



Building the Way Forward in Primary Care

Summary of Responses
to the Consultation
September 2001

Department of Health, Social Services and Public Safety
An Roinn Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

BUILDING THE WAY FORWARD IN PRIMARY CARE

SUMMARY OF RESPONSES TO THE CONSULTATION



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Building the Way Forward in Primary Care

SECTION 1

Introduction

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- 1.1** On 11 December 2000, Ms Bairbre de Brún, Minister for Health, Social Services and Public Safety, published the consultation paper *Building the Way Forward in Primary Care*. The paper set out proposals for new arrangements in primary care to be put in place after the GP Fundholding Scheme ends, and for a policy framework to improve the delivery of primary care services.
- 1.2** The consultation period was initially scheduled to end on 2 March 2001, but was extended until 30 March 2001. A total of 190 responses to the consultation paper were received from a cross-section of organisations and individuals, including voluntary and community bodies, political parties, local councils, trade unions, professional bodies, primary care professionals, Health and Social Services Boards and Trusts, and Health and Social Services Councils. A full list of those who responded is at Annex 1.
- 1.3** Almost 15,000 copies of the consultation paper were issued. Over 400 callers contacted the special telephone helpline which

operated during the consultation period, mostly to request copies of the paper, and nearly 100 E-mail messages were received. There were 21 requests for the consultation paper in languages other than English.

- 1.4** Many people took up the offer to meet officials from the Department to discuss the contents of the paper. During the consultation period staff from the Department were involved in over 50 meetings, seminars and workshops with individuals and interested groups to give presentations and discuss issues surrounding the consultation paper.
- 1.5** The Department commissioned two organisations to assist with the consultation exercise. The Institute of Health Care Management organised four participative half-day consultation workshops held in different areas over a two-week period in February 2001. A wide range of participants, including Family Health Services practitioners, nurses, practice staff and representatives from both Trusts and Health and Social Services Boards, attended the workshops. A report giving feedback from the workshops was submitted as a response to the consultation exercise.

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- 1.6** The Community Development and Health Network prepared its own summary of the consultation paper, which it circulated to community and voluntary sector bodies. The comments received were incorporated in the organisation's response.
- 1.7** In keeping with the commitment given in the consultation paper to make special effort to obtain views from groups representing categories identified in the equality legislation, over 40 organisations were contacted and offered help to facilitate their responses. Some sought clarification on specific issues, while others availed of the offer of more direct assistance. Departmental officials attended workshops to present and discuss issues.
- 1.8** The Department wishes to thank all those individuals and organisations who submitted responses. These have all been carefully considered and are summarised in this report. As it is impossible to reflect all of the views expressed, the report focuses on the key messages and common themes which emerged from the consultation responses.
- 1.9** A copy of any response on the list in Annex 1 may be obtained by contacting the address, telephone number or E-mail address below. Requests for additional copies of this report, including alternative and other language versions, should also be directed to the address below. This document is also available on the Department's website at www.dhsspsni.gov.uk/publications/
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- 1.10** The next section of this report highlights a number of the recurring themes that emerged from the consultation. Thereafter, each section of the report deals in turn with responses to the main issues raised in the consultation paper.



SECTION 2

Overview

2.1 The responses to *Building the Way Forward in Primary Care* represented a diverse range of interests. This section highlights some of the recurring themes which emerged from the consultation responses.

2.2 There was broad support for the vision and principles proposed to guide the changes and for the functions outlined for primary care.

2.3 There was general agreement on the need for the development of primary care to provide a quality service to meet the growing demands on this sector of the health and personal social services, for a more integrated approach to the planning and delivery of services, including the involvement of local communities, and for a strong primary care influence in the commissioning of services.

2.4 While a number of respondents felt that the proposals should have been more radical, there was broad support for the proposed structure for primary care, particularly the commitment to foster closer co-operation between primary care professionals. This support was often qualified, particularly in relation to lines of accountability, funding and timetabling, on which there was disappointment expressed about a lack of detail. There was some opposition to Local Health and Social Care Groups being constituted as committees of Health and Social Services Boards. It was felt in some quarters that this might inhibit their independence and progress. The prospect of practice budgets being devolved to multi-professional Groups was of particular concern to GPs and their representative bodies.

2.5 A significant number of respondents suggested that the future of primary care could not be decided in isolation and must take account of the outcome of the Acute Hospitals Review and the consultation on *Investing for Health*.

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- 2.6** There were many calls for additional financial resources to be made available to primary care and disappointment that the new arrangements were to be introduced within existing funding.
- 2.7** There were concerns expressed about the transition to the new arrangements, particularly in relation to the human resource implications. Many respondents agreed that the implementation of new arrangements in primary care would have to be supported by a training and development programme.



SECTION 3

Vision and Principles

Consultation paper

The consultation paper states that primary care should work in close partnership with all other parts of the health and social services in a seamless system of care and provide convenient, accessible and high quality care to people in their own communities. It proposes that new arrangements in primary care should:

- focus on improving services for service users;
- promote equity of access and service quality;
- be based on partnership within and beyond the health and social services;
- adopt a locality-based approach to needs assessment and service delivery;
- have a strong input from local communities and service users;
- minimise bureaucracy and reduce administrative costs; and
- have clear, simple lines of accountability.

Issues for Consultation

Comments were invited on the above principles and the following questions posed:

- *Are they appropriate for primary care?*
- *Are there any others which should be included?*
- *Should any relative priority be given to these principles, or any other principles, in developing new arrangements in primary care?*

Responses

3.1 Respondents mostly agreed with the proposed principles, particularly partnership working and the reference in the paper to the need to break down traditional lines of demarcation between the different professions. Some questioned the ability of the service to respond to this innovation and others expressed disappointment that a “primary care-centred service” was not an established principle within the document.

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3.2 A range of other principles were suggested for inclusion:

- addressing health inequalities through, for example, the Targeting Health and Social Need, Equality and Human Rights agendas;
- improving communication and information sharing, particularly between the primary and secondary care sectors;
- promoting continuity of care;
- maximising the potential of integrated health and social services;
- ensuring value for money;
- creating a joined-up, cohesive approach to the delivery of services;
- centering primary care around patient needs;
- linking primary care with public health;
- reinforcing locality based commissioning;
- empowering local communities;

- providing high quality management and supporting an open learning culture;
- promoting evidence based practice and public service values; and
- providing equal access to funding by primary and secondary care.

3.3 On the question of whether any priority should be given to the principles listed in the paper, a number of respondents considered that “improving services” was the most important. Others felt that “equity of access and service quality” would be their top priority, while accountability, minimising bureaucracy and preventing ill health also featured. A number of respondents commented that all of the principles were inter-related and of equal importance and that they could not be prioritised.



SECTION 4

Functions

Consultation paper

The following core functions were proposed for primary care:

- to deliver high quality primary care services;
- to promote the health and wellbeing of local populations;
- to target health and social need and to tackle inequalities; and
- to contribute to the planning and commissioning of health and social services for local populations.

Issues for Consultation

Comments were invited on these proposed core functions and the following questions posed:

- *Do they adequately cover the main functions of primary care and provide a basis for developing new arrangements?*
- *Do any other issues need to be included?*
- *Should any relative priority be given to these, or any other functions?*

Responses

4.1 There was strong support for the main functions outlined for primary care, though some respondents referred to a lack of detail. There was criticism about the absence of any reference to the contribution made to primary care by voluntary and community groups and by carers. Several respondents suggested that the commissioning function needed to reflect a stronger role for primary care than merely to “contribute”.

4.2 Other functions for primary care suggested by respondents referred to:

- the gatekeeper to secondary care role of primary care professionals;
- development and delivery of a primary care investment plan;
- advocacy on behalf of patients and clients;
- training and development;
- health promotion and education;
- the statutory functions associated with the provision of community care;

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- locality based needs assessment and matching resources with local priorities;
- auditing and evaluation of services; and
- the maintenance of effective patient and client-centred services across primary and secondary care.

4.3 A small number of respondents listed functions which they considered to be a priority. For the most part, it was felt that the delivery of high quality primary care services should be the main priority, though others mentioned commissioning and the prevention of ill health. It was suggested that the first function listed in the paper should be amended to read “to deliver relevant and affordable high quality primary care services”. One respondent commented that priorities would be determined by targeting those functions that deliver the maximum health gain from the limited funds available.



SECTION 5

Proposed Approach

Consultation Paper

The paper set out a number of approaches which were considered for new arrangements in primary care, namely:

1. **Returning to the arrangements that existed before the introduction of the GP Fundholding Scheme.**
2. **The introduction of the proposals previously published in the document *Fit for the Future: A New Approach*.**
3. **Multi-professional Local Health and Social Care Groups without devolved budgets for commissioning services.**
4. **Multi-professional Local Health and Social Care Groups progressively receiving budgets devolved from Health and Social Services Boards for the purposes of commissioning services for the populations they served.**
5. **Local Health and Social Care Groups which would be linked to Health and Social Services Trusts that provide community services.**

The proposed approach was the model described at 3 above, evolving to the model at 4.

Issues for Consultation

Respondents were asked if they agreed with the proposed approach.

Responses

- 5.1 Only a few respondents categorically opposed the approach proposed in the paper, but many who agreed with it did so with qualification and concern.
- 5.2 A few respondents expressed the view that it would not deliver the vision and principles outlined in the paper, particularly on minimising bureaucracy and reducing administrative costs. Others felt the approach did not go far enough or address fundamental flaws in the current system, or give a commitment to provide a primary care-centred service.
- 5.3 A few respondents described model 3 as a backward step for those in general practice with experience of commissioning. They also suggested that model 4 should be the immediate aim for most Groups, with model 3 used only as a fallback for those who had no commissioning experience.

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- 5.4** There was concern from some respondents that Local Health and Social Care Groups would not be allowed to progress beyond model 3 or that they would not have a sufficient level of influence if constituted as committees of Health and Social Services Boards. There were fears about the degree of control and influence that Health and Social Services Boards would have over Groups. One respondent stressed the importance of the new organisations being free to deliver change without undue bureaucracy and interference from Boards.
- 5.5** Many respondents were content to support model 3 as a starting point, provided there was a clear timetable and agreed criteria for progression. Others suggested that model 4 should not be the final stage of development for Groups, but rather an interim arrangement before progressing to a more autonomous status resembling the arrangements described in *Fit for the Future: A New Approach*. A few respondents expressed a preference for model 3 only, without the option of progression to model 4, until a clearer picture emerged of the shape of the wider health and personal social services in the future.
- 5.6** Comments in support of the proposed approach referred to it as being the only feasible option and representing a sensible balance between the need for change and the need to minimise upheaval, at a time of structural uncertainty for the service as a whole.
- 5.7** A few respondents expressed support for a merging or combination of model 3 and 4, with the latter being the norm.
- 5.8** The most common areas on which there were calls for clarity or more detail related to funding, accountability and a timetable for progression to model 4. There were similar calls for clarity concerning the statutory functions currently carried out by Trusts in the context of commissioning of services by Local Health and Social Care Groups.
- 5.9** Two of the other models attracted support, particularly model 5 which envisaged Local Health and Social Care Groups being linked to Health and Social Services Trusts. Comments from those supporting model 5 said it had been too lightly dismissed, was deserving of greater consideration and should have been argued more vigorously and in greater detail. Some respondents felt that model 3 and 4 would naturally

progress towards model 5 and drew comparisons with the development of Primary Care Trusts in England.



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- 5.10** Model 2 *Fit for the Future: A New Approach* also found support, with some feeling that the consultation paper had ignored the widespread support for the arrangements proposed in that document. Some argued that there was a need to press ahead with radical changes to health and social services structures, even in advance of the planned wider review of public administration. They felt that this review should not be used to prevent implementation of the model set out in *Fit for the Future: A New Approach*.

SECTION 6

Population Coverage

Consultation Paper

The paper envisaged that the actual population coverage would vary according to local geography and demography and suggested that a range of population coverage between 50,000 to 150,000 may be appropriate. GP practice populations would be a natural starting point for the development of Groups and areas covered should represent natural communities. The size of the area and population that Local Health and Social Care Groups would serve would be determined locally by Health and Social Services Boards, in consultation with Family Health Services practitioners, Trusts and local communities.

Issues for Consultation

The following questions were posed:

- *What would be an appropriate population coverage for Local Health and Social Care Groups?*
- *How should population coverage for Local Health and Social Care Groups be decided?*

Responses

- 6.1** Many respondents did not specify a figure for population coverage. Of those who did, the vast majority agreed with the 50,000 to 150,000 range proposed in the consultation paper. One respondent advocated a figure of over 200,000, while a few felt that anything over 10,000 would result in a loss of local focus. The opposite view was also expressed by another group of respondents, namely that a population towards the top of the suggested range would be more appropriate if management costs were to be used effectively and a multiplicity of Groups avoided. Some respondents recommended that all Groups should be equal in size to ensure equity of influence.
- 6.2** Concerns were expressed about the robustness of the capitation formula for allocating budgets to smaller Groups, as well as the technical difficulties in calculating budgets and maintaining administrative support.

6.3 There was considerable agreement among respondents that population coverage should:

- be based on GP practice lists;
- encompass natural communities/areas that make sense to people;
- take account of the functions of Groups;
- be co-terminous with other organisations such as Community Trusts and District Councils; and
- take account of local geography and demography.

6.4 Respondents also listed a number of other factors which they felt were important in deciding population coverage:

- economies of scale;
- population density;
- value for money;
- sociological boundaries;
- accessibility; and
- the capacity of practices to work together.

6.5 Many respondents stressed the need for stakeholder and local community involvement in determining the shape and make-up of the new Groups. Some respondents suggested that Groups should self-select and expressed concern about the prospect of configurations being imposed by Health and Social Services Boards.

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SECTION 7

Constitution, Accountability and Governance

Consultation Paper

The consultation paper proposed that Local Health and Social Care Groups would be committees of their local Health and Social Services Board. A Chairperson of the Group, elected from among its members, would be accountable through the Board's Chief Executive to its parent Board for the activities of and resources used by the Group. A Management Board, whose membership would be drawn from representatives of primary care professionals, community and service users and representatives of Health and Social Services Boards and Trusts, would run the Group. All professionals should feel that they had equal status.

Issues for consultation

The following questions were posed:

- *Are the proposed lines of accountability sufficiently robust?*
- *Would such a structure facilitate co-operation between all primary care professionals?*

- *What balance of representation amongst the various interests would be appropriate for the management arrangements for the Local Health and Social Care Groups?*

Responses

7.1 While a number of respondents were content that the accountability arrangements were sufficiently robust for model 3, many felt that there was an absence of detail and a need for clarification about accountability arrangements for model 4 in which budgets for commissioning would be involved. The other main aspects on which respondents called for more detail and clarity concerned:

- the legal requirements of the proposed new model;
- the impact of the proposed new Groups on Health and Social Services Boards' Standing Orders;
- financial reporting arrangements;
- respective roles and responsibilities of Health and Social Services Boards and Trusts; and





- relationships within the Groups and between the Chairs of the Groups and Board Chief Executives.

7.2 Several respondents expressed opposition to Groups being constituted as committees of Health and Social Services Boards, suggesting that Boards could become dominant, be reluctant to devolve authority or hinder the development of local initiatives. Some respondents felt that Groups should be accountable directly to the Department. Others felt that Chairs of the Groups should have a seat and voting rights on Health and Social Services Boards.

7.3 Other comments referred to the desirability of Groups being accountable to the communities they serve, with one respondent commenting that the development of Health and Well-being Improvement Plans would provide a more robust form of accountability open to public scrutiny.

7.4 Many respondents highlighted the need for clear guidance on accountability arrangements.

7.5 In response to the question about whether such a structure would facilitate co-operation between all primary care professionals, some felt

this would depend on the effort put into making the new arrangements work and the perceived ability of the arrangements to deliver results. Some referred to the importance of building trust, sharing knowledge and having a balanced representation on Groups, with members enjoying equal status. It was suggested that co-operation would be facilitated by an improved training policy, which would address historical prejudices. One respondent felt that the structure would facilitate co-operation provided GPs had the right of majority on the Groups.

7.6 The issue of professional representation on the Groups aroused a great deal of interest and comment. A common view expressed was that no one profession should have an overall majority and that all professions should be represented on the Groups, but some feared an unwieldy, cumbersome Management Board structure which would be too large to function properly. It was suggested that the introduction of a two-tier structure, with a Management Board and a series of sub-groups or project boards, might resolve this. A few respondents felt that GPs should be in the majority on the Management Board.

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7.7 Many of the responses from the different professional groups and their representative bodies emphasised their respective contributions to primary care and their strong desire to be fully involved in the new arrangements. The responses from dentists and optometrists and their representative bodies stated that they wanted to be automatically included in the management arrangements of the Groups and have equal status with other members. A similar message came from the other professions. Many respondents endorsed the proposed role for representatives of the community and service users. A significant number of respondents felt that Trust representation should be at a more senior level than care manager or equivalent.

7.8 Some respondents highlighted potential problems in relation to Health and Social Services Boards' existing Standing Orders and the proposed composition of the Management Boards of Groups.

7.9 Most agreed that the composition of the Management Boards of Groups should:

- reflect the range of stakeholders involved;
- reflect the balance and configuration of professions locally;
- reflect the local situation;
- be proportional to the public or patient expectation of who influences their care; and
- reflect the core functions of Groups.

7.10 It was suggested that the Chair and members should be selected on the basis of appropriate competencies rather than by appointment or election. It was also proposed that the Chair should be elected on an annual basis and rotated through the professions.



SECTION 8

Community and User Participation

Consultation Paper

The consultation paper stated that the Management Boards of the proposed new Local Health and Social Care Groups should include community and service user representatives.

Issues for Consultation

Views were invited on how community and user participation in the work of the Local Health and Social Care Groups could best be achieved.

Responses

8.1 The principle of involving community and service users in the new arrangements was welcomed and endorsed by the majority of respondents. Some, however, saw this as one of the most difficult aspects of the new arrangements, on which there would be a need for clear guidance. Some felt there was no one right way to engage the public and that each Group should adopt the method most suited to its circumstances. Some placed emphasis on the need for community and user representatives on Groups' Management Boards to have equal status with other members.

8.2 On the specific question of how their participation might best be achieved, the views which were most commonly expressed were:

- existing community networks and voluntary structures should be used;
- representatives should be selected through the public appointment process;
- Health and Social Services Councils and District Councils could be potential sources of user representation;
- Assembly Members and District Councillors should not be chosen to represent communities and users; and
- the need to draw on the innovative examples of community and user involvement by the existing primary care commissioning pilots.

SECTION 9

Devolution of Budgets

Consultation Paper

It was proposed that, in addition to budgets for administrative expenses, Boards could delegate to Groups budgets for:

- prescribing of medicines and appliances;
- practice staff;
- premises;
- information technology;
- development of primary care services at local level.

It was stated that Groups would also work with Boards in deciding how to use resources for out-of-hours services.

As Groups became established, they would receive devolved budgets from Boards to commission services for the populations they served. Targets could be set for the percentage of the total health and social care budgets for Groups' populations that should be devolved over a set timescale. Progress would also depend on the ability of Groups to take on this role.

Issues for Consultation

The following questions were posed:

- *What kind of budgets should be devolved to Local Health and Social Care Groups?*
- *Are there any particular problems or potential conflicts of interest with the proposals for devolving budgets?*
- *At what pace should budgets for commissioning services be devolved to Local Health and Social Care Groups?*

Responses

- 9.1** While many respondents agreed that the devolution of primary care budgets was a natural starting point, concern was expressed by a number of GPs and GP representative bodies about the implications of devolving practice budgets to multi-professional groups. For some, this was unacceptable. Others argued that, if practice budgets were to be devolved, then GPs would need to have significant representation on Group Management Boards. It was suggested that other professional groups might also bring their budgets to the table for corporate distribution, but generally it was felt that practice budgets would have to be ring-fenced and allocated at practice level.

9.2 With regard to the devolution of budgets for commissioning services, there was a body of opinion which held that budgets for community nursing, professions allied to medicine (PAMs) services and elective services could be devolved to Groups immediately. One respondent expressed the view that the majority of GPs had neither the time nor the interest to become heavily involved in the commissioning process. Some bodies representing the dental profession expressed concern about the arrangements for handling general dental services budgets in the context of local commissioning and devolved budgets. Some Trusts were concerned about what would happen to the statutory functions which were currently devolved to them, with children's services quoted as an example. A number of respondents warned of the dangers of fragmentation in commissioning. The view was expressed that specialist services such as palliative care would need to be protected and that some services would need to be commissioned on a regional basis.

9.3 Generally, respondents foresaw two main problems with the proposals for devolving budgets. The first of these related to the methodology for allocating

resources and budgets to Groups. The other stemmed from concerns that Health and Social Services Boards might be unwilling to devolve budgets and could frustrate the progress of Groups. The view was expressed that Boards should be given very specific and measurable targets for full delegation of commissioning. Some also expressed concerns about probity, and the need for the decision-making process within Groups to be as transparent as possible. A number of respondents saw potential for conflict arising from the involvement of Trusts in the management arrangements of Groups, in that Trust-employed staff in Groups could find themselves in conflict with the interests of the Trust in taking commissioning decisions. There was also thought to be an inherent conflict of interest for Trust staff who might be engaged in the commissioning of services from their own Trust. Those who had expressed opposition to the devolution of practice budgets to Groups also saw this as a source of potential conflict within Groups. One respondent foresaw potential conflicts of interest arising among Group members themselves.

9.4 There were differing views on the pace with which budgets for commissioning services should be devolved to Groups. While some felt that Groups should receive budgets for community nursing, PAMs and elective services from the start, many felt that the process of devolving budgets for commissioning services should be evolutionary, at a pace appropriate to the capacity of Groups and linked to competence demonstrated by them. Many, however, stressed that a clear timetable and criteria for progress would be needed. Others suggested that Groups should be in a position to accept budgets by the end of a two-year period. Another timetable suggested was that two years should be the absolute target for the devolution of full commissioning budgets, and yet another that movement to model 4 should take place over a maximum of 4 years, with devolution of total healthcare budgets within 5 years. Some respondents suggested that Groups with the necessary experience should be permitted to fast track to model 4. It was the view of one respondent that there should be no devolution of budgets for commissioning services until a wider review of the organisational arrangements of Health and Personal Social Services had been carried out.



SECTION 10

Resource Implications

Consultation Paper

The paper explained that the direct cost of administering GP Fundholding and the various primary care commissioning pilots was £7.4m each year. It was proposed that the administrative costs associated with putting in place new arrangements should be capped so that a significant proportion of this total resource could be moved from administration to front line care. These resources would be retained within primary care and made available to Boards to use, in conjunction with Local Health and Social Care Groups, to provide primary care services. It was further proposed that Groups should receive a management allowance of up to £3 per head of population covered. A management allowance of this scale would release up to £2.5m each year to be made available to Boards and Groups for the delivery of primary care services.

Issues for Consultation

The consultation paper posed the following questions:

- *Is it an appropriate strategy to move some of the resources currently used on administration in primary care to front line services?*
- *Is a management allowance for Local Health and Social Care Groups of up to £3 per head of resident population covered appropriate?*

Responses

10.1 While there was some support for the first proposal, many concerns were voiced about the appropriateness of moving management resources from primary care at this time. It was felt that greater, rather than fewer, resources would be required to deliver the agenda outlined in the document. One respondent agreed that while new resources were needed for front line services, additional investment in high quality primary care management was also important. Another commented that effective management and administrative support in primary care should not be seen as merely bureaucracy.

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10.2 The majority of those who commented specifically on the proposed management allowance for Local Health and Social Care Groups felt that £3 per head was unrealistically low and that it would be insufficient, particularly to support model 4. It was suggested by some that a figure closer to £6 would be needed if Groups were to undertake a significant commissioning role. A small number of respondents took the view that a sliding scale approach should be used, based on a weighted capitation formula. A few questioned the linking of the allowance to the funding released by GP Fundholding and felt that the level of the allowance should instead be determined by the functions to be carried out by Groups.



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SECTION 11

Supporting Change

Consultation Paper

The paper acknowledged that putting new primary care arrangements in place would present challenges to all involved. Primary care professionals would start from differing levels of knowledge and expertise in collaborative working arrangements and would not progress at a similar pace. It was proposed that this process would need to be supported by a training and development programme to equip people and organisations for this task and that such a programme would have to be developed in conjunction with all the main parties involved.

Issues for Consultation

The following question was posed:

- *Is it accepted that the implementation of new arrangements in primary care would have to be supported by a training and development programme?*

Responses

11.1 Many respondents agreed that the implementation of new arrangements in primary care would have to be supported by a training and development programme. There was support for the involvement of key stakeholders in developing a training and development programme, although a few respondents commented that the programme should be run by the Groups themselves and not delivered on a centralist basis by the Department. The point was made by a number of respondents that training should be multi-professional and should also include community representatives and service users. A few respondents pointed to the need for staff to have protected time for training and to be funded for their expenses.

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SECTION 12

Evaluation

Consultation Paper

It was proposed that, in keeping with good practice in policy development, it would be important to build in mechanisms for future policy evaluation at the outset of the implementation of any new arrangements in primary care. This would support a continuing learning process as the new arrangements evolved and permit policy and guidance from the Department to be adjusted over time, as appropriate, in response to any lessons learned.

Issue for Consultation

The paper posed the following question:

- *Would it be appropriate to build in an evaluation programme to the implementation of the new arrangements?*

Responses

12.1 There was considerable support for the proposal and no opposition to it. Many respondents stated that an evaluation and review mechanism was a fundamental requirement to ensure the effectiveness of the new arrangements. Some respondents stressed the need for the evaluation process to be independent, to have an agreed remit and to contain measurable criteria for judging effectiveness. There were calls by a number of respondents for the evaluation methodology and the areas it covered to be agreed at the start with all stakeholders, and also for locality involvement in agreeing timescales and reporting arrangements. One respondent suggested that the evaluation should include an assessment of the impact of the new arrangements on equality. Another felt that evaluation during the transition to increased devolution of budgets should be carried out to provide essential information.

SECTION 13

A Policy Development Agenda

Consultation Paper

The paper proposed the following priority areas for development in primary care:

- investment in the infrastructure of primary care;
- promoting service development in primary care;
- promoting quality in primary care; and
- promoting value for money.

Issues for Consultation

The following questions were posed:

- *Do they together provide the foundations for a comprehensive and coherent policy development agenda?*
- *Do any other issues need to be included?*
- *Should any of the areas proposed receive particular priority?*

Responses

13.1 The majority of those who responded to the first question agreed that the proposed priority areas were entirely appropriate, but many were disappointed by the lack of detail on, and commitment to, funding for the development of primary care. There was particular concern that the reference to new investment in the infrastructure of primary care was qualified by the words “resources permitting”. The need for an adequately resourced Information and Communication Technology (ICT) strategy was emphasised by many. A number of respondents saw considerable potential in the development of Personal Medical Services pilots, although one GP representative body commented that there was not much enthusiasm in Northern Ireland for the concept. Some respondents considered that primary care services as defined in the document were too narrow and tended to concentrate on general medical services. A few were concerned that there was a focus on general practice almost to the exclusion of other primary care staff and social services. One pointed out that investment should be in all primary care premises, not

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just GP surgeries. One GP grouping felt that the agenda should be developed in conjunction with primary care professionals and that they must feel a sense of inclusion.

13.2 The issue which respondents most commonly felt needed to be included in the policy development agenda was a specific commitment to funding. There were calls also for an explicit timetable for real and substantial investment in the primary care sector. One respondent felt there was a need for a blueprint for primary care facilities, which could demonstrate the necessity for investment. Other issues put forward for inclusion were:

- a commitment to the development of primary care commissioning;
- the promotion of equity and reducing inequalities in health;
- investment to meet obligations under the Disability Discrimination Act;
- communication/joint working between the primary and secondary care sectors;
- out-of-hours services;

- infrastructure outside general medical practices, such as those provided by Trusts and other family practitioners;
- extending prescribing to other nurses and midwives;
- the role of practice managers;
- the contribution of local communities in developing the policy;
- the development of walk-in centres, NHS Direct, telephone triage; and
- investment in primary care research.

13.3 For the majority of those who responded to the third question, investment in the infrastructure of primary care was the top priority. Workforce planning, the development of Information and Communications Technology and adequate premises were seen to be central to any plans for improving the infrastructure of primary care. The need for an Information and Communications Technology strategy for primary care was particularly emphasised by a number of respondents.

Other priority areas identified by respondents were:

- promoting service development in primary care;
- investment in research;
- medicines management in community pharmacy and repeat dispensing by pharmacists;
- clinical and social care governance, audit, benchmarking and spread of best practice;
- a human resource strategy;
- a review of the quality and level of out-of-hours services;
- the Policy Development Agenda must be related to key policy areas such as Targeting Health and Social Need, Equality and Human Rights and *Investing in Health*;
- the second and third priorities listed in the document should be exchanged in order of priority; and
- investment in primary care must go beyond general practice.

SECTION 14

Equality Issues

Consultation Paper

The paper explained that Section 75 of and Schedule 9 to the Northern Ireland Act 1998 placed new statutory obligations on Departments and other public authorities in carrying out their functions. Such bodies were to have due regard to the need to promote equality of opportunity:

- between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;
- between men and women generally;
- between persons with a disability and persons without; and
- between persons with dependants and persons without.

Without prejudice to the above, they were also to have regard, in carrying out their functions, to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group.

The paper stated that, as part of the consultation process, the Department wished to pay particular attention to the equality aspects of its proposals.

Issues for Consultation

The paper invited comments on whether the proposals in this paper had any particular implications for equality of opportunity between the nine categories specified in the equality legislation in the Northern Ireland Act; or for promoting good relations between persons of different religious belief, political opinion or racial group.

Responses

14.1 Most respondents made no comment on the specific issue raised. Some of those who did comment felt that the proposals had no particular implications for equality, while others made more general comments around the issue of equality, in particular the implications of the equality agenda for the proposed new Local Health and Social Care Groups. A number stressed the importance of the equitable distribution of resources to Groups, while others suggested that Groups would require guidance and training on their responsibilities under the Equality and Human Rights legislation. One

respondent felt that the appointment of Group Board members should also take cognisance of the Equality legislation. One respondent saw the need for primary care services to be distributed evenly to both urban and rural communities as an equality issue.

- 14.2** There were a number of calls for the proposals to be subject to a full equality impact assessment, while one respondent was of the view that the Department would be expected to initiate a fresh consultation on the specific model to be implemented, in line with the Equality Commission's guidelines. There was criticism of Section 8 of the paper by one respondent, who felt that no attempt had been made to show how the requirements of Section 75 of the legislation had been taken into account. Section 8 was felt to be an add-on, which did not allow the proposals to be assessed in the context of an even preliminary equality impact assessment. Disappointment was also expressed by the same respondent that the concepts of equality and equity appeared to be confused in this section of the paper.

Summary of Responses to the Consultation

SECTION 15

General Comments

- 15.1** This section of the report reflects some of the more general comments received, which do not readily align with any of the questions posed in the consultation paper.
- 15.2** Some respondents felt that the future of primary care had already been decided by virtue of a preferred model being identified in the consultation paper and that the genuineness of the consultation process was therefore questionable.
- 15.3** The consultation paper was criticised for not containing enough detail which some felt inhibited them from making informed comments. It was suggested that it should have contained firm information about timescales, resources and methods.
- 15.4** A few commented that the paper failed to show how the proposals would improve performance and health outcomes for users.
- 15.5** A significant number of respondents suggested that the future of primary care could not be decided in isolation and must take account of the outcome of the Acute Hospitals Review and the *Investing for Health* consultation.
- 15.6** A few respondents suggested that the definition of primary care was too narrow and that the contribution of carers and the voluntary and community sectors had been largely ignored.
- 15.7** There were concerns expressed about the transition to the new arrangements, particularly in relation to the human resource implications and fears about redundancies occurring with the ending of the GP Fundholding Scheme. The importance of not compromising patient care during transition was stressed, as was the need to maintain services funded through fundholding.
- 15.8** A number of respondents were disappointed that the proposals did not go further and that the scope for organisational change was limited because of the prospect of a wider review of public administration. Some felt this review was a long way off and was an unnecessary obstacle.

15.9 Several respondents said how important it was to learn lessons from the Commissioning and Purchasing Pilots in implementing new arrangements.

15.10 A number of respondents made the point that incentives would be needed to encourage primary care professionals to participate in the new arrangements.

15.11 A number of respondents complained about omissions. There was disappointment expressed that there was no mention in the paper of managers in general practice. It was suggested that there should have been reference to complementary/alternative medicine, the oral health implications of the proposed policy and the contribution of family planning/sexual health to primary care.

15.12 A few comments were made on the text and format of the consultation paper. One respondent felt it was long-winded, repetitive, and full of jargon, while another said it was well structured and easy to read. The addition of the glossary and explanatory appendices was welcomed.

15.13 Although the consultation period ran from the middle of December until the end of March and was extended by four weeks, there were a few complaints about it being too short.

15.14 One respondent emphasized the need for support and capacity building in order to engage the public and particularly those more disadvantaged in consultations and decision-making regarding public services. Another said umbrella bodies for ethnic groups did not have the capacity to widely distribute consultation papers. It was suggested that future consultation papers should be translated and distributed throughout communities, followed by meetings with ethnic minority groups, where papers and leaflets etc. could be introduced through translators.

GLOSSARY

Acute Hospital Review - an independent review of the current provision of acute hospital services.

Assembly – the NI Legislative Assembly which was set up by the Northern Ireland Act 1998 in accordance with the provisions of the Belfast Agreement of April 1998. It has full legislative and executive authority for a wide range of devolved responsibilities, including health and personal social services matters.

Audit (Medical) – the systematic critical analysis of the quality of medical care, including the procedures used for diagnosis and treatment, the use of resources and the resulting outcome of quality of life for the patient.

Benchmarking – a process whereby organisations identify the best performers in particular areas and measure themselves against the best, with a view to securing improvements in their own performance.

Capitation formula – a method of allocating resources based on the number of people living in a given area. Sometimes the formula is adjusted, or “weighted”, to take account of the particular characteristics of the population, for example in relation to age or economic and social factors.

Care manager – someone who takes responsibility for designing and assembling a package of care tailored to the client's needs and ensures that the services provided are effectively coordinated, delivered and monitored.

Central Services Agency – the Agency is responsible for the registration of patients and for making payments to Family Health Services practitioners (see page 36).

Clinical and social care governance – the organisation of services in line with set standards together with the minimisation and appropriate handling of adverse events.

Commissioning – the process of identifying local health and social care needs, making agreements with service providers to deliver services, and monitoring outcomes.

Commissioning Pilots – a general term used to refer collectively to Primary Care Commissioning Group Pilots (see page 38) and Total Purchasing Pilots (see page 38).

Community (care) services – health or social care services provided outside hospital.

Community nurses – nurses who work in GP practices, district nurses, health visitors and school nurses.



Community Pharmacy – the provision of pharmaceutical services from a registered pharmacy in a local community. Typically this would include the supply and sale of medicines, dispensing of prescriptions and provision of over-the-counter medicines for self-medication. It also includes the provision of health care advice and the wider application of pharmacists' skills to ensure that medicines are used safely and effectively.

Community Trusts – Trusts which provide community health and social services, but not acute hospital services.

Co-terminous - having a common boundary.

Elective services - non-emergency treatments in hospital which are planned in advance.

Disability Discrimination Act 1995 – protects disabled people against discrimination in the areas of employment, access to goods, facilities and services and the management, buying or renting of land or property.

Equality Impact Assessment – an assessment carried out to test new or existing policies to ensure they do not disadvantage or unfairly discriminate against individuals or groups on the basis of religion, gender, political affiliation, marital status, number of dependants, ethnicity, disability or sexual orientation.

Evidence-based practice – the use of current best evidence in making decisions about the care of individuals by combining the clinician's clinical expertise with the best external clinical evidence available from systematic research.

Executive – the First Minister and Deputy First Minister, together with the 10 Ministers of the Legislative Assembly, constitute the Executive. The Committee is responsible for drawing up a programme for government, incorporating an agreed budget, and for the development of policy in those areas for which the Assembly has full legislative and executive authority.

Family Health Services (FHS) – a general term used to cover general medical, general dental, general ophthalmic and pharmaceutical services provided by FHS practitioners.

Family Health Services practitioners – a general term used to describe the independent contractors - family doctors/GPs, dentists, pharmacists and optometrists - who provide Family Health Services.

GP Fundholding Scheme – a scheme which allows some GPs to manage budgets for certain services.

Summary of Responses to the Consultation

Health and (Personal) Social Services (HPSS) – includes hospital services, family and community health services and personal social services.

Health and Social Services Boards – There are 4 Health and Social Services Boards. As agents of the DHSS&PS they are responsible for planning and commissioning health and social services for their resident populations. They use the resources allocated to them by the Department to secure the necessary services from Health and Social Services Trusts and other service providers.

Health and Social Services Trusts – organisations responsible for providing health and social services, and for exercising certain statutory functions on behalf of Health and Social Services Boards. There are 19 Trusts.

Integrated health and social services – health and social services which are commissioned or delivered together by one organisation.

Investing for Health - the title of a consultation paper which set out the Executive's proposals for an innovative new approach to improving health status.

Management Allowance – public money paid to GPs to meet the extra administrative costs of running the GP Fundholding Scheme.

Needs assessment – a formal process undertaken to assess the health and social care needs of a given population.

Optometrists – independent contractors who provide general ophthalmic services.

Out-of-hours services – services provided by primary care professionals, particularly GPs, outside normal working hours, for example at weekends, during the night or during public holidays.

Palliative care - the active total care of patients whose disease no longer responds to curative treatment.

Personal Medical Services (legislation) – the development and piloting of new ways of delivering general medical services in order to address local service problems and tailor services to meet local needs.

Policy Evaluation – the examination and assessment of the effects of new policies.

Primary care – includes family and community health services and major components of social care which are delivered outside the hospital setting and which an individual can access on his/her own behalf.





Primary Care Commissioning

Pilots – groups of GPs and other primary care professionals who manage a prescribing budget and work with Health and Social Services Boards to develop health strategies and advise about service developments for local populations.

Primary Care Groups – local organisations which were set up in England to bring together groups of GPs and other primary care professionals to commission and provide care for their resident populations.

Primary care professionals – FHS practitioners, community nurses, community midwives, professions allied to medicine and social workers who provide primary care services.

Professions allied to medicine (PAMs) – groups of professionals working in the health and social services including, physiotherapists, occupational therapists, speech therapists, chiropodists/podiatrists, dieticians and orthoptists.

Providers (of services) – organisations which provide health and/or social services, for example Health and Social Services Trusts.

Public health – how society is organised to prevent disease, prolong life and promote health.

Repeat dispensing – this allows patients to obtain prescriptions which can then be dispensed in several instalments, rather than going back to their GP for a new prescription.

Secondary care – specialist care, typically provided in a hospital setting or following referral from a primary or community health professional.

Social (care) services – personal care services for vulnerable people, including those with special needs because of old age or physical or mental disability, and children in need of care and protection.

Specialist services – services which are provided in a limited number of centres for people with rare and complex conditions.

Targeting health and social need – the process of identifying inequalities in health and social wellbeing and securing the resources to address such differences.

Total Purchasing Pilots – groups of GPs who purchase hospital and community care services not covered by the Fundholding Scheme on behalf of their patients and clients. Legal responsibility for these services remains with the relevant Health and Social Services Board.

Summary of Responses to the Consultation

(Telephone) Triage – the practice of sorting casualties into categories of priority for treatment.

Weighted Capitation Formula - see capitation formula.



ANNEX 1

Building the Way Forward in Primary Care – Consultation Responses

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Action Cancer
Action MS
ACTPAM (Advisory Committee for the Professions Allied to Medicine)
Age Concern
Alliance Party
Altnagelvin Hospitals HSS Trust
Antrim/Ballymena Commissioning Pilot
Ards Borough Council
Ards Peninsula and Comber Group
Armagh & Dungannon HSS Trust
Armagh & Dungannon HSS Trust - Area Community Dental Service
Armagh & Dungannon HSS Trust - Professions Allied to Medicine
Armagh City & District HSS Community Forum
Armagh Primary Care Commissioning Pilot
Association of Optometrists

Ballymena Borough Council
Ballymoney District Council
Banbridge District Council
Belfast City Council
Boots the Chemists
British Association of Social Workers (NI)
British Psychological Society
Bryson House

Carers National Association (NI)
Causeway HSS Trust
Celtic Dimensions
Central Pharmaceutical Advisory Committee
Central Services Agency
Chartered Society of Physiotherapists
Church of Ireland
Church of Ireland, Armagh Diocesan Board of Social Responsibility
Coleraine Borough Council
Committee on Administration of Justice (CAJ)
Community and District Nursing Association
Community Development & Health Network
Community Health & Social Wellbeing Group
Community Practitioners & Health Visitors Association (CPHVA)
Craigavon & Banbridge Community HSS Trust
Craigavon Borough Council
Craigavon Group Trust - Senior Nursing Staff

Dalriada Doctor on Call
Dental Practice Committee NI
Department of Child Health, Queen's University Belfast
Department of Enterprise Trade & Investment for NI
Department of Social Development (Belfast Regeneration Office)
Derry Well Women
Development Programme for Nursing in Primary Care
DHSS&PS Central Nursing Advisory Committee
DHSS&PS Personal Social Services Advisory Committee

Summary of Responses to the Consultation

Diabetes UK (NI)
Disability Action
District Nurses, Health Visitors and
Midwives attending an
Education and Development
Programme
Donard Commissioning Group
Down District Council
Down Lisburn HSS Trust
Down Lisburn HSS Trust - PAMs
Managers Forum
Downe Residential Project
Dr S Bailey & Partners, Portrush
Drs Baird, Douglas & Drew,
Bangor
Dr P Bradley, Omagh
Dr J Browne, Carryduff
Dr O Daly, Lagan Valley Hospital
Dr V Davidson & Partners,
Enniskillen
Dr O Elder, North & West Belfast
HSS Trust
Dr R Green, Templepatrick
Dr S Harper, Newtownabbey
Dr J G Jenkins, Hospital Services
Sub-Committee
Drs T D & M C Magowan,
Ballymena
Dr W R Thompson, General
Medical Care Sub-Committee
Dunadry Group

Eastern Area Dental Advisory
Committee
Eastern Board GP Forum
Eastern Health & Social Services
Board
Eastern Health & Social Services
Council
Eastern Multifund
Equality Commission for Northern
Ireland
Extra Care

Fermanagh District Council
Foyle HSS Trust

General Osteopathic Council
General Practitioners Committee,
BMA (NI)
Green Park HealthCare HSS Trust
Guild of Health Care Pharmacists

Health Care Financial
Management Association (NI)
Health Policy Group, School of
Public Policy, University of
Ulster
Health, Social Services and Public
Safety Committee
Help the Aged
Homefirst Community HSS Trust
Homefirst HSS Trust Dental
Department

Institute for Conflict Research
Institute of Healthcare
Management
Institute of Healthcare
Management (Feedback from
Workshops)
Institute of Public Health NI

Link Group of General Medical
Practices
Link Group Sub Section
Lisburn Borough Council
Lisburn Commissioning Pilot

Macmillan Cancer Relief
Mencap NI
Mid-Ulster Commissioning Pilot
Mid-Ulster Pharmacy Locality
Group
Mr B Beattie, Chartered Society of
Physiotherapists
Mr G Addy, Lowwood Pharmacy
Mr J Coll, The Pharmacy, Bangor



Building the Way Forward in Primary Care



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Mr Mussen, The Hill Medical Group & Dumurry Community Services Patient Participation Group

Mr M J Kerr, Robert McMullan Ltd, Dispensing Chemists, Belfast

Mr T A Maguire, The Pharmacy, Belfast

Ms B Campbell, Practice Nurse, Bessbrook

Ms N Colgan, Nurse Education Consultant

Ms P McGovern, District Nurse, Newcastle

Ms V Addy, Windsor Pharmacy Multi Cultural Resource Centre

National Association of Primary Care

National Board for Nursing, Midwifery and Health Visiting for NI

National Council for Hospice & Specialist Palliative Care

National Schizophrenic Fellowship

Newry & Mourne HSS Trust

NI Ambulance Service

NI Association of Homeopaths

NI Centre for Post Graduate Pharmaceutical Education & Training

NI Committee for Community & Public Health Dentistry (NICCPHD)

NI Confederation for Health & Social Services

NI Council for Ethnic Minorities (NICEM)

NI Council for Post Medical & Dental Education (NICPMDE)

NI GP Forum

NI Managers in General Practice

NI Optometric Society

NI Primary Care Forum

NI Regional Dental Services Managers Group

NI Women's Coalition

Northern Ireland Public Service Alliance (NIPSA)

North & West Belfast HSS Trust

North & West Locality Consortium (Total Purchasing Pilot)

North Down Borough Council

North Down Primary Care Organisation (Total Purchasing Pilot)

Northern Health & Social Services Board

Northern Health & Social Services Board - Local Dental Committee

Northern Health & Social Services Board - Local Optical Committee

Northern Health & Social Services Board - Pharmaceutical Advisory Committee

Northern Health & Social Services Council

Northern Health & Social Services Board - Professions Allied to Medicine

Northern Local Medical Committee

Nurse Practitioner Practice & Policy Steering Group

Omagh District Council

Pharmaceutical Contractors Committee

Pharmaceutical Society of NI Prescribing Advisors, Commissioning & Total Purchasing Pilots

Primary Care Nurses participating in an Education and Development Programme

Summary of Responses to the Consultation

Radox Laboratories
Regional Oral Health Promotion Group
Royal College of Anaesthetists
Royal College of General Practitioners
Royal College of Midwives
Royal College of Nursing NI Board
Royal College of Ophthalmologists
Royal College of Paediatrics and Child Health
Royal College of Psychiatrists
Royal Group of Hospitals HSS Trust
Royal Society for the Prevention of Accidents (ROSPA)
Rural Development Council

Simon Community
Sinn Féin
Social Democratic & Labour Party
South & East Belfast HSS Trust
South & East Belfast HSS Trust - Senior Physiotherapists
South & East Belfast Primary Care Group
South East Antrim Locality Group (Total Purchasing Pilot)
Southern Area Dental Advisory Committee
Southern Area Medical Advisory Committee
Southern Area Pharmaceutical Advisory Committee
Southern Health & Social Services Board
Southern Health & Social Services Council
Southern Local Medical Committee
Southern PAM Managers Forum
Sperrin Lakeland HSS Trust
Strabane District Council

The Hill Medical Group
The Hill Medical Group and Dunmurry Community Services Patient Participation Group
Threshold

UK Central Council for Nursing, Midwifery & Health Visiting
Ulster Chemists Association
Ulster Community and Hospitals HSS Trust
Unison (NI)
United Hospitals HSS Trust
University of Ulster Faculty of Business

Voluntary Service Belfast

West Belfast Homeopathy Support Group
Western Education & Library Board
Western Health & Social Services Board
Western Local Medical Committee
Whitehead Health Centre
Women's Forum (NI)



Building the Way Forward in Primary Care



