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THE CONCERNS OF FAMILY PRACTITIONER COMMITTEES

A Preliminary Analysis of FPC Annual Programmes for 1985-86

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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.

Objectives and Priorities

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.

Deputising Services

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.

INTRODUCTION

Family practitioner committees (FPCs) attained independent status on 1 April 1985, and became directly accountable to the Secretary of State. The Department of Health and Social Security (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. The King's Fund Institute agreed with the DHSS that it would undertake some preliminary analysis of the annual programmes for 1985-86 of the 90 FPCs in England.

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 general dental services (GDS). We approached the task of analysis by selecting - to begin with - two topics of interest and examining the content of the 87 available annual programmes on each of them. First, we looked at the general, and central, issue of objectives and priorities for the FPC and family practitioner services. Secondly, we chose, as an example of the concerns of general medical services, the topic of deputising services.

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.

THE FORMULATION AND PRESENTATION OF OBJECTIVES AND PRIORITIES

The setting of objectives is a crucial factor in FPCs' participation in NHS planning and in their direct accountability to the Secretary of State. FPC annual programmes and five yearly profile and strategy statements are key documents in the accountability process, which comprises annual scrutinies and

periodic performance reviews. In this context, the annual programme 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).

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, concealed within the description of services, or 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 (see Appendix 1). 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 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; and 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 availability of service, 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 administration 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 management and administration. 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.

DEPUTISING SERVICES

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, para 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 (see Appendix 1).

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.

This preliminary analysis of the 1985-86 documents has considered the extent to which FPCs met the requirements of DHSS circulars in the content of their annual programmes on the topics of objectives and priorities and deputising services. After further analysis of a range of topics in the annual programmes for the years 1985-86 and 1986-87, we hope to set the concerns of FPCs in the wider context of primary health care.

DP2/sb

EXAMPLES OF GOOD PRACTICE

Cheshire FPC's Criteria foruse of Deputising Services

APPENDIX 1

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 Deputising 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 to greater use.

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

7.0 p.m. on Weekdays to 8.0 a.m. the following morning and from
1.0 p.m. on Saturdays to 8.0 a.m. on the following Monday morning.

Signed .....

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.....

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Date .....

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 orgnised 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 Water 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 and 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 made 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.

6.4.11 **To monitor the use of the Emergency Dental Service and develop it as necessary:-**

(a) By devising, with the DDO, a questionnaire to be completed by or on behalf of patients attending Emergency Dental Service sessions in order to ascertain the effectiveness of the publicity given to the Service, whether they had attempted to contact their own dentist and, if so, with what result, whether they attend a dentist regularly and any other information which might be useful.

(b) By ascertaining how many patients were treated by their own dentists at times when the Emergency Dental Service was in operation.

(c) By ascertaining how many patients attend dentists in an emergency immediately after a holiday weekend when the Emergency Dental Service was in operation and to find out why they did not use the Service.

(d) By ascertaining how many patients attended dentists in an emergency immediately after weekends when the Emergency Dental Service was not in operation and find out whether they would have been prepared to use the Service had it been available.

(e) By ascertaining how many Calderdale patients attend the Dental Hospital at Leeds in an emergency and why.