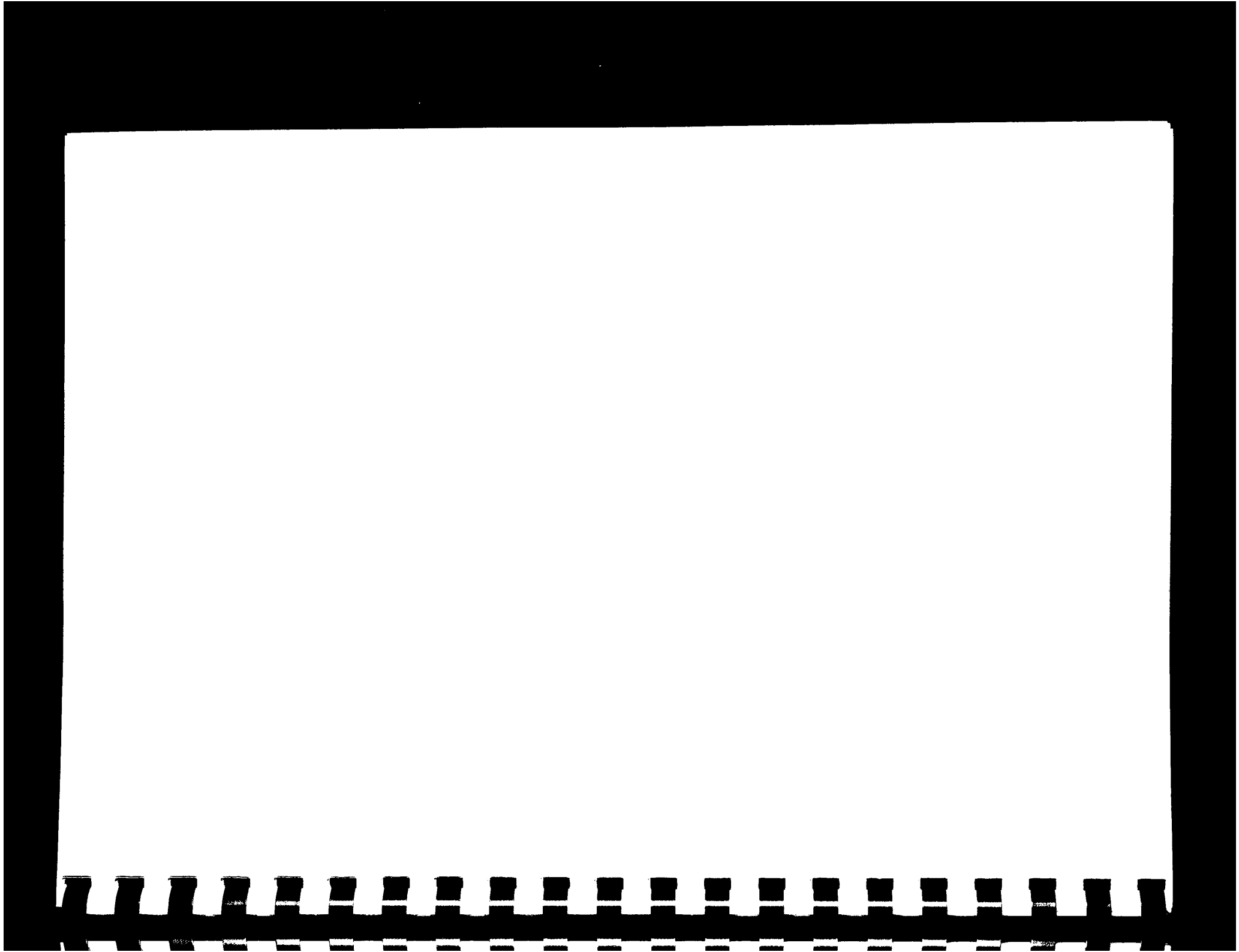
> 'Arising form the experience gained during the year, the Committee agreed that in 1986-87, greater emphasis should be given to providing persons making complaints with more information about the scope and limitations of the service committee procedure...It is, therefore, intended to improve public relations by producing a suitable leaflet and making it



available to the public. It is also intended to issue a press notice with the Annual Programme drawing attention to the number of complaints dealt with by service committees and the end results.'

Concern to minimise delays and to make the complaints procedure more comprehensible to patients were usually cited as specific reasons for reviewing the complaints procedure.

One further objective was to consult CHCs on the complaints arrangements. Although CHCs play a part in advising patients on making a complaint to the FPC, few FPCs commented on this CHC role in their annual programmes. Where the CHC was mentioned, the FPC usually indicated that it advised complainants that they could obtain help from the CHC, for example: 'The Committee recognises the role of the CHC in respect of patients' interests, and seeks to ensure patient-awareness of this facility' (Wolverhampton FPC,1986). As the current regulations do not allow paid advocates to represent parties at service committee hearings, CHC secretaries may only attend service committees as 'patient's friend' rather than as a paid official. The question of representation of parties at hearings is under review in the DHSS consultation document (1986). In their annual programmes a few FPCs made positive statements about their relationship with the CHC concerning complaints, and, in some cases, gave their policy of allowing CHC secretaries to attend service committee hearings as patient's friend. For example, Barnsley FPC (1985) commented on CHC involvement:



'The Committee do not regard such involvement as unhelpful since an experienced Secretary may be able to offer assistance and guidance not only in relation to an actual grievance, but also in presenting written evidence. Appointed Service Committee Chairmen accept the role of a CHC representative being in a position of assisting a complainant in the formal hearing of a complaint as the 'patient's friend' and will allow attendance at hearings to act in this capacity'.

Most FPCs, however, did not mention such a policy; it is thus not possible to estimate the extent to which the role of the CHC Secretary as 'patient's friend' at hearings was welcomed by FPCs.

Response to DHSS requests for specific information.

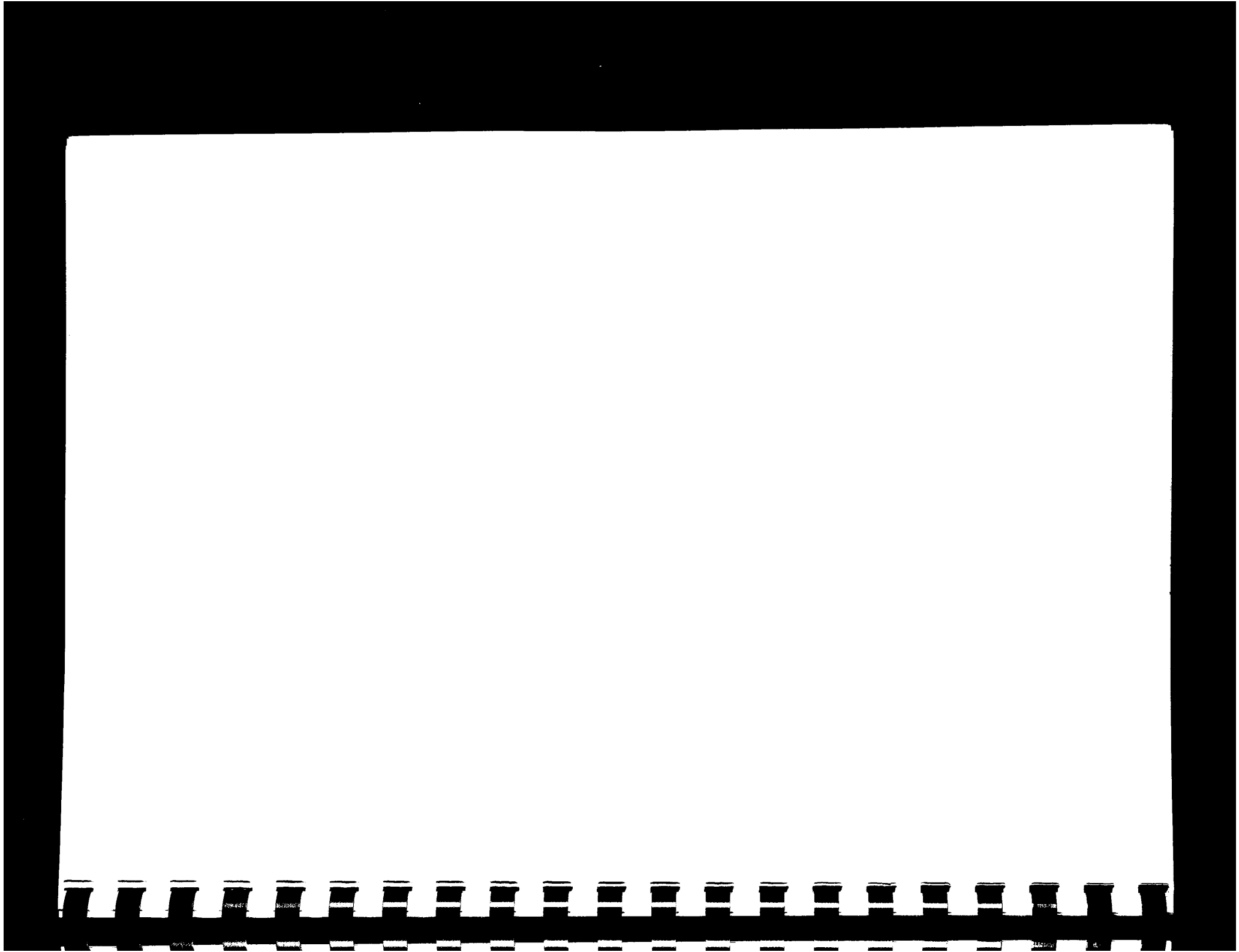
DHSS operational requirements for 1985-86 asked FPCs to record the incidence of complaints and 'the average time taken to investigate and determine complaints' [HC(FP)(85)10]. FPCs were also asked to give in their annual programmes 'illustrations of good practice which speed up proceedings without disadvantaging complainants or respondents'.

Very few FPCs included such examples of good practice in their 1985 annual programmes and only 17 per cent gave any information on the time taken to handle complaints. Several FPCs commented on the difficulty of indicating an average time, usually because the necessary records were not kept. Other FPCs expressed concern about the waiting time for the Secretary of State's decision once the FPC's recommendation had reached the DHSS; this stage could take a further 12 months or more.

Most FPCs, when indicating an average time for handling a complaint gave the period from its receipt to the date of the FPC's recommendation. But it was clear from the few responses given that there were inconsistencies in the stage to which the 'average time' related. Merton, Sutton and Wandsworth FPC gave an average of just over nine months but commented: 'However, this includes no hearing cases as well as hearing cases and does not include cases which reached neither stage. It is clear that for the delay factor to be monitored adequately cases must be analysed according to the various stages at which they fail to warrant further action by the Committee'.

Caution should thus be exercised in considering the average times given by FPCs. For formal complains about general medical services the time from receipt to FPC recommendation ranged from four to nine months with a median of 5.3 months; informally handled complaints took from two to six weeks. Formal complaints about general dental services took from 4.5 to nine months with a median of 5.5 months. Very few average times were given for complaints about other services; examples are three months and 5.5 months for pharmaceutical and five months for ophthalmic services.

Operational requirements for 1986-87 were based on the finding that the previous year's annual programmes included variations in the definition and recording of complaints. FPCs were 'encouraged to lay down clear principles for this...and to ensure that there is no under-recording of complaints which do not result in a formal investigation' and 'to analyse the material recorded locally under this heading to see whether improvements can be made to their own procedures or in the provision of FPS' [HC(FP)(86)2]. Only eight FPCs



included in their 1986 annual programmes information on their principles for recording complaints, and only five mentioned analysis of the complaints data with the aim of making improvements.

Four FPCs gave details of their policy or procedures for recording all formal and informal written complaints; for example Suffolk FPC reported that:

> 'The Committee is now recording all complaints received from patients on a micro-computer, whether or not they are dealt with under the 'informal' or 'formal' procedures, so that a more accurate assessment may be made on the level of complaints dealt with by various means by the Committee'.

Solihull FPC included a definition of complaints as:

> 'Such written communications that are received by the Committee which express or imply a criticism of an identifiable contractor and are submitted by or on behalf of persons who, prima facie, are entitled to service. The Administrator, or in his absence, the most senior officer in attendance will ensure that action is initiated on a daily basis by opening a complaints' file in accordance with the principles outlined above. This system will ensure that all "complaints" are properly logged and recorded and that follow up action is promptly taken'.

Bury, Lancashire and Wolverhampton FPCs emphasised their policy to record all complaints, whether written or verbal. Bury FPC stated that:

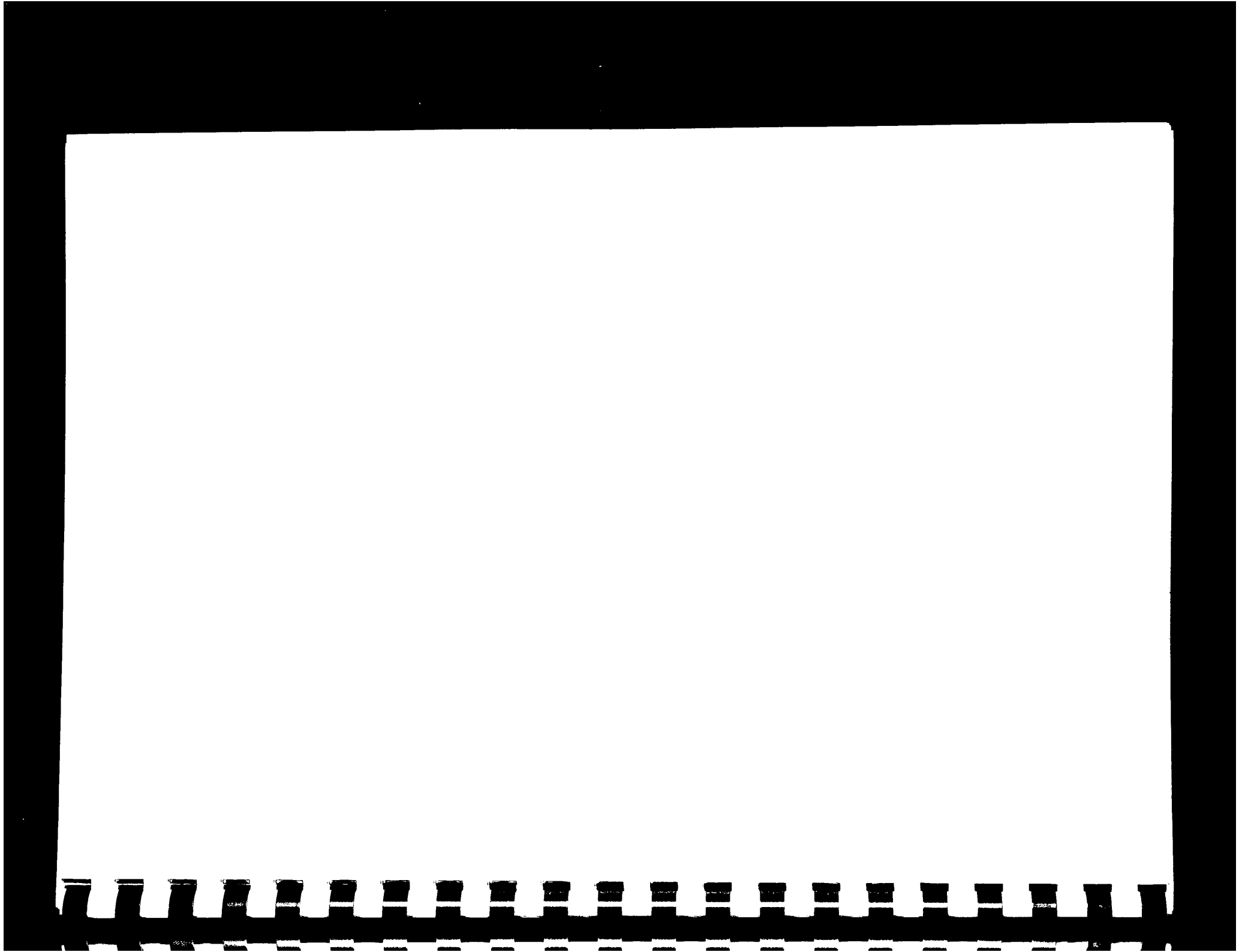
'In the past the number of recorded complaints received has been based on written complaints received and dealt with under the Service Committee and Tribunal Regulations. This procedure has meant that verbal complaints go unrecorded.

Procedures within the office have been amended and a system centrally recording all complaints will shortly be implemented. The central record will include details of the nature of the complaint, the identity of the patient and practitioner concerned and information on the substance of the complaint. The identity of the officer receiving the complaint will be recorded and the action taken'.

Wolverhampton FPC made the link between recording all complaints and monitoring 'specific areas of dissatisfaction' in order to improve services and 'reduce the potential for complaint'. The other few comments on using complaints data to identify improvements mainly indicated intentions to do so in the future rather than reporting on analyses already completed.

Incidence and outcome of complaints.

As already indicated, statistical data on the incidence of complaints recorded in FPC annual programmes for 1985 and 1986 were not collected nor presented in any consistent way, the main difficulty being the definition of what was recorded as a 'complaint'. Some FPCs recorded only the formal complaints which reached a service committee, while others gave figures for all formal and informal complaints. There were variations in the recording of general



enquiries and verbal or minor complaints which were not treated as official complaints either formally or informally. Some FPCs included these in the total number of complaints, some gave separate figures for 'general enquiries', others included them with informal complaints while others excluded them completely.

Further inconsistencies concerned whether or not cases carried forward from the previous year, and cases received 'out of time' were recorded. The number of formal hearings was not always given, and when given it was not clear whether this referred to the number of cases or to the number of times the service committee sat. If more than one practitioner was the subject of a complaint, for example against members of a group practice, this was not always indicated. Complaints about dental services were occasionally divided into those brought by the Dental Estimates Board and those by patients.

It is clear, therefore, that any comparisons between FPCs, or any aggregated figures based on the data for complaints given in FPC annual programmes, should be treated with caution. Table 1 shows the incidence of complaints reported using FPC annual programme data which have been collated as consistently as possible for the years 1984-85 and 1985-86 given in the 1985 and 1986 documents. Previous years' figures cannot be given for comparison as only about one-quarter of FPCs included these.

Table 1

Total complaints recorded for the four family practitioner services for the years 1984-5 and 1985-6.

Service	Year	Minimum	Maximum	Mean	Coefficient of variation	N
Medical	1984-85	0	257	41.1	1.068	83
	1985-86	3	209	47.8	0.955	68
Dental	1984-85	0	19	3.0	1.393	82
	1985-86	0	77	4.8	2.084	66
Pharmaceutical	1984-85	0	151	18.7	1.417	82
	1985-86	0	202	27.0	1.176	67
Ophthalmic	1984-85	0	175	4.5	4.502	82
	1985-86	0	30	3.1	1.697	66

(The total number of complaints about ophthalmic services in 1984-5 is distorted by the very high number of informal complaints presented by one FPC entirely consistently with its figures for the other services).

The figures in Table 1 suggest that the incidence of complaints recorded has risen between 1984-5 and 1985-6. This may indicate increasing dissatisfaction with the services, but could also be explained by more comprehensive recording of complaints in response to DHSS operational requirements. It will not be possible to make realistic comparisons between statistics for different years until a consistent method of recording complaints has been agreed and implemented.

Using data from those FPCs which indicated whether complaints were handled formally or informally, Table 2 shows that the proportion of informally handled complaints varied between the four services.

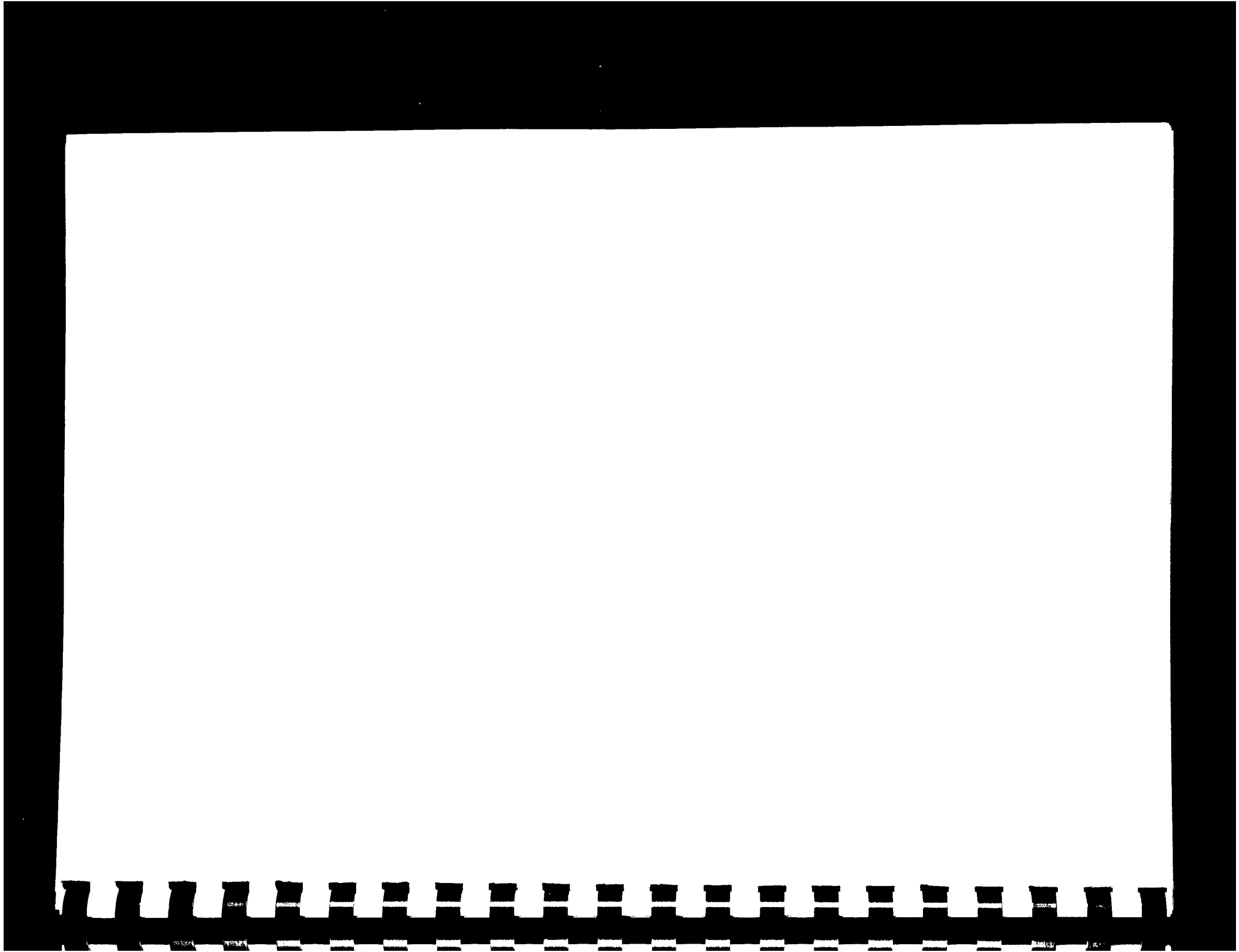


Table 2

Proportion of complaints about the four family practitioner services which were handled informally in the years 1984-5 and 1985-6

	1984-5		1985-6	
	% of total	N	% of total	N
General Medical Services	51	59	49	49
Pharmaceutical Services	73	15	84	20
General Dental Services	60	23	52	34
General Ophthalmic Services	99	13	86	21

About half of all complaints about general medical services were thus handled informally as was a slightly higher proportion of general dental complaints. Although based on a small number of FPCs, the figures suggest that a large majority of complaints about pharmaceutical and ophthalmic services were handled informally. This is probably explained by the nature of complaints about the latter two services which tended to be less serious and more of the 'general enquiry' type rather than official complaints.

The proportion of complaints which reached a service committee hearing also varied between the services; the lowest proportion was for complaints about general medical services as shown in Table 3.

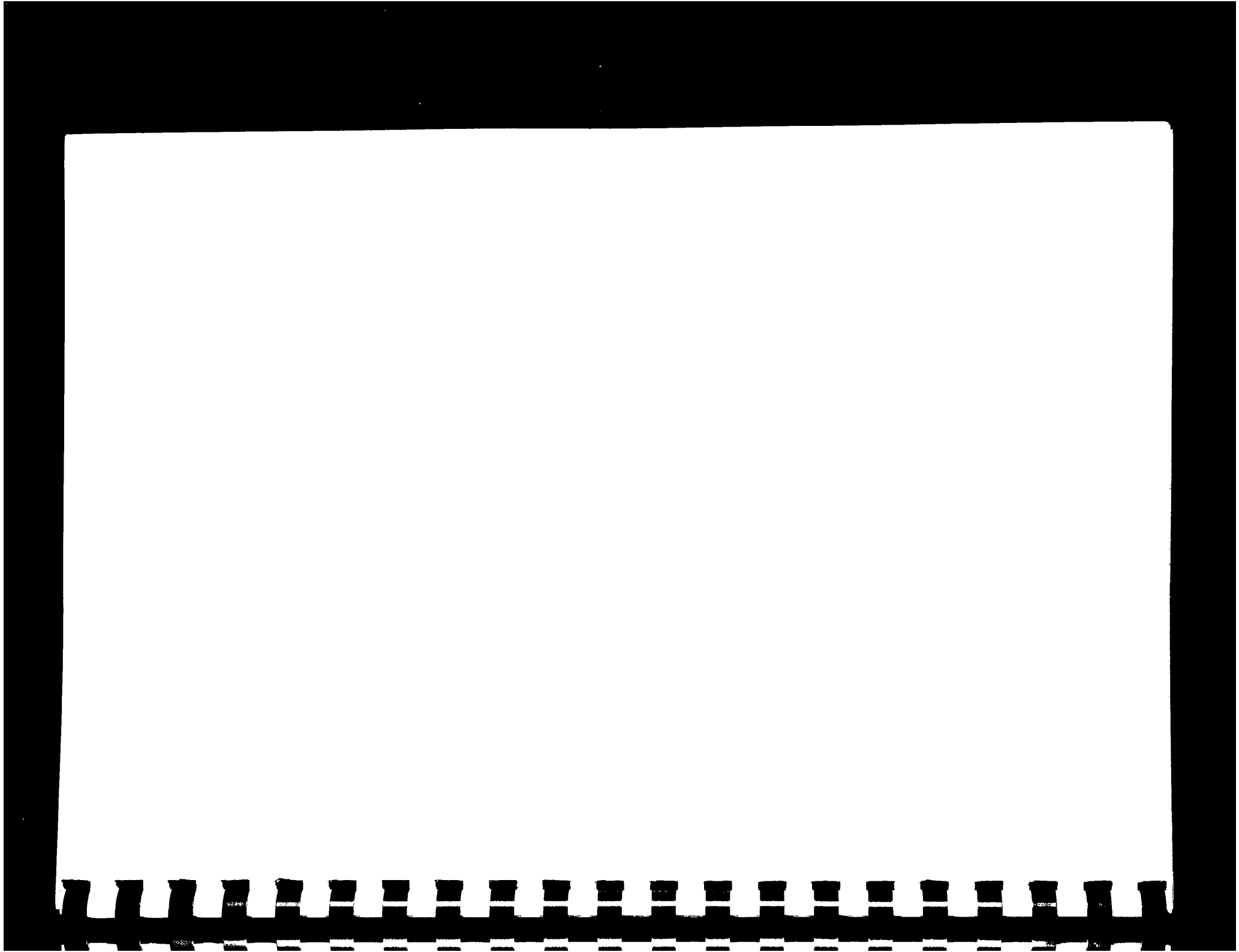


Table 3

Proportion of complaints about the four family practitioner services which reached service committee hearing in the years 1984-5 and 1985-6.

	1984-5		1985-6	
	% of total	N	% of total	N
General Medical Services	12	59	11	39
Pharmaceutical Services	46	28	38	20
General Dental Services	25	45	16	31
General Ophthalmic Services	14	11	(25)	(3)

Although the data are incomplete, the proportion of complaints heard at pharmaceutical service committees seems to be considerably higher than that for other services. This could suggest that the small number of formal complaints made about pharmaceutical services are considered serious matters. However, the nature of a complaint, about any service, is not the only factor influencing whether or not it reaches a hearing. Even from the incomplete data on the outcome of complaints reported in FPC annual programmes, it is clear that many complaints, especially about medical and dental services, are not pursued by the complainant, or are withdrawn before the service committee stage. This may be as a result of discussion with FPC officers, or of frustration with the procedures and delays involved; it may also be because

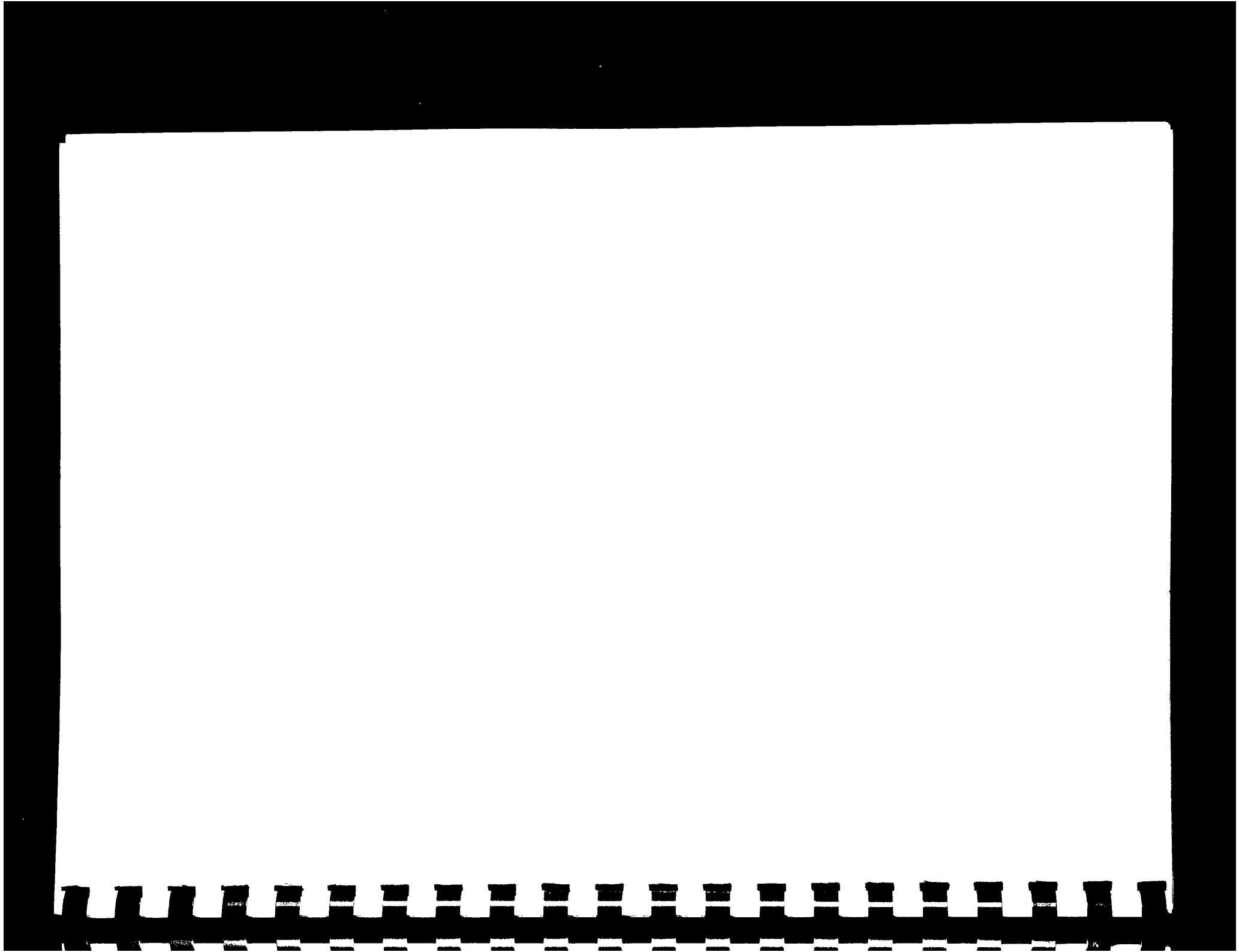
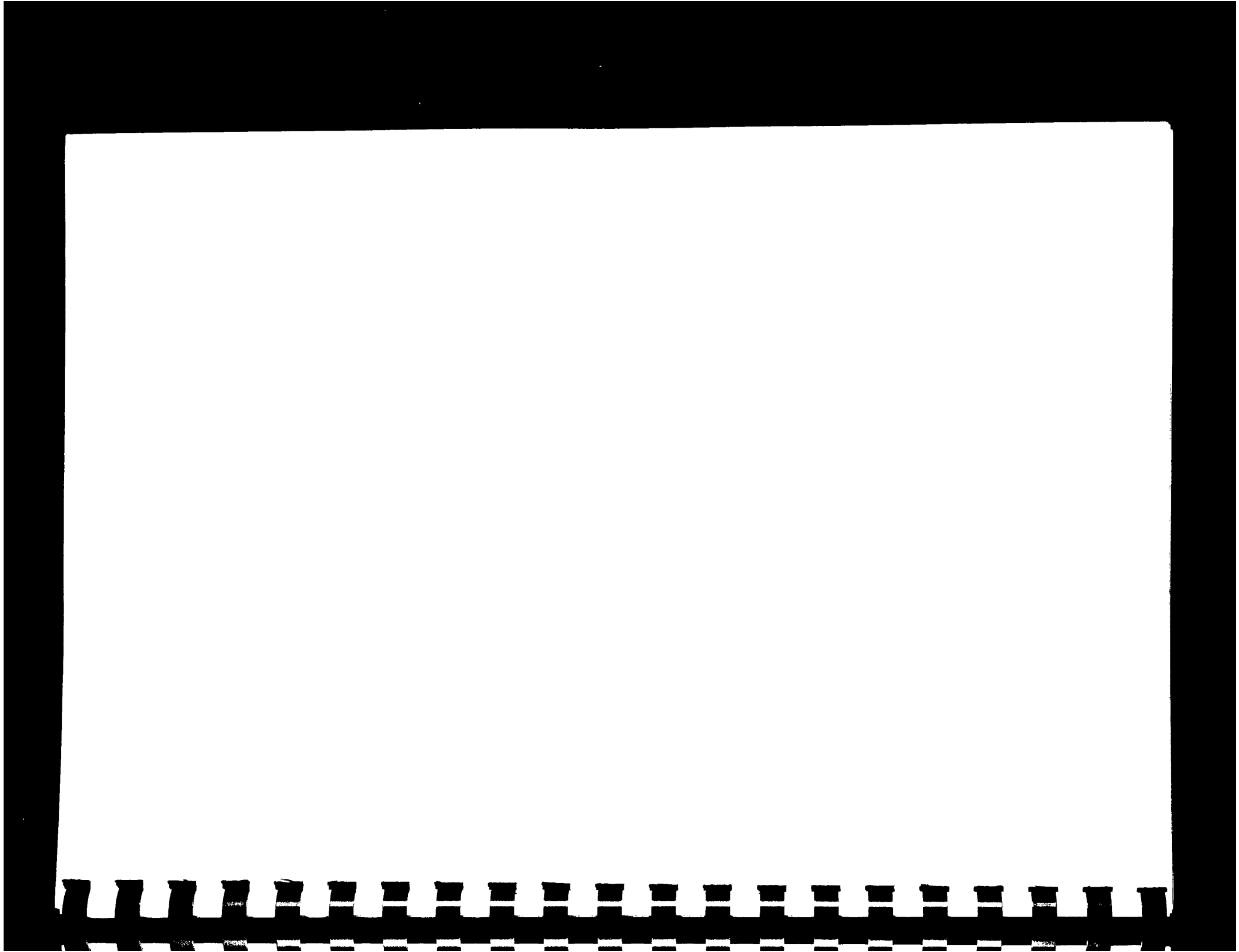


Table 4

Breaches in practitioners' terms of service found as a result of complaints about family practitioner services in the years 1984-5 and 1985-6.

	1984-5			1985-6		
	total breaches	% of complaints	N	total breaches	% of complaints	N
General Medical Services	155	5	75	144	5	61
Pharmaceutical Services	72	44	40	66	34	39
General Dental Services	193	15	61	180	12	53
General Ophthalmic Services	6	16	14	4	18	8

The lowest proportion of complaints resulting in a finding of breach of the terms of service was about general medical service, whereas the highest proportion was about pharmaceutical services. However, these differences may be attributable, again, not only to the nature of the complaints but also to the procedures of recording and handling complaints. The largest number of breaches found concerned general dental practitioners, while very few breaches were found in cases about ophthalmic services. The incomplete data, however, do not allow reliable explanations to be given of differences between FPCs, services or years.



the present complaints procedures are inappropriate for the type of dissatisfaction which patients wish to express.

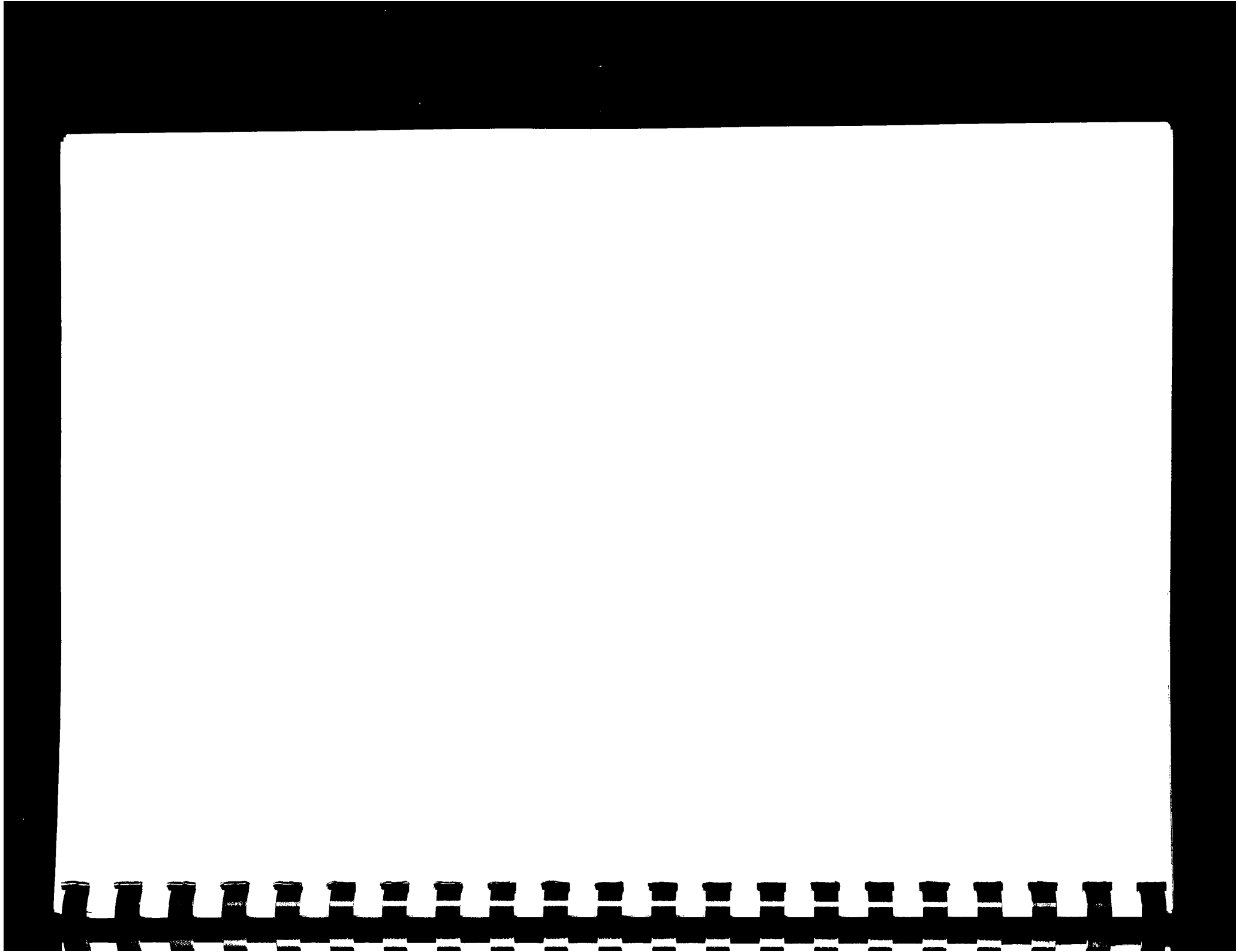
Inconsistencies in the presentation of the outcomes of complaints made it difficult to interpret the figures. Some FPCs showed which complaints had been resolved informally or by discussion or correspondence between FPC officers and the parties concerned. Others gave as their only outcome figures the number of breaches in terms of service; occasionally information was given on whether or not either party appealed and whether the FPC's recommendation was confirmed by the Secretary of State. As the whole procedure could often take longer than a year, many cases were pending at the end of a year and the outcomes of such cases often did not appear in the following year's statistics. A few FPCs recorded information on the substance of the complaints and/or the penalties imposed on practitioners found in breach of their terms of service, for example withholding of remuneration by the FPC. The only indicator of outcome which most FPCs included, however, was whether or not a breach was found. Again the proportion of the total number of complaints resulting in a breach finding varied between the services, as shown in Table 4.

Comment

Complaints and enquiries are an important aspect of FPCs' contact with the public. The annual programme is a potentially useful method of informing the public, practitioners and the DHSS not only about the incidence and outcome of individual complaints, but also about the complaints procedure, and any lessons learned from trends identified from the complaints and enquiries handled. Many FPCs, however, presented in their annual programmes only the statistics without any commentary or explanation.

Further, the figures which were presented were often incomplete, or difficult for the reader to follow, for example because figures did not sum to the total shown. The information given varied between FPCs and the data were not presented consistently, which made it difficult to analyse and interpret the figures given in the annual programmes. It is evident that the various items which might be reported are numerous and difficult to record or present clearly, and that guidance could be given to FPCs as to the precise information required and its presentation.

Such guidance should be based on an understanding of the purposes of reporting on complaints. If one purpose is to make comparisons over time, and between services and FPCs, of the incidence of complaints, then it should be stressed that the recording of complaints should be as comprehensive as possible, including written and verbal, formal and informal complaints. For the purpose of monitoring the progress of complaints through the various stages to ensure that procedures are fair and delays minimised, the stages and timespans necessary for such monitoring should be specified. Another major purpose of



recording complaints is to identify trends with the aim of improving the aspects of services with which people are dissatisfied; this would require categories for the complaints recorded for each service.

It is clear that more sophisticated methods are needed for recording the various stages in determining the outcome of complaints. However, this process should be as simple as possible and limited to the most useful items for the purposes of monitoring complaints. Once computerised systems are established the handling of such data should become a routine matter. It would then be possible for FPCs to present in their annual programmes complaints statistics and interpretation in a way that would be more useful to all interested parties than the information given in the first two annual programmes.

APPENDIX 1

Calderdale FPC's Objectives for General Dental Services
(1985-86 Annual Programme)

6.4 Objectives and Priorities for Services

During the year 1986/87 the FPC propose to pursue the priority aims and objectives set out below in paragraphs 6.4.1 to 6.4.6. During the year 1987/88 the FPC hope to be able to start on the aims and objectives set out in paragraphs 6.4.7 to 6.4.11. These aims and objectives have been agreed with the LDC and the DHA. Formal consultation with the CHC and Local Authority has taken place.

6.4.1 To encourage a dentist to set up practice in Mixenden:-

(a) By providing statistical and other information to demonstrate the need for a dentist in Mixenden.

(b) By sending this information to dentists in Calderdale and surrounding areas.

(c) By advertisement, if necessary.

(d) By supporting applications for planning approval.

6.4.2 To find ways of reducing the waiting list for orthodontic and oral surgery:-

By establishing a working party with an approved brief from the DHA/FPC to review problems.

6.4.3 To arrange for an organised transfer of patients from the Community Dental Service to the GDS:-

By setting up a working party with agreed brief in order to develop and agree the means of transferring children from the Community Dental Service to the GDS at age 15.

6.4.4 To establish a procedure with the CHC, CRC and Citizens Advice Bureaux for handling the complaints they receive:-

(a) In the case of the CHC, by agreeing a procedure which will not precipitate a formal complaint to the detriment of the patient/dentist relationship whilst at the same time retaining the right of the CHC to act in the best interests of the patient.

(b) In the case of the Citizens Advice Bureaux, to arrange that all complainants are advised to contact the FPC and/or the CHC.

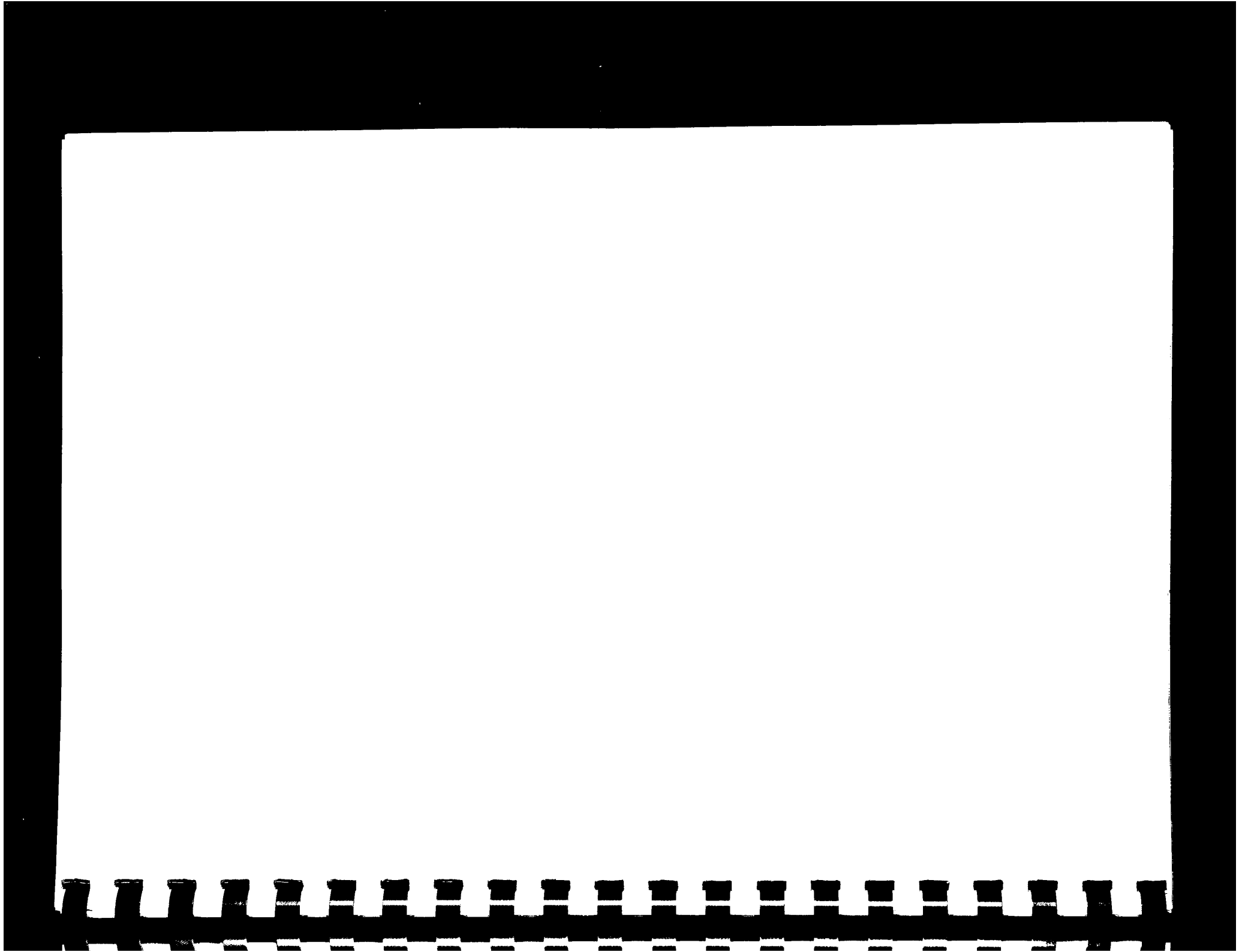
6.4.5 To introduce an informal complaints procedure:-

(a) By establishing administrative procedures, approved by the LDC, for dealing with minor complaints along the lines of those used for dealing with medical complaints informally.

(b) By producing guidelines, in agreement with the LDC, to assist the lay member appointed to deal informally with such complaints.

6.4.6 To press for the fluoridation of the water supply:-

By securing the support of other affected FPCs in order to press the relevant DHAs and/or RHAs to approach the Yorkshire Health



Authority.

6.4.7 To carry out an epidemiological study to ascertain indicators of need:-

(a) By agreeing the aims and objectives with the DDO and LDC.

(b) By agreeing the form the study will take by ascertaining the methods of collating data.

(c) By agreeing and implementing an action plan.

6.4.8 To obtain statistical information from FPC and DEB records to assist in formulating future policy:-

(a) By identifying information needs.

(b) By establishing the feasibility of collecting statistics from existing FPC and DEB records.

(c) By establishing a system for collecting and collating available information.

(d) By exploring the possibility of introducing arrangements for collecting statistical information not readily available from FPC and DEB records.

6.4.9 To explore ways of increasing public awareness of the need for and ways of achieving dental health:-

(a) By securing the help and assistance of the health education officer.

(b) By publicity through dentists' and doctors' surgeries, DHA clinics and hospital out patient departments.

(c) By including leaflets with communications to patients.

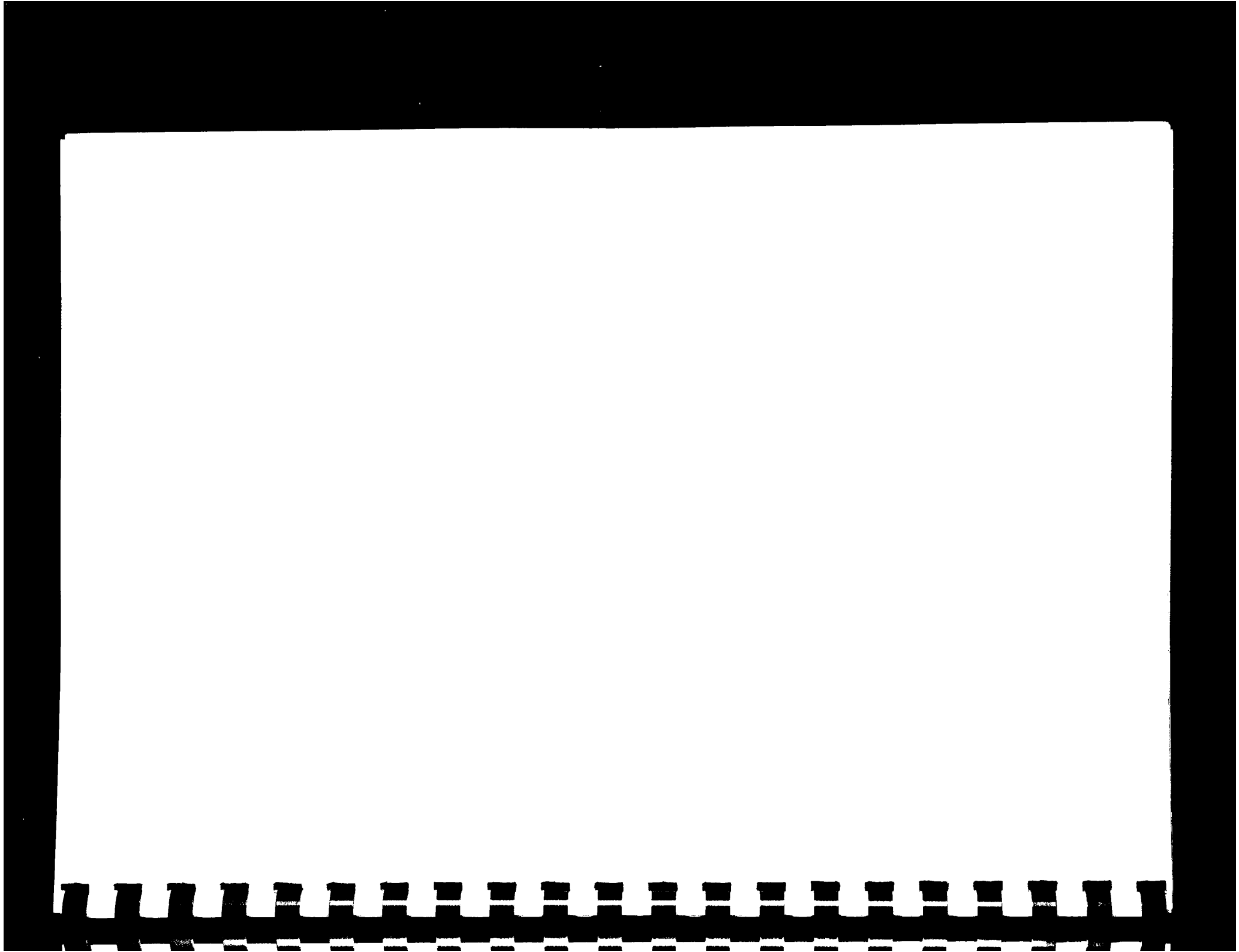
(d) In the longer term, by using the FPC computer to identify patients who do not visit the dentist.

6.4.10 To explore the possibility of providing portable equipment for use by GDPs in patients' homes:-

(a) By establishing the amount of use which would be likely to be make of such equipment.

(b) By ascertaining the cost effectiveness of GDPs undertaking domiciliary work using such equipment rather than it being carried out through the community dental service.

(c) By establishing whether such equipment could be provided by the DHA.



EXAMPLES OF GOOD PRACTICE APPENDIX 2

Cheshire FPC's Criteria for use of Deputising Services
(1985-86 Annual Programme) Form Dep 1

APPLICATION TO USE A DEPUTISING SERVICE

I/We apply to use .....
Deputising Service in accordance with the criteria agreed by the Deputising Services Sub-Committee of Cheshire Family Practitioner Committee as set out below.

CRITERIA

1. An average limit of 9 visits per one thousand patients per month per doctor spread over a year will be imposed on doctors using Deputising Services in Cheshire. In the case of partnership practices, the Sub-Committee has agreed that this limit should be spread over the partnership on a notional basis.

2. Applications to make use of a Deputising Service in excess of the agreed level requires special approval by the Sub-Committee. The Sub-Committee has decided that doctors/practices wishing to use a Deputsing Service in excess of the Sub-Committee's permitted limits should be invited to attend for interview by members of the Sub-Committee.

3. Authority has been given to the Chairman of the Sub-Committee and Administrator to approve applications to use Deputising Services within the limits approved by the Sub-Committee, subject to later confirmation.

4. Doctors using Deputising Services will be asked to submit a quarterly return to the Family Practitioner Committee about their use of Deputising Services. The Sub-Committee will take a serious view of doctors using a Deputising Service in excess of the limit imposed by the Sub-Committee and without first obtaining the Sub-Committee's approval of greater use.

5. The Red Book definition of "Out-of-Hours" will be adopted so far as the use of Deputising Services is concerned viz:

   7.00pm on Weekdays to 8.00am the following morning and from 1.00pm on Saturdays to 8.00am on the following Monday morning.

Signed .....

.....

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.....

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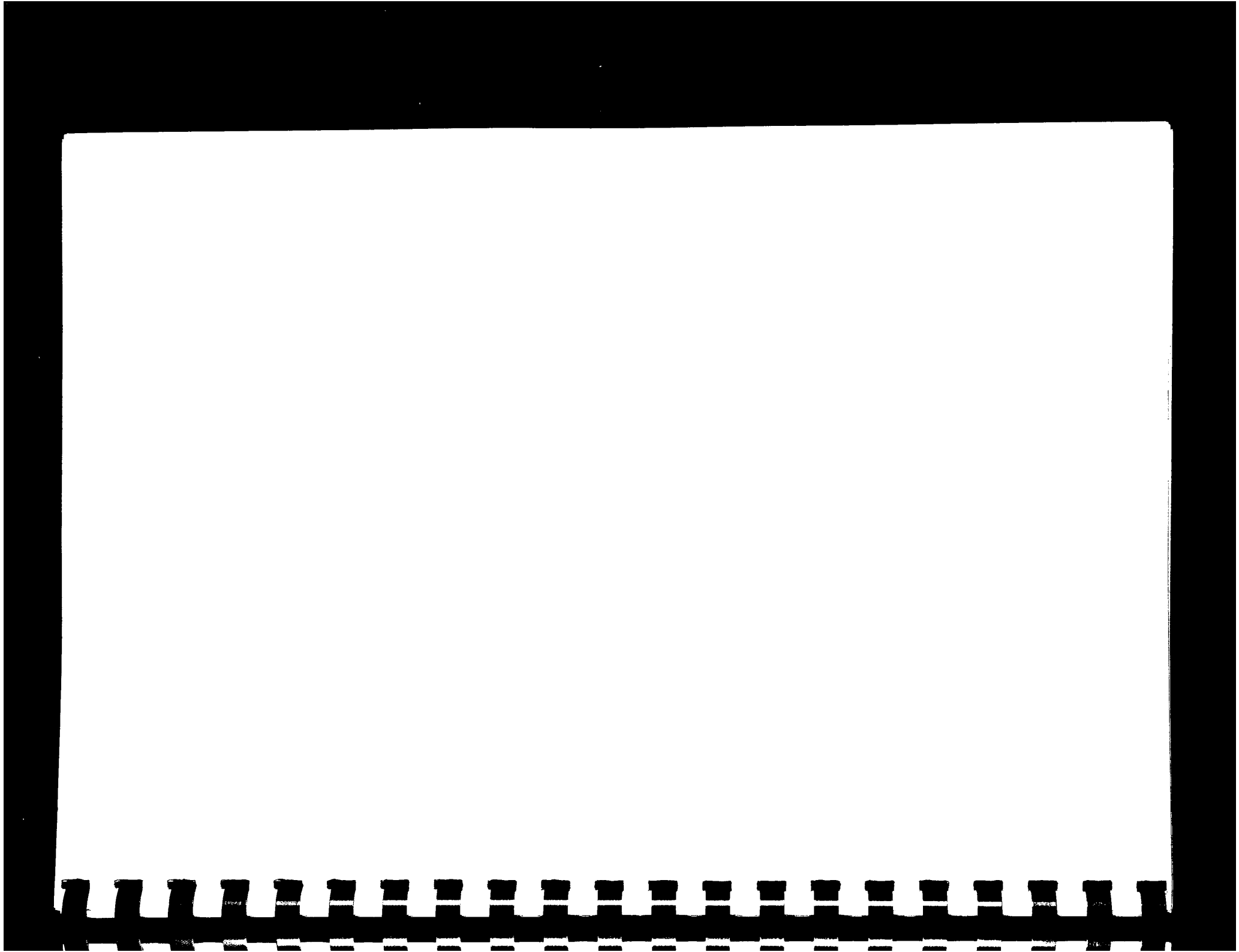
Date .....



APPENDIX 3(a)

Trafford FPC
(1985 Annual Programme)

3.12 **PREMISES**

3.12.1 **Procedure for regular inspection of premises**

This procedure has been devised to meet the requirements of Health Notice HN(FP)(84)42 and its content has been agreed with the Trafford Local Medical Committee.

Purpose

(a) To satisfy the FPC that minimum standards are being met in surgery premises within its locality.

(b) To assist general medical practitioners in achieving improvements in their surgery premises.

(c) To meet the Secretary of State's requirements for annual progress reports on improvements to premises.

Regular Inspection

The FPC has a responsibility to ensure that surgery premises provide proper and sufficient accommodation having regard to the circumstances of the practice. In addition it needs to ensure that the premises approved under the Rent and Rates Scheme for reimbursement meet the required criteria. A formal visit will be made by prior arrangement once every three years to each surgery premises within Trafford. The visit will be made by a member of the Local Medical Committee, a Lay Member of the FPC and by an officer of the FPC.

Nature of the Inspection

Those conducting the visit will inspect the premises with a member of the practice. The inspecting will be carried out with a view to ensuring that the following minimum standards are met:-

1. That there is ease of access to premises and movement within them, bearing in mind the needs for the elderly, disabled and mothers with young children.

2. That there is a properly equipped consulting room with adequate arrangements to ensure the privacy of consultations and the right of patients to personal privacy when dressing or undressing, either in a separate examination room or in a screened off area around an examination couch within the consulting room.

3. That the practitioner, staff and patients have convenient access to adequate lavatory and washing facilities and that practitioners have a wash basin in their consulting room and if not then immediately adjacent.

4. That there are adequate internal waiting areas with enough seating to meet all normal requirements.

5. That the premises, fittings and furniture are clean and in good repair, with adequate standards of lighting, heating and ventilation.

6. That satisfactory arrangements exist to ensure confidentiality of medical records and that security of prescription forms and medical certificates is adequately maintained.

Where deficiencies are noted, these will be brought to the attention of the doctors during the visit and advice will be offered on how the premises should be improved so that the required standard can be ahcieved.

Reports

Following each visit a report will be prepared by those who carried out the inspection and a copy of the signed report will be submitted to the Administrator who will decide what further action is required.

Other Action

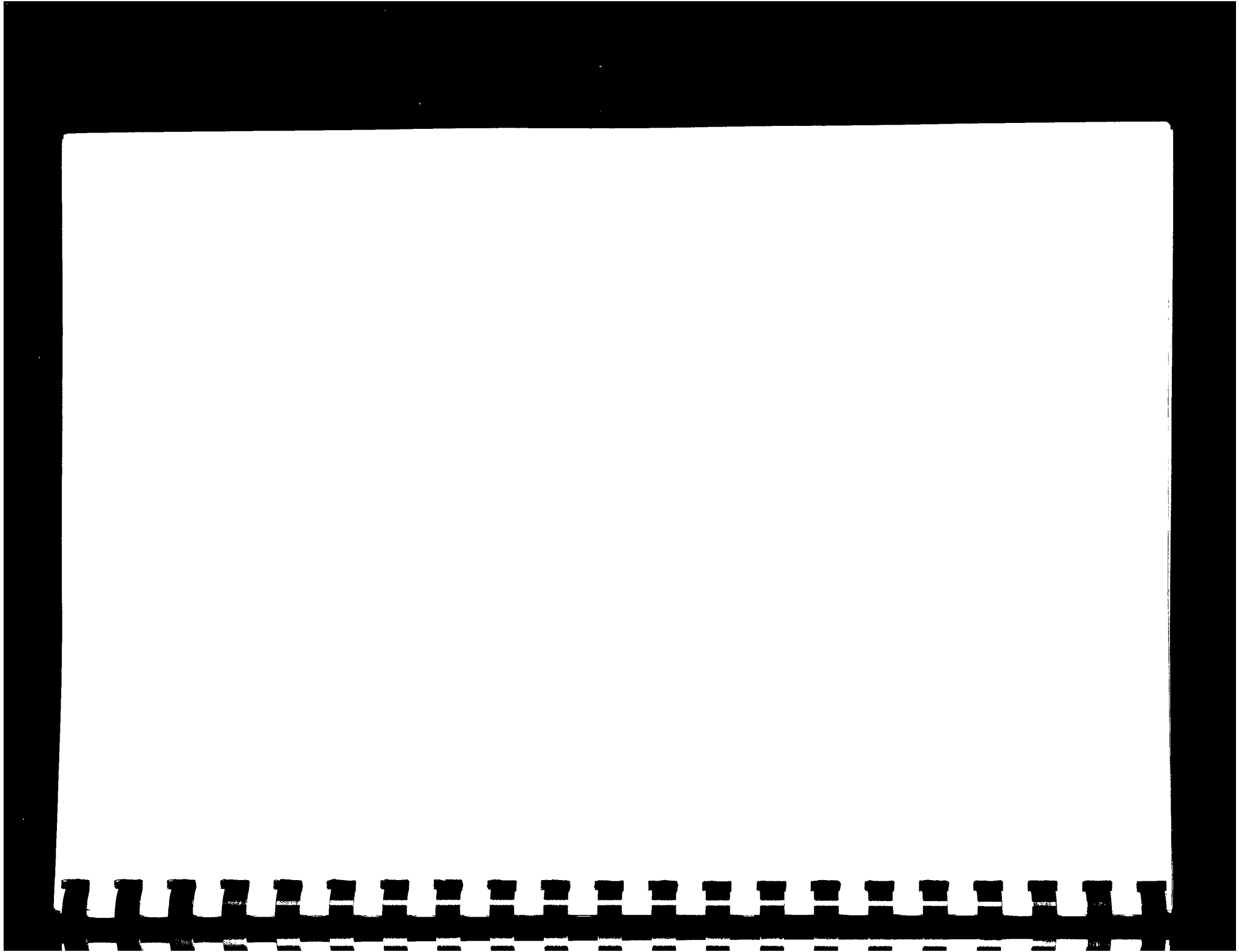
Where the report is favourable, no further action will be taken until the date of the next scheduled visit to the premises concerned.

Where the report is unfavourable, the practice concerned will be advised of the specific action required and the period within which they will be expected to complete such action. A second visit will be arranged for the end of the specified period to see if the improvements have been carried out. If in a particular case the Administrator considers the circumstances appear to warrant a withholding of payment under the Rent and Rates Scheme she will take the necessary steps to ensure that the matter is brought to the attention of the full FPC.

In all such cases the guidance in HN(FP)(84)42 will be observed in full.

Annual Progress Report

Annual progress reports on improvements to premises will be made to the FPC, covering the period 1 January to 31 December, before submission to the DHSS.



3.12.2 **Inspection Programme**

The first surgery inspection in Trafford will be held on the 20th September 1985.

Operational Plan for 1985/86

1.	Dr S A Rahuja 176 Chorlton Road, Manchester 16	September 1985
2.	Dr W D Nicholson & Partners 63 Washway Road, Sale	October 1985
3.	Dr K M Graham & Partners "Alliston", Crofts Bank Road, Urmston	November 1985
4.	Dr A Firoze & Partner 122 Victoria Road, Stretford	December 1985
5.	Dr H G Arnall & Partner 196 Stockport Road, Timperley	January 1986
6.	Dr W J Donnelly 406 Moorside Road, Flixton	February 1986
7.	Dr S P Robinson & Partners 277 Manchester Road West, Timperley	March 1986
8.	Dr A Franks 12 Derbyshire Road South, Sale	April 1986
9.	Dr J B Jacovelli & Partners Dr A Noar & Partners 187 Hale Road, Hale	May 1986
10.	Dr N R Shah 490 Barton Road, Stretford	June 1986
11.	Dr J Phillips & Partners Dr P Wolstencroft & Partners the Health Centre, Conway Road, Sale	July 1986
12.	Dr J C Turnbull & Partner The Lindens, Barrington Road, Altrincham	August 1986

Strategic Plan

To complete the inspection of all surgery premises by the end of 1988 on the basis of one per month.

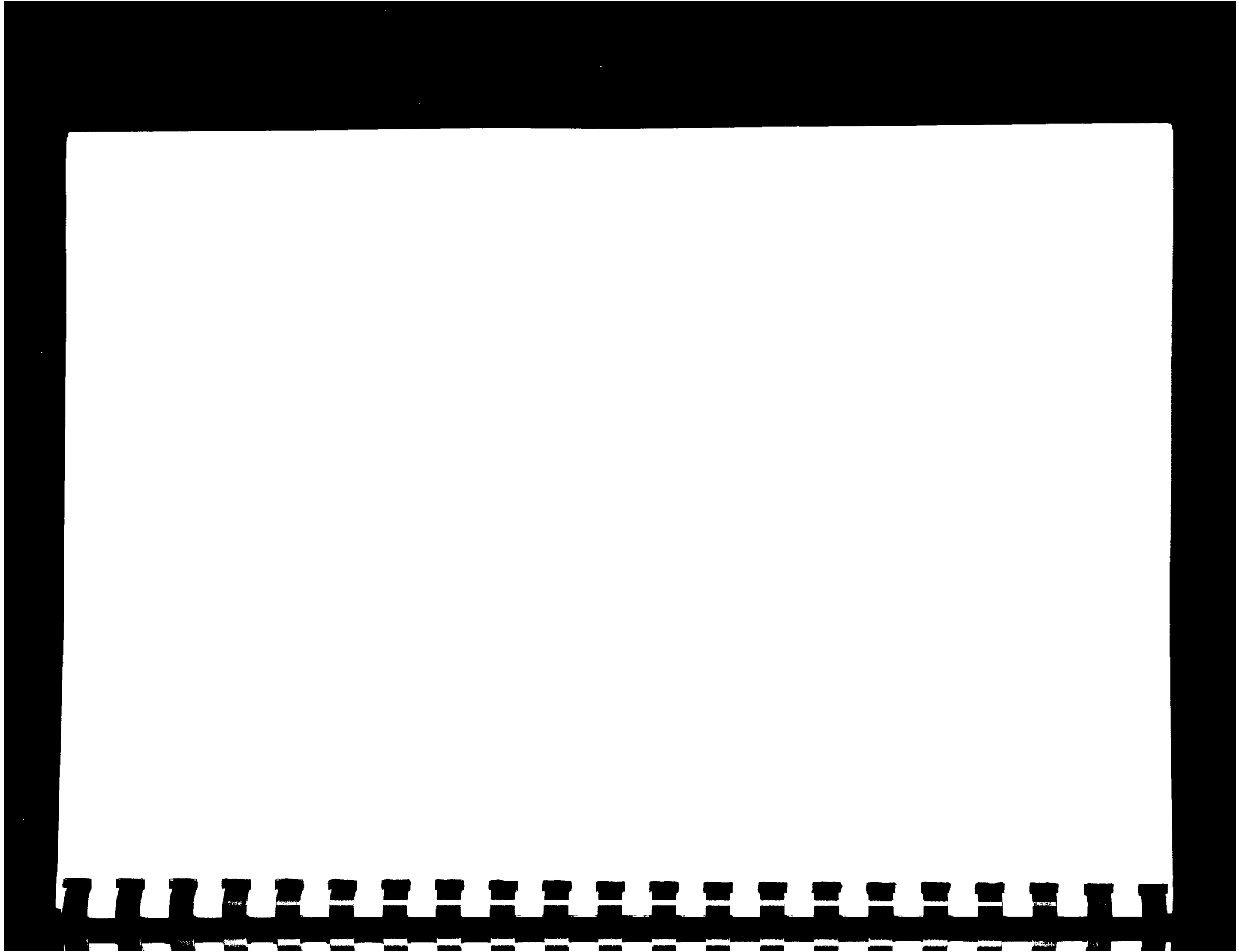
APPENDIX 3(b)

(a) Trafford FPC
1986 Annual Programme

8.3 Inspection of Surgery Premises

Since its inception the Trafford Family Pracitioner Committee has had a programme for inspection of surgery premises. The latest programme for carrying out surgery inspections commenced in September 1985 and since that date, six surgeries have been inspected and by the end of 1988 all surgeries will have been inspected again.

Of the six premises inspected, all were found to provide proper and sufficient accommodation having regard to the circumstances of the practice. The inspection committee advised two of the doctors to carry out slight modifications - these have since been completed. The two Members who visit take the opportunity to discuss related issues with practitioners, such as the possibility of improvement grants or cost rent schemes.



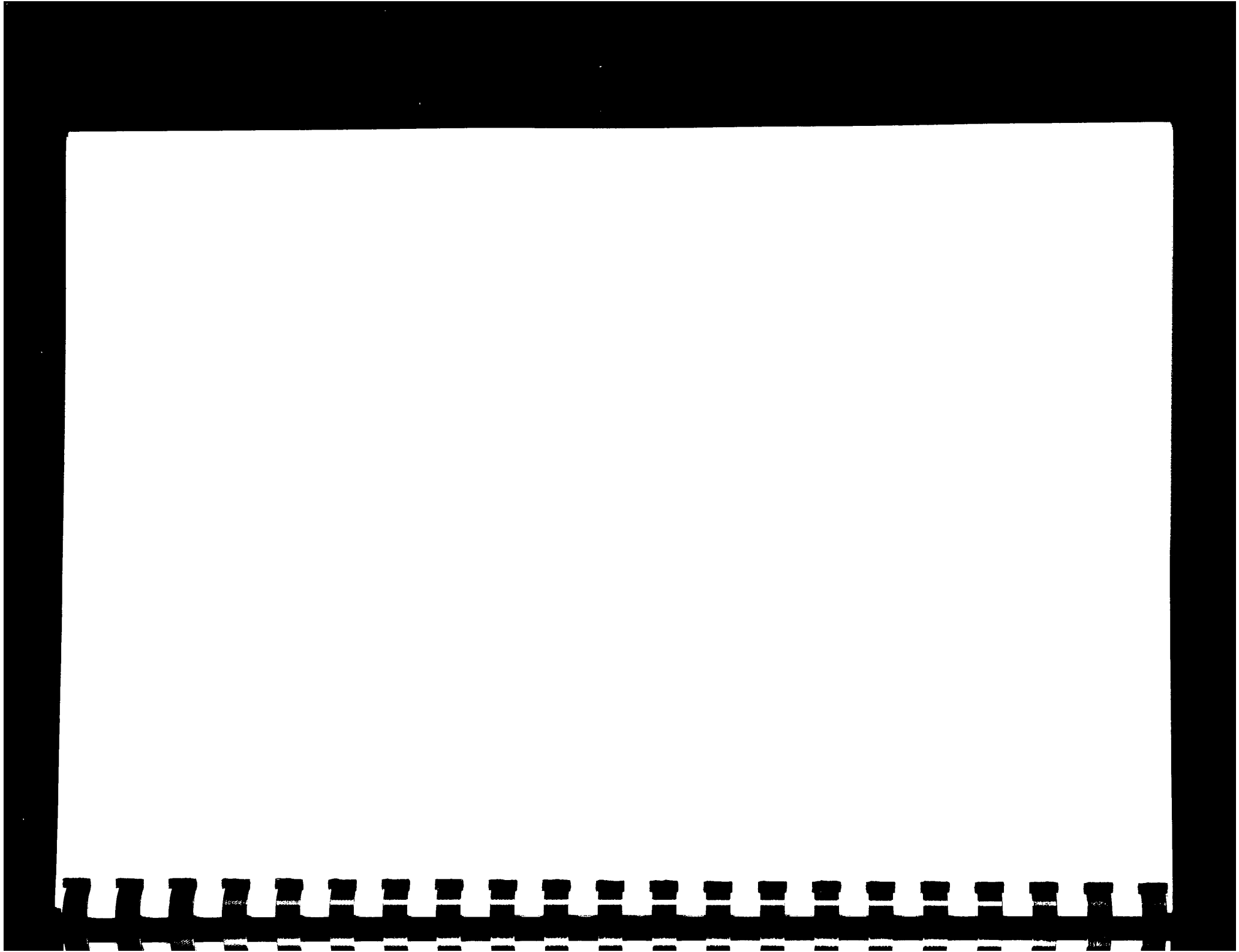
APPENDIX 4

Humberside FPC
(1986 Annual Programme)

Figure 9

CHANGES IN PREMISES SINCE 30TH JUNE 1985 IN RESPECT OF HEALTH CENTRES, OWNER OCCUPIERS AND RENTED SURGERIES

	Premises as at 30.6.85			Changes during period			Premises as at 1.4.86		
	Premises Owned	Premises Rented	Health Centre	Premises Owned	Premises Rented	Health Centre	Premises Owned	Premises Rented	Health Centre
East Yorkshire	28	11	4	-1	–	–	27	11	4
Grimsby	31	10	1	-1	–	–	31	10	4
Hull	49	19	3	-1	+2	–	48	21	3
Scunthorpe	22	27	7	–	+2	–	22	29	7
	130	67	15	-2	+4	–	128	71	15



(a) Manchester FPC
Annual Programme 1986

9 Collaborative Issues with Health Authorities

The following are examples of current and projected collaborative issues:-

(i) Child Health

The launch of the scheme for the developmental screening of pre-school children will take place in the early summer of 1986. This has been achieved by a North District Working Party including FPC and LMC representation and will incorporate Health Visitor assessment, dental, orthoptic, speech therapy, hearing and psychological screening.

(ii) Maternity

The FPC and LMC are represented on the District Maternity Services Liaison Committees which are currently considering the recommendations arising from the 'Maternity Care in Action' reports. Issues arising include the provision of intra partum care by GPs and the introduction of a GP based schematic approach to pre-natal care.

All three Authorities provide GPs with access to maternity beds and in Central District there has been a very significant increase in bed bookings over the last 2 years. As a result of this, the Authority increased the number of community midwives carrying out deliveries on the GP unit.

(iii) Homeless People and Travelling Families

The FPC has placed high priority on the problems of the single homeless, homeless families and travelling families in relation to primary health care. The Committee has supported the Manchester and Salford Health Care Team for Homeless People funded from Inner City monies and has provided input to the various sub-groups of the Joint Consultative Committee concerned with the homeless to ensure informed consideration of issues relating to GP services. Steps have been taken to improve access for the homeless to generic services. These include facilitating the provision of GP care; improving access to hospital care by liaison, for example, by the Community Psychiatric Nursing Service or the Community Midwife and better dental care through efforts of the Project Team.

Mention was made on page 2 of the document that problems of registration with GPs for homeless families are growing and this issue has been discussed with officers of South Manchester Health Authority. It is further addressed in Paragraph 20.2.

(iv) Dental

Discussions are currently being held with district Dental Officers on the distribution of dental services; the planning and organisation of the projected vocational training scheme for dental practitioners; the provision of information; emergency services; fluoridation; and the

objective of family dental practitioners caring for the dental health of children and their parents.

(v) Alcohol-Related Problems

This issue has been considered up till now primarily in the context of the single homeless since the alcoholic problems of the latter group have been the most manifest. However, it is also pertinent that in the case of one consultant psychiatrist, 36% of his out-patient referrals have a drink problem. In addition, about 1 in 7 of his acute psychiatric beds are used for detoxification. The Homeless Project Team have supported the temporary drying-out hostel established in the early part of 1986 and early liaison with local GPs facilitated the provision of GMS. The Local Authority, in collaboration with Health Authorities and the FPC and under the aegis of the Guiness Trust, is currently planning the provision of a permanent drying-out facility in the vicinity of the City Centre.

It is recognised that alcohol problems are by no means confined to the single homeless and the FPC will incorporate this consideration into their strategic planning primarily in a health promotion context.

(vi) Screening

Following extensive discussions involving the FPC, the LMC, local GPs, the Specialist in Community Medicine and the District Health Education Department, two pilot screening projects were launched in North Manchester in the early part of April 1986 viz a well-men and elderly screening programmes.

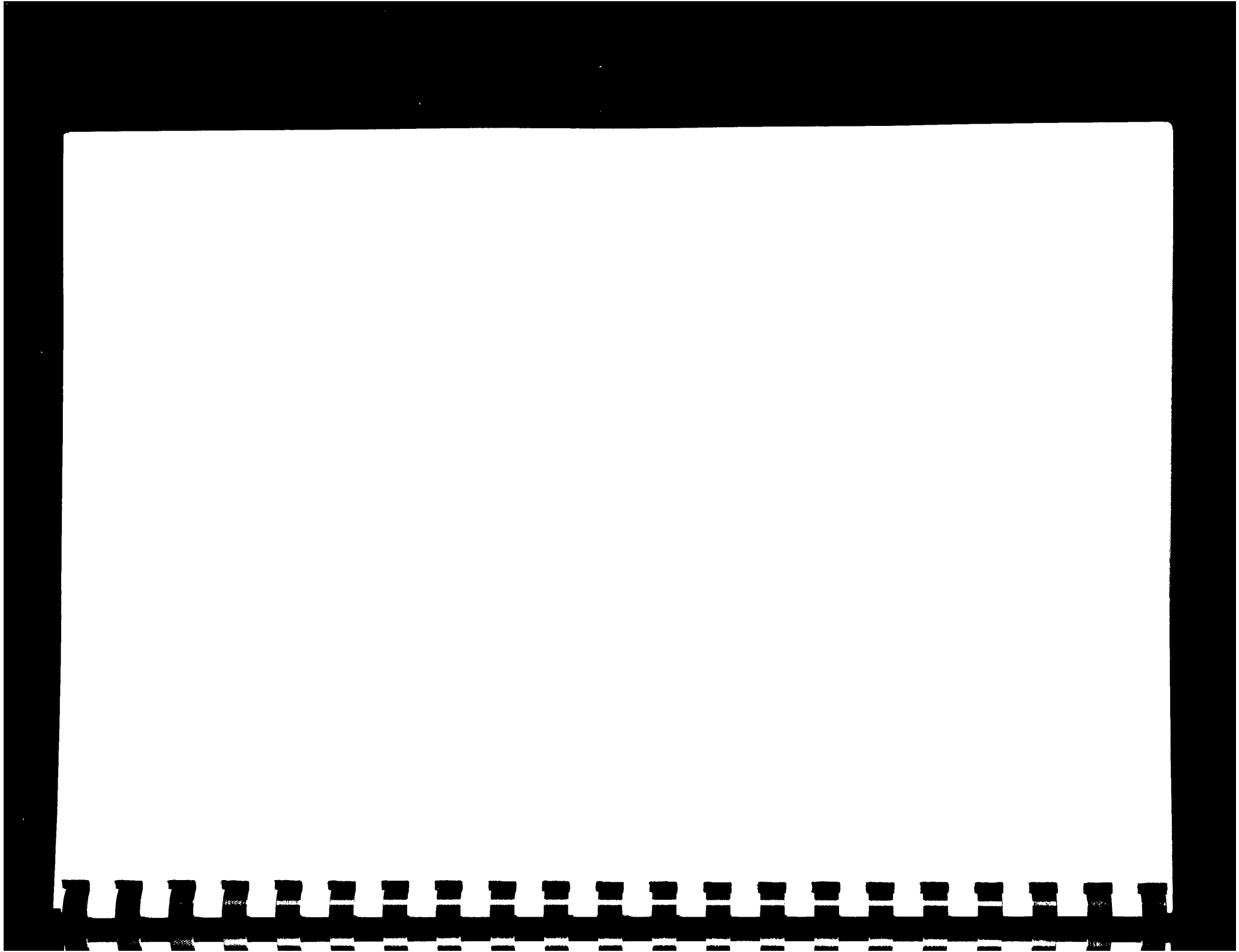
The programme for well-men has been established to test the effectiveness and acceptability of a multi-faceted screening and health promotion programme for middle-aged men by conducting and evaluating a pilot with clients in the age band 35-40 years registered with one GP. The men undergo full screening for hypertension, lung function, alcohol consumption, body fats, welfare rights, general fitness and blood cholesterol. The health promotion aspects include a health quiz, advice on smoking and information on exercise. All clients are counselled by the GP at the end of the session.

The elderly screening is for people over 65 and is also a pilot scheme to enable a decision to be made on the need for a permanently funded service. The selection of the clients has been determined geographically and involves the patients of a large number of GPs all of whom have supported the initiative. The screening incorporates checks on foot health and welfare rights.

(vii) Family Planning and Immunisation/Vaccination

Family planning and immunisation/vaccination are two areas where there is a particular danger of unplanned overlap and duplication of services by GPs and Health Authority community services. It is recognised that there may be instances, particularly relating to family planning, when it is appropriate for the patient to have a choice but such a situation should be the result of rational planning of services rather than coincidental.

It is intended, therefore, when the information profile on practice



activities is available, that the FPC and the Health Authorities, in association with the LMC and the FPC Planning Panels, should jointly review the provision of these services and plan a future strategy.

(viii) Diabetes

Central Manchester Health Authority have proposed the phasing out of their hospital-based diabetic clinic and the introduction of a Diabetes Day Centre which would enable a multi-disciplinary and integrated approach. Patients and GPs would have open access to the unit which would operate on a five day basis and incorporate comprehensive screening. Self-management of the disease by patients would be encouraged.

In addition, the intention would be to establish nine diabetic clinics in the community involving GPs as well as other appropriate health professionals.

The FPC and LMC support this initiative which places an appropriate emphasis on the contribution of the family doctor.

(ix) General Psychiatry

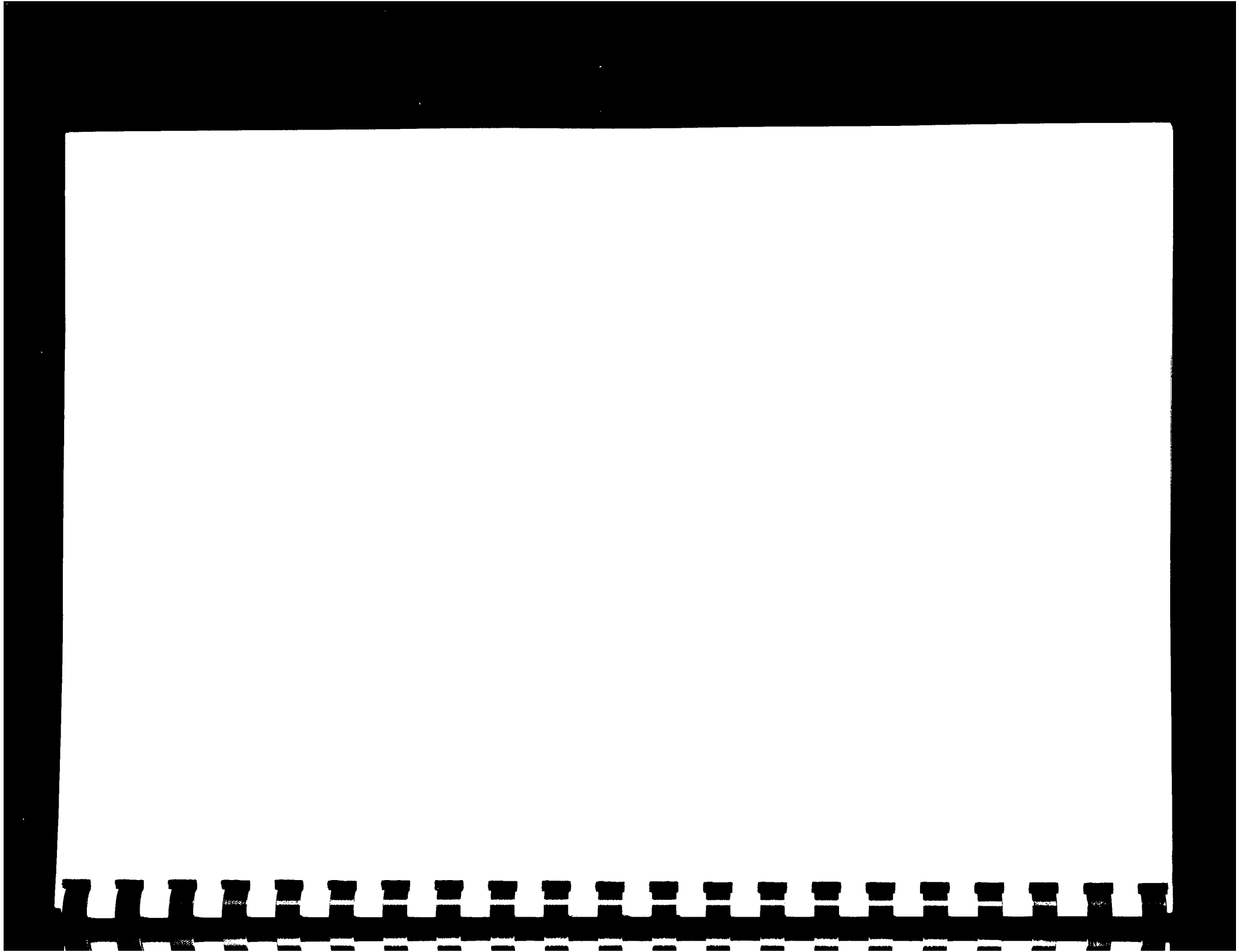
The North Western Regional Health Authority strategy on mental illness, which incorporates the run-down of large hospitals and a reduction of the acute mental illness bed norm will have a significant impact on GPs. The LMC is particularly concerned that this will increase difficulties with emergency admissions and affect their rights of referral. The FPC shares these concerns and looks to close co-ordination with Health Authorities when it is proposed to resettle mentally ill patients in the community so that the provision of GMS to these people can be assured and effective.

More specifically, there is a community mental health project based at Powell Street in North Manchester which aims to improve access from the point of view of patients and GPs and a community facility for treating post-natal depression is envisaged in the near future.

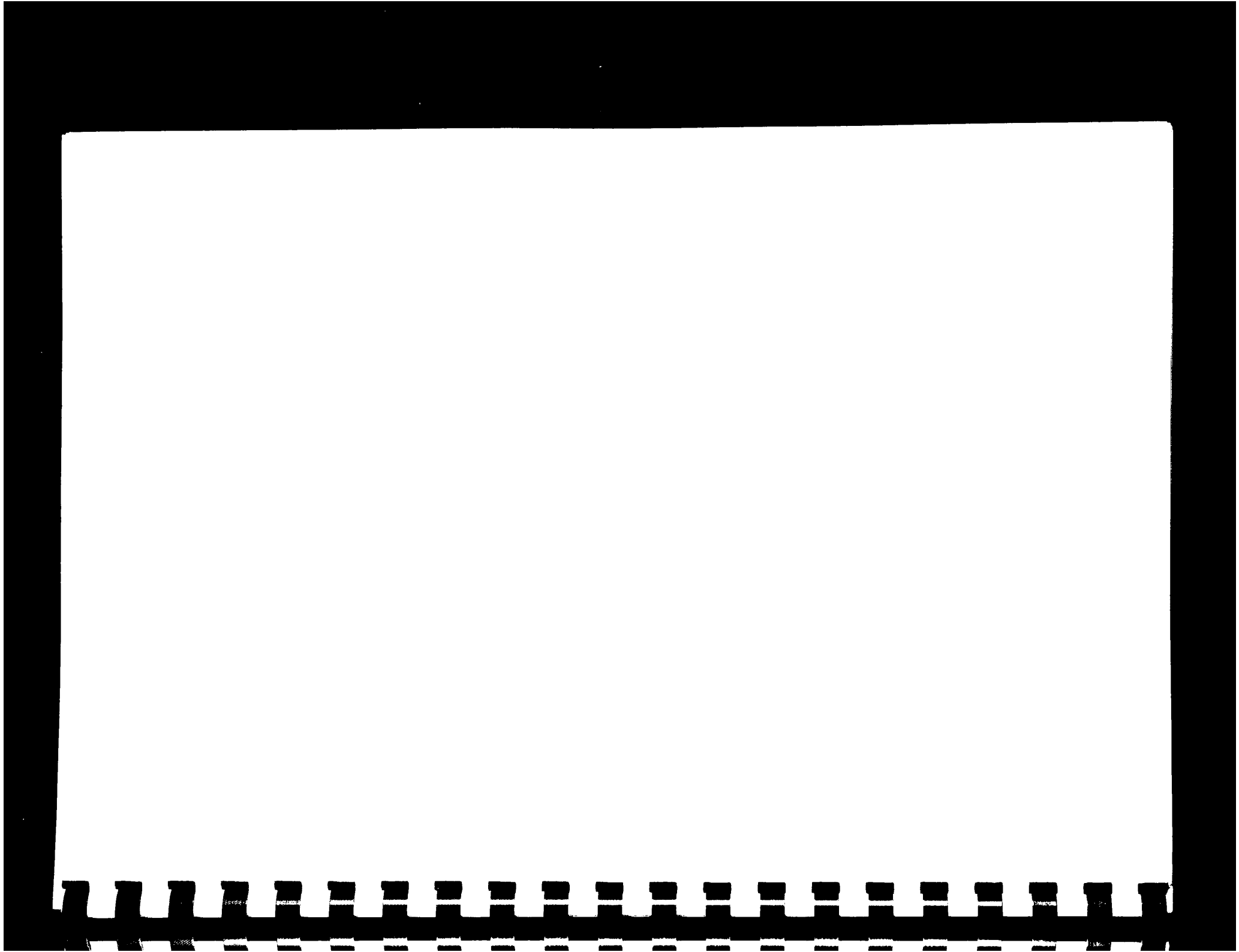
The high psychiatric morbidity among homeless people is recognised and will continue to require efforts in particular from the Community Psychiatric Nursing Service and from GPs. It is estimated that 50% of referrals to the Community Psychiatric Nursing Service come from GPs and there are psychiatric out-patient facilities in the community eg Central Manchester hold 6 out-patient clinics in Health Centres.

(x) The Elderly (including the Elderly Mentally Infirm (EMI)

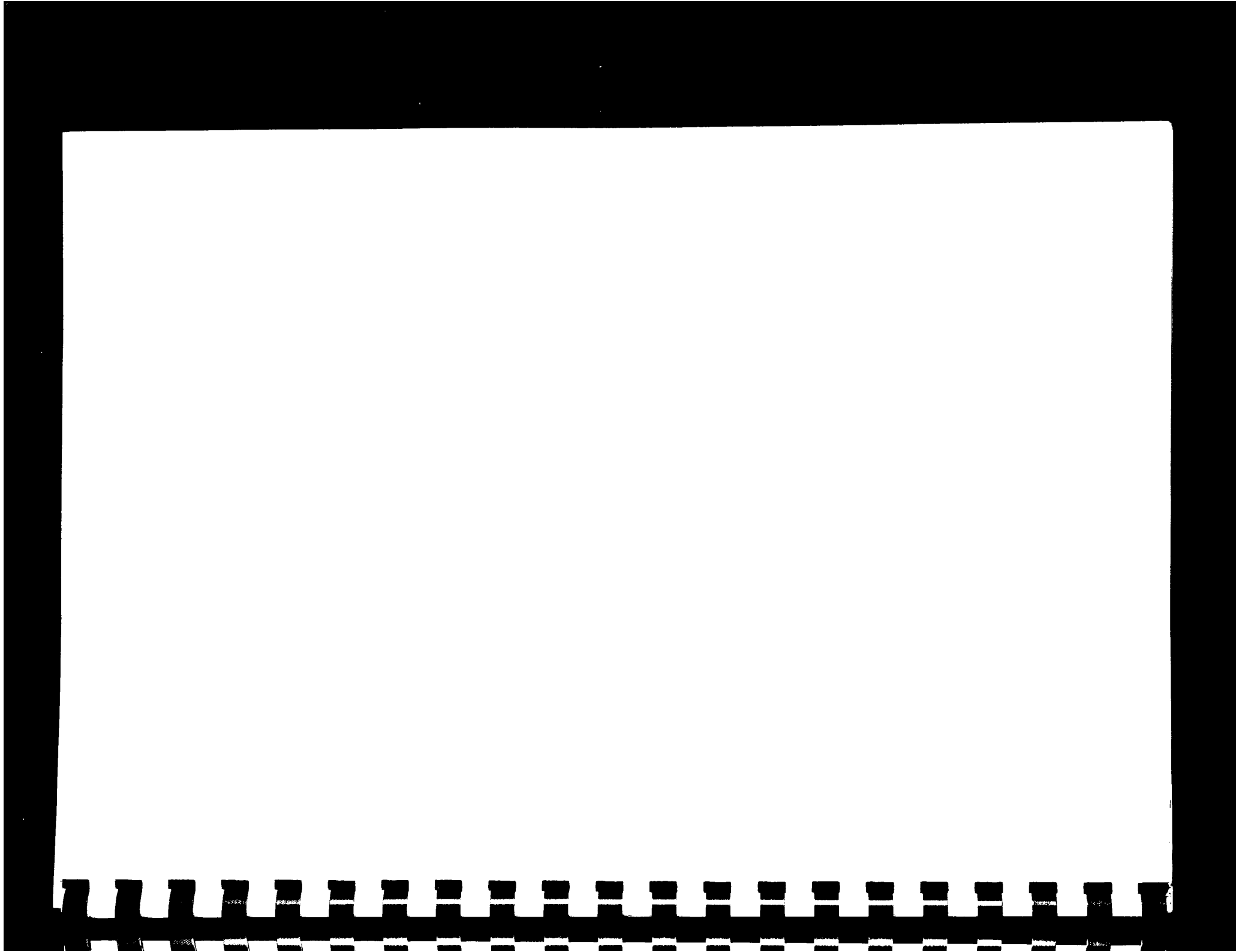
All demographic projections point to a very significant increase in the elderly population of the remainder of the century particularly in the 85 and above age group. Publications such as 'The Rising Tide' and 'Growing Older' seek to provide strategies for coping with this phenomenon and it will be paramount for the FPC to collaborate closely with all affected bodies on this issue. North Manchester has recently initiated EMI out-patient clinics and Central carry out home assessments of all referred EMI patients. The latter Authority is also experimenting with a scheme involving clinic sessions for referred elderly patients.



	Item	1986/7	1987/8	Progress Report/Comments
6	**Collaboration** Nottinghamshire FPC, places great emphasis on collaboration with other health care organisations. The following objectives reflect the FPC's desire for continued co-operation with those organisations in developing comprehensive information on services available and required, eliminating unnecessary duplication of services, and improving the effectiveness of service delivery. The FPC will also promote research on public opinion of FPS which, together with that on General Medical Services, will be used to gauge those areas where changes in services are desired.			
6.1	The FPC will consult Community Health Councils (CHCs), to obtain their assistance in identifying under or over provision of services, difficulties of access, and the quality of care	*	*	This work will link with the proposals made elsewhere in the Annual Programme for the identification of public opinion of FPS and the Survey of General Practice.
6.2	The FPC will seek to persuade the Minister that FPCs should also be the subject of joint funding arrangements and that transfer of resources should take place when patients are discharged from 'inappropriate' hospital care to community care.	*		The FPC has submitted its views to the society of FPCs with a view to ensuring the FPC's greater participation in Joint consultative Committees.
6.3	The FPC, in consultation with LRCs, Nottingham University, CHCs, and other	*	*	Discussions are underway with the University, and it is intended that a



	Item	1986/7	1987/8	Progress Report/Comments
	Collaboration (Continued)			
	interested bodies, will undertake research to identify public expectation of FPS and desired levels and methods of service provision for the future.			submission to the DHSS for assistance in funding this research will be made within the next six months.
6.4	The FPC will co-operate with DHAs in the implementation of a cervical cytology call and recall system during 1986 as and when the DHA computing equipment becomes available.	*	*	A call and recall service will be implemented for Nottingham DHA in September 1986. A service to Central Nottinghamshire and Bassetlaw DHAs will be introduced shortly thereafter.
6.5	The FPC will examin, together with the three DHAs, the possibility of basing a vaccination and immunisation system on the FPCs computerised register.	*	*	Agreement in principle has been reached with the three DHAs, and work has already taken place on the writing of suitable computer software.
6.6	The FPC will collaborate with the LRCs and DHAs in the extension and improvement of appropriate screening facilities.	*	*	Preliminary discussions have taken place but it is not anticipated that significant progress will be made until 1987/8.
6.7	The FPC will seek to establish closer links with District Councils over the processing of applications for planning permission by FPC contractors.		*	The level of co-operation has improved markedly following discussions with LAs.
6.8	The FPC will consult with the three DHAs over the possibility of locating additional community psychiatric nurses within Primary Care Teams and the publicising of existing services provided by community psychiatric nurses.	*	*	Consultations are given additional impetus by the likelihood that two major psychiatric hospitals will be closing in the next 2/3 years.
6.9	The FPC and LMC, will collaborate with the central Nottinghamshire DHA in the development of community hospitals and services.	*	*	Preliminary discussions have taken place in response to Central Nottinghamshire DHA's recently published Strategy.



Item	1986/87	1987/88	Progress Reports/Comments
Collaboration (Continued)			
6.10 The FPC will continue to collaborate closely with the Newark Constituency Group of the LMC, and the Central Nottinghamshire DHA, over the provision of hospital and community services in Newark. Services in the remainder of the county will also be reviewed in the longer term.	*	*	Detailed discussions are continuing and it is envisaged that a programme for the development of the services will be available in the forthcoming year.
6.11 The FPC will commence discussions with the LMC and DHAs with a view to extending and improving health promotion facilities in general practice premises.	*	*	Initial discussions have indicated the Joint desire to develop improved health promotion facilities in general practice. Positive proposals will be develo[ped in the next year.
6.12 The FPC will seek to collaborate with the Nottinghamshire County Council Social Services Deparment on joint planning and the provision of joint services.	*	*	Collaboration is already taking place via the Joint Consultative Committee mechanism, and between officers on a frequent basis.
6.13 The FPC will arrange discussions with the LMC and Bassetlaw DHA, to consider the level of clinical psychology and education psychology services provided to GPs.	*		
6.14 The FPC will seek to obtain finance in order to introduce a new post, the purpose of which would be to research the implications upon the FPC and its contractors of proposals in Nottinghamshire for 'Care in the Community'.	*	*	The FPC seeks to appoint an evaluation and Development Officer, whose duties would include research in the field of Mental Illness and Mental Handicapped Services, and to foster collaboration in the planning of these services. The matter will be raised at the next meetings of the Joint Consultative Committees.