NHS REVIEW WORKING PAPER (8)

IMPLICATIONS FOR FAMILY PRACTITIONER COMMITTEES

Foreword

This paper is number 8 in a series of eight working papers following the Review of the NHS. Other papers are:

1. Self-governing Hospitals
2. Funding and Contracts for Hospital Services
3. Practice Budgets for General Medical Practitioners
4. Indicative Prescribing Budgets for General Medical Practitioners
5. Capital Charges
6. Medical Audit
7. NHS Consultants: Appointments, Contracts and Distinction Awards

These papers describe in greater detail how particular proposals in the White Paper "Working for Patients" (Cm 555) will be implemented, and will form the basis of further discussions with interested parties. Many of the White Paper proposals will depend on primary legislation. The Government intends to complete discussions on any such matter by May 1989 to enable preparation of the necessary legislation.

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Summary

This paper deals with the following aspects:

SECTION 1	(paragraphs 1.1 - 1.5)	Change in membership of FPCs
SECTION 2	(paragraphs 2.1 - 2.7)	Appointment of chief executives
SECTION 3	(paragraphs 3.1 - 3.10)	The chain of command
SECTION 4	(paragraphs 4.1 - 4.8)	Implementation

IMPLICATIONS FOR FAMILY PRACTITIONER COMMITTEES

Introduction

Prior to 1985, FPCs played little part in the planning, development and monitoring of the provision of Family Practitioner Services. In April 1985, however, FPCs became fully responsible for the planning and management of these services, including the level and quality of provision and the monitoring and enforcement of standards. In "Promoting Better Health" the Government recognised the generally substantial progress which FPCs had made towards establishing managerial control over the services for which they are responsible and made it clear that they intended to extend their responsibilities and to strengthen their management role in a variety of ways (see Chapter 10 of "Promoting Better Health").

In the White Paper, "Working for Patients", the Government further demonstrated its confidence in the managerial potential of FPCs by giving them a number of additional tasks, including oversight of the introduction of:

- indicative prescribing budgets for general practitioners;

- GP practice budgets for certain practices;

- medical audit;

- information technology to facilitate monitoring of GP prescribing and referral rates.

The Government also made clear in Chapter 7 of "Working for Patients" that, in order to enable FPCs to undertake these additional tasks effectively, certain changes to the structure, management and line of accountability of FPCs were necessary.

The key changes are:

- to slim down the size of FPCs so that they are better placed effectively to discharge their additional managerial responsibilities;

- to appoint chief executives to ensure the effective introduction of the changes set out in both the Primary Care and NHS White Papers;

- to change the line of accountability of FPCs from the Department of Health to the Regional Health Authorities.

This paper, therefore, deals with each of these key topics in turn.

SECTION 1 : CHANGES IN MEMBERSHIP

1.1 The NHS Review White Paper sets out the Government's intention to legislate for a change in the composition of FPCs so that they can discharge their responsibilities, including those which they are now to acquire, in a more business-like way.

1.2 Each will have 11 members. The Secretary of State will, as now, appoint the Chairmen. RHAs will appoint the other members and in the case of professional members will seek nominations from local representative committees and other professional bodies. Under the legislation to be introduced, the terms of office of existing members will expire, but there will be a measure of continuity among the lay members. The legislation will provide for Chairmen and members to be appointed for up to four years so that terms of office may be staggered.

1.3 Over the years the Department has laid down requirements for FPCs to set up sub-committees for particular purposes. Some of these will clearly still be needed (for example, the Service Committees which look at patients' complaints), and the White Paper requires FPCs to set up Medical Audit Committees to help with the development of procedures in this new field for FPCs. But it is the intention that FPCs should otherwise be free to determine their own committee structures in order to discharge effectively both their continuing and their new responsibilities. The way in which the committee structure adopted enables each FPC to perform effectively will of course be a matter considered during the performance reviews discussed in paragraph 3.7 below.

FPCs will be able to co-opt members to sub-committees as necessary, provided that (save for Service and Medical Audit Advisory Committees) there is a clear majority of lay members.

1.4 Service Committees, which deal with complaints that practitioners have breached their contracts, will continue to be formed in accordance with the NHS (Service Committees and Tribunals) Regulations 1974; ie there will be parity of lay and professional membership under a lay chairman.

1.5 The Medical Audit Advisory Committee (see Working Paper 6) will have a majority of professional members.

SECTION 2 : APPOINTMENT OF CHIEF EXECUTIVES

2.1 The White Paper announced the creation of chief executive posts. The post will be completely new and the appointee will be known as General Manager. He or she will be charged with the management of the changes set out in both "Working for Patients" and "Promoting Better Health". The General Manager will be

responsible for the efficient management of the administrative affairs of the FPC, and will have further responsibilities including:

- preparing for the transition to the reconstituted FPC, including the development of a management structure to enable it to perform its total responsibilities as now envisaged;

- implementing policies to bring about service development, including the monitoring and review of the family practitioner services;

- controlling and targeting new cash-limited budgets for the improvement of general practitioners' premises and for primary care teams;

- instituting, controlling and monitoring of the indicative prescribing budgets for general practitioners (as set out in Working Paper 4);

- managing FPC professional staff (eg dental practice advisers, independent medical advisers).

Subject to the passing of the necessary legislation, the General Manager will become a member of the reconstituted Family Practitioner Committee.

2.2 The new posts will be filled by open competition and will be advertised widely within and outside the NHS. Existing Administrators will be free to apply.

2.3 The new General Managers will play a key role in preparing for the transition to the reconstituted FPCs and in establishing the means for taking on the additional functions. They will therefore be appointed during 1989, and FPCs will be provided with the additional resources required. This will of course mean that they will be appointed during the lifetime of the existing FPCs, and will need to establish the key features of the new arrangements while maintaining and developing the FPC's present responsibilities. To facilitate this dual role the Government proposes that:

- the Chairman and lay members of the present FPC, together with a person appointed by the RHA Chairman, should draw up a short-list for the RHA to approve;

- a short-listing panel will then be responsible for interviewing and making the final selection, subject to prior approval by the NHS Management Executive.

2.4 The pay and conditions of service of General Managers will follow those of General Managers in health authorities and will be based on rolling short-term contracts. The NHS Management Executive will have discussions with FPC and RHA management before deciding on the final details of the eventual General Manager package.

2.5 The posts will carry enhanced remuneration to reflect the important new responsibilities. Performance-related pay and individual performance review will be key elements of the package. When the reconstituted FPCs are accountable to RHAs, the "grandparent" for the General Manager (ie for purposes of counter-signing assessment of performance) will be the Regional

General Manager in consultation with the Regional Chairman. If someone is required to act in this role in the meantime, he could be either:

- one FPC Chairman in each Region, with a substitute Chairman nominated to act as "grandparent" for that Chairman's own General Manager, or

- the Regional General Manager in consultation with the Regional Chairman.

2.6 Management will need to be strengthened at all levels of the reconstituted FPCs to carry out the new tasks. The appointment of General Managers is an essential first step in that process, but the Government will consider the extent to which the existing NHS senior management arrangements should apply to other FPC management posts.

2.7 Existing Administrators who are not appointed to General Manager posts will be eligible for protection of their existing salary scale and conditions of service in the normal way. If no place is found for the present holder of that post in the revised management structure, the RHA will be expected to assist him or her in finding a suitable alternative post in the NHS. The usual provisions regarding redundancy and superannuation will otherwise be available.

SECTION 3 : THE CHAIN OF COMMAND

3.1 "Working for Patients" sets out the Government's intention to legislate for FPCs to become directly accountable to RHAs instead of, as at present, to the Department.

Central management of the NHS

3.2 The White Paper makes clear that the management of the FPS will be the responsibility of the NHS Management Executive. Present liaison functions as regards health authorities and FPCs will be integrated.

3.3 The Management Executive will be responsible for:

- guidance on implementation of policy;
- major operational guidance;
- information strategy;
- central development of information technology;
- allocating to RHAs funds for the FPS in the Region, including revenue and capital for FPC administration, cash-limited funds for the development of GP premises and practice teams, budgets for GP practices and indicative drug budgets.

Role of RHAs

3.4 The functions for which RHAs will become responsible include:

- appointing FPC members;
- allocating funds to FPCs;

- monitoring plans, co-ordinated with those of the DHAs;

- reviewing the performance of FPCs.

3.5 Management of family practitioner services is a new role for RHAs and they will need to be prepared for it. To help them in this, one of their members will in future be an FPC Chairman, but they will also need to ensure that a clear responsibility lies at senior management level for carrying out their new functions. They will also need to review their advisory machinery to ensure that it covers primary health care adequately.

Managing the transition

3.6 RHAs will need to liaise with the NHS Management Executive in the period before they become directly responsible for FPCs. They should identify as soon as possible a senior officer whose responsibility this will be. Among his or her early tasks will be establishing links with:

- the Management Executive's liaison officer for the FPCs in
- the Region;

the Administrator (and General Manager when appointed) of those FPCs.

3.7 The present position of FPCs in regard to the allocation of resources, planning and monitoring of performance is as follows:

Resources. FPC administrative allocations for 1989/90 were issued in January 1989 (representing a real terms increase of just under 10 per cent, in addition to a real terms increase of about 6 per cent in 1988/89). Separate cash-limited sums for the development of GPs' premises and

practice teams will be issued later this year. Capital, almost exclusively used for the acquisition of office premises for FPCs whose leases expire, is at present centrally administered on a basis of a published 3-year rolling programme.

Operational Planning. An operational planning cycle has been established for FPCs. Compatible with the existing HCHS system, it is based on the preparation of 2-year rolling operational plans to the following broad timetable:

- September : provisional plan submitted - Departmental comments

- January : the Department announces resources and resource assumptions

- March : provisional plans firmed up

- June : out-turn report for the previous year.

FPCs are required to consult DHAs when drawing up their plans.

Performance Reviews. Each FPC's performance is reviewed every year. The nature of the review is decided by the Department and may range from an exchange of correspondence to a formal review conducted either at the FPC offices or in the Department's Headquarters. Every FPC has a full-scale performance review every four years, conducted either by a Minister or by a senior official. Performance reviews are based on:

- a health "profile" of the population;

- performance indicators;

- operational plans;

- a report on the achievement of previous objectives.

3.8 RHAs should already have copies of each FPC's strategic and operational plans. As soon as an RHA contact is notified, the Department will routinely copy to him or her all correspondence relating to FPCs' plans, and FPCs will be expected to do the same. RHAs will be asked to offer comments at the different planning stages set out above.

3.9 RHA representatives should attend the full-scale (ie the 4-yearly) FPC performance reviews, as observers. They should become involved in the intermediate performance reviews as soon as possible.

3.10 Regardless of the extent and pace of RHA involvement in FPC plans and performance reviews, the Government expects RHAs to step up their efforts to secure maximum collaboration between DHAs and FPCs. This is essential for the carrying out of present responsibilities and will become even more important as the FPC's role is enhanced with the implementation of the Primary Care White Paper, not to mention the substantial further changes set out in the NHS Review White Paper.

SECTION 4: IMPLEMENTATION

Changes in membership

4.1 The Department will identify what changes are needed in primary and secondary legislation, in order to secure the changes in membership and committee structure set out in Phase 2 of the programme for reform.

4.2 Information held by the Department on appointments of members of FPCs will be passed to RHAs.

Contact point for enquiries:

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Appointment of chief executives

4.3 RHAs and FPC management will be consulted on the details of a package of remuneration, conditions of service and contractual arrangements for general managers of FPCs.

4.4 Guidance will be issued on the procedures to be followed for advertisement, recruitment, selection and appointment.

4.5 The aim is to have general managers in post in every FPC by the end of the calendar year 1989 at the latest.

4.6 Guidance will also be issued during the year on the strengthening of senior and middle management.

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Chain of command

4.7 The legislative changes needed to secure the transfer of accountability from the Department to RHAs in 1990 will be identified and put in hand.

4.8 Decisions will take place with RHA and FPC management as soon as possible on the necessary arrangements, both permanent and transitional. Resultant guidance, covering operational planning and performance reviews, will be issued to all authorities.

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