The Health
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Primary care group standards

Pilot edition
April 1999

King's Fund

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Introduction

Background

The White Paper, *The new NHS: Modern and Dependable* signalled a new departure, with the establishment of primary care groups at the heart of government health policy.

These new organisations have a key role in improving the health of local populations and their effective development will be crucial to their success.

The King's Fund Primary Care Programme and the Health Quality Service have collaborated on a project to define standards of good practice for primary care groups in England. The purpose of the standards is to define good practice from inception and to guide primary care groups in developing as effective organisations. In doing this, they provide a developmental framework, rather than a performance management tool.

Further work is being carried out by the Health Quality Service to establish relevant standards for the other countries of the United Kingdom.

During the spring and summer of 1999 these standards will be put to the test in 15 different settings as 15 health authorities and boards and their primary care groups work with the Health Quality Service on a project to implement these standards as part of a quality improvement programme. Following the project, the standards will be revised and published as part of a widely available programme for the NHS. It is hoped, however, that this first attempt at developing standards will be useful to primary care groups as they evolve.

Standards development

The project has involved a wide range of individuals and organisations with particular interest and expertise in primary care groups.

This included:

1. Establishing a core group of individuals to guide the project and to develop an initial framework for the standards.

2. Convening a standards development group, which included individuals from general practice, public health departments, community health services and health authorities.

   Workshops were held over three days to enable this group to use their collective expertise and experience to define standards

and criteria for primary care groups within the agreed framework.

3. Consulting an advisory panel comprising representatives from a broad constituency with an interest in the development of primary care groups. The advisory panel was consulted at a number of key stages and the comments received shaped and refined the development of the standards and criteria.

Standards of good practice have been defined in four areas: the organisation of primary care groups, clinical governance, the functions of primary care groups and development to higher levels.

The standards are overall statements of desired performance, which are achieved by meeting a number of criteria.

The standards and criteria have been developed to be:

achievable
: some primary care groups will find it more difficult to achieve the standards and criteria than others, but there is little point in including criteria that are unachievable

flexible
: so that they can be used by any primary care group in England

acceptable
: representing a consensus on the roles and responsibilities of primary care groups

adaptable
: non-prescriptive – stating what should be in place and not how it should be put in place – so they can be put into practice in accordance with local needs

nationally applicable
: a common framework against which any primary care group in England can be assessed.

There is, and will continue to be, considerable divergence between primary care groups. To reflect this, the approach to developing the standards and criteria has been inclusive; thus the enclosed criteria are comprehensive and should be viewed as a goal to be achieved over time, as part of a process of continuous development. Working towards the criteria will need, therefore, to be carried out in phased stages to reflect local circumstances.

Putting the standards into practice

Primary care groups can use the standards and criteria in this document to guide their development. They provide a clear framework within which primary care groups can work towards ensuring best practice.

Initial assessment
Representative members of the primary care group should work through this manual to assess current practice against the criteria. This should be a reflective process and staff should consider not only whether there is a system in place to meet the criteria, but also whether this system is working well. For some criteria, guidance is included in the text to indicate measures that may be taken to implement a criterion. Examples are also given to act as a guide for the primary care group.

Comments sheets are included at the end of the manual to enable primary care groups to feedback any comments they have on the applicability or relevance of standards and criteria. This information will be used to inform ongoing development.

Prioritising areas for action
The primary care group's initial assessment will confirm existing good practice as well as identify those areas where further work is required. Prioritising this work should be realistic and determined by local circumstances, and an action plan should be developed.

Implementing the action plan
Staff throughout the primary care group should be involved in working to meet the criteria relevant to their area of work. The *Competency Framework for the Management of Primary Care Groups*, developed as part of the NHSE Development Unit's Phoenix Agenda project can be referred to to assist the primary care group in identifying the skills needed for this work.

The standards and criteria should be revisited periodically to monitor progress and to identify any difficulties. These should be communicated and shared with other members of the primary care group where relevant.

Reviewing progress
Progress towards meeting the standards and criteria should be reviewed at agreed intervals. The results of any review of progress should be fed into future action plans aimed at continual improvement of the primary care group's practice.

Future development

The publication of this edition of the standards for primary care groups marks the end of the first stage of this project. As previously indicated, the Health Quality Service will work with the primary care groups within a number of health authority areas who have volunteered to pilot the standards and criteria. This work will focus on:

- supporting those primary care groups in implementing the standards and criteria in their area
- reviewing the standards and criteria in the light of developments in practice and further legislation and guidance
- developing criteria to reflect primary care groups' roles and responsibilities in Scotland and Wales
- allocating a priority weighting to each criterion

- developing a process of external peer review
- considering the feasibility of developing an accreditation process for primary care groups
- developing more comprehensive criteria that reflect the transition to primary care trust status.

The King's Fund and the Health Quality Service extend their thanks to the following organisations who are acting as partners and pilot sites during the project.

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Gateshead and South Tyneside Health Authority
North and Mid Hampshire Health Authority
Portsmouth and South East Hampshire Health Authority
Rotherham Health Authority
Somerset Health Authority
South and West Devon Health Authority
Stockport Health Authority
West Sussex Health Authority
Wiltshire Health Authority

If you have any questions or comments about these standards or about the future programme, please contact:

Steve Gillam
Director, Primary Care Programme
King's Fund
11-13 Cavendish Square
London
W1M 0AN

0171 307 2651

sgillam@kehf.org.uk

or

Sally-Anne Vidall
Primary Care Project Manager
The Health Quality Service
11-13 Cavendish Square
London
W1M 0AN

0171 307 2450

svidall@kehf.org.uk

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Standards Development Group

Sarah Andrews, Co-Director of Nursing, Camden & Islington Community Health Services NHS Trust
Peter Atkins, GP, Nettleham Medical Practice, Lincolnshire
Linden Boothby, Business Manager, The Surgery, Lincolnshire
Greg Cairns, GP Commissioning Manager, Croydon Health Authority
Ann Foreman, Primary Care Quality Manager, Northumberland Health Authority
Gill Galdins, Assistant Director of Primary Care/Head of Nursing, Wakefield Health Authority
Clare Geralda, Chair, Lambeth GP Commissioning Group
Geoff Hanlon, GP, Dr Middleton & Partners, Leicestershire
Judith Hooper, Consultant in Public Health, Calderdale & Kirklees Health Authority
Paul Johnstone, Public Health Consultant, Berkshire Health Authority
Debbie Kennedy, Planning Manager, Portsmouth & South East Hampshire Health Authority
Roz Lowe, Chief Executive, Hounslow and Spelthorne Community NHS Trust
Caroline Machray, Quintessent (facilitator)
Kate McKay, Public Health Consultant, Barnet Health Authority
Chaand Nagpaul, GP, Honeypot Surgery, London
Bernie Naughton, Practice Manager, Lea Vale Practice
Kath Pearson, Co-ordinator , Northampton Commissioning Group, Northampton Health Authority
Mike Richards, GP, Albany Surgery, Devon
Tracey Sparkes, Quintessent (facilitator)
Peter Stanley, GP, Riverside Surgery, Devon
Paul Steward, Locality Director, Dales Primary Care Group, Durham Health Authority
Chris Sutcliffe, Senior Development Manager - Primary Care, Leicester Health Authority
Julia Taylor, QED Department, Wakefield & Pontefract Community NHS Trust

Advisory Panel Members

Richard Armstrong, Implementation Manager, Primary Care Directorate, NHSE
Sue Botes, Professional Officer, CPHVA
Jennifer Dixon, Policy Advisor, Department of Health
Roz Eve, School of Health and Related Research

Malcolm Forsythe, Professorial Fellow in Public Health, Centre for Health Services Studies
Rosey Foster, Chief Executive, AMGP
Leigh Garraway, Director of Health Policy, Bedfordshire Health Authority
Sara Harries, Quality Manager, Bromley Health Authority
Paul Hodgkin, School of Health and Related Research, University of Sheffield
Sally Irvine, Chairman, Newcastle City Health NHS Trust
Dipak Kalra, Centre for Health Informatics and Multi-professional Education, University College London
Richard Leete, GP, Wyndham House Surgery, Devon
Peter Mitford, Medical Advisor, Northumberland Health Authority
Ackbar Mohamedali, GP, Grove Medical Centre, London
Kate Money, Director of Primary Care, East Sussex, Brighton and Hove Health Authority
Mike Newton, Director of Performance Management, Sheffield Health Authority
Mike Pringle, Royal College of General Practitioners
Barry Robinson, Unit General Manager, Lyme Community Care Unit
Theo Schofield, GP, The Medical Centre, Warwickshire
Nigel Starey, Primary Care Department, University of Derby
John Swain, Director of Primary Care, Bedfordshire Health Authority
Nicola Walsh, Health Services Mangement Centre, University of Birmingham
Moris Watt, GP, Grosvenor Road Surgery, Devon
Lynne Young, Community Health Advisor, Royal College of Nursing

Key Leads in Partner Health Authorities

Ann Bullen, Quality Manager, Portsmouth and South East Hampshire Health Authority
Tim Carter, Medical Advisor, West Sussex Health Authority
Peter Greagsby, Director of Health Care Development, Rotherham Health Authority
Michele Grimes, Performance Manager, Stockport Health Authority
Adrian Jacobs, Locality Team Leader, South and West Devon Health Authority
Joyce Kelly, Primary Care Manager, Fife Health Board
Elaine Maggs, Senior Locality Manager, East Surrey Health Authority
Alison Middleton, Senior Manager – Primary Care and Commissioning, Wiltshire Health Authority
Jean Sait, Director of Patient Care, Dyfed Powys Health Authority
Gill Sanders, Director of Public Health, Gateshead and South Tyneside Health Authority
Helen Suddes, Primary Care Development Manager, County Durham Health Authority
Helen Walters, Primary Care Medical Advisor, North and Mid Hampshire Health Authority
Sally Windsor, Locality Manager, Somerset Health Authority
Peter Wood, Head of Quality, East Norfolk Health Authority
Steve Young, Assistant Director – Primary Care, Buckinghamshire Health Authority

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Andrew Corbett-Nolan, Director of Development, Health Quality Service
Charles Flynn, Director of Clinical Services, Southport & Formby Community Health Services NHS Trust
Richard Lewis, Independent Consultant, King's Fund Primary Care Programme
Geoff Roberts, Consultant in Primary Medical Care, Merton Sutton and Wandsworth Health Authority
Anthony Worth, The Transformation Group

In order for health care organisations to be able to focus their energies on providing high quality patient care, they need to have a strong infrastructure, with clearly defined systems and processes for operating effectively.

Effective organisations embrace good management (doing the right things) and good administration (doing things the right way) but are concerned overall with:

- *shaping and managing change and improvement for the future taking account of the experience, views and aspirations of service users, providers and funders*

- *providing the necessary supportive, physical, technical and organisational environment that enable and encourage individuals and teams to make the best use of their skills, experience and creativity*

- *defining and seeking to continuously improve standards of care and service.*

This standard was developed with these thoughts in mind. It is not intended to be overly bureaucratic, even if at first sight it might appear so. The intention behind this standard is to ensure that primary care groups and their health authority clearly define how each primary care group will operate, thus allowing primary care groups the freedom and responsibility to deliver effective health care to their populations safe in the knowledge that they are empowered and equipped to do this.

Primary care groups at level one and two will need to work through these issues.

Standard 1: The organisation of the primary care group

A constitution and organisational framework exists which enables the primary care group to meet its local, national and statutory responsibilities while remaining patient centred and accountable.

Board arrangements

Notes

1.1 There is a management structure for the primary care group board which:

1.1.1 is documented

1.1.2 identifies lines of responsibility

1.1.3 identifies lines of accountability

1.1.4 is in the public domain.

1.2 There are designated board members or representatives with responsibility for aspects of the primary care group.

Guidance

Identified responsibilities include, for example:

- *clinical governance*
- *primary care development*
- *commissioning*
- *corporate governance*
- *education*
- *information management and technology*
- *administration and finance*
- *prescribing.*

1.3 The roles and responsibilities of each board member are documented.

1.4 The constitutional arrangements of the primary care group are documented.

1.5 The constitution is available to:

1.5.1 all members of the primary care group

Notes

1.5.2 stakeholders

Guidance

These include, for example:

- *local medical, dental, optometry and pharmaceutical committees*
- *social services*
- *other local authority departments, for example housing and environmental health*
- *education departments*
- *NHS trusts*
- *Community Health Councils*
- *voluntary organisations.*

1.5.3 members of the public.

1.6 The constitution includes policies on:

1.6.1 membership of the primary care group

1.6.2 a council/advisory committee

Guidance

Although primary care groups are not required to have a council/advisory group, they should consider whether a council/advisory group would be helpful in advising on decision making. (Further reference: National Association of Primary Care pamphlet: Primary Care Group Constitutions). Membership may include representatives external to the primary care group.

1.6.3 agreed principles by which the primary care group will operate

1.6.4 decision making processes

1.6.5 appeal processes

Guidance

This includes the process of appeal for board members who wish to appeal and the process for members within the primary care group who wish to appeal about a decision made by the board.

1.6.6 regulatory procedures

Guidance

These should include:

- *standing financial instructions*
- *dealing with NHS Guidelines*
- *standards of business conduct*
- *controls assurance (defined as the systematic review by boards, audit committees, managers and staff of the procedures, process and practices within an organisation which represent the internal system of control. NHSE1998.)*

In the initial stages, primary care groups will adopt the standing orders of the health authority.

1.6.7 the use of deputies to the board

1.6.8 Elections

1.6.9 co-option of members to the board

1.6.10 involving the public

1.6.11 openness, including what information is in the public domain

1.6.12 public relations.

Guidance

This should include statements about the collective responsibility of board members and the need to present to the press or public the views of the primary care group rather than the individual.

1.7 There are processes for delegating responsibility to sub-groups of the primary care group.

Guidance

The aim here is to allow sub-groups the freedom to be innovative, within defined terms of reference.

1.8 There are arrangements for recruiting members of the primary care group onto sub-groups.

1.9 There is a policy on the requirement of primary care group members to disclose information to the board about any current investigations by professional bodies, the health authorities or the police.

Guidance

This information should be treated in confidence.

1.10 There is a register of interests for board members and sub-group members.

Guidance

Given the nature of primary care groups (including their size, familiarity and proximity to local health care organisations) the threshold for registering an interest should be low. For example, relationships with other primary care group members, employment of relatives in local health care organisations, business interests or any other interest in local health care organisations, involvement in drug company trials.

1.11 Interests are declared where possible conflicts exist.

Guidance

Documented guidance on possible conflicts of interest should be available to primary care group board members.

1.12 Primary care group corporate policies and procedures are:

1.12.1 dated and have a review date

1.12.2 disseminated to all members of the primary care group

1.12.3 made available to the public

Notes

Notes

1.12.4 centrally indexed and compiled in a policy manual.

Operational arrangements

1.13 Areas of responsibility delegated by the health authority to the primary care group are agreed and documented.

Guidance

Examples include responsibility for commissioning specific services and level of budget devolution.

1.14 The level of provision of support functions from the health authority is agreed and documented.

Guidance

Examples of support include:

- *commissioning advice*
- *public health*
- *legal advice*
- *human resources*
- *information technology*
- *finance*
- *primary care development*
- *organisational development*
- *prescribing advice*
- *public relations.*

Service level agreements could be developed for the delivery of these support functions.

1.15 There is an operational procedure for the primary care group which includes:

1.15.1 involving the public

Guidance

Both in influencing decision making and service development.

1.15.2 arrangements for meetings

1.15.3 access to the primary care group board

Guidance

This includes, for example:

- *primary care group office arrangements*
- *points of contact for board members during office hours*
- *telephone and fax numbers*
- *e-mail addresses.*

1.15.4 communicating with primary care group members

1.15.5 involving stakeholders

Guidance

These include, for example:

- *local medical, dental, optometry and pharmaceutical committees*
- *social services*
- *other local authority departments, for example housing and environmental health*
- *education departments*
- *NHS trusts*
- *Community Health Councils*
- *voluntary organisations*
- *nursing/residential homes.*

1.15.6 local arrangements for working with other primary care groups (collegiate working).

1.16 There is a planning cycle which is linked to the health improvement programme.

Guidance

This includes, for example:

- *consultation*
- *decision making*
- *feedback*
- *review.*

1.17 There is a documented programme of action for the primary care group, which is line with published guidance.

Guidance

This should include achievable, measurable and shared objectives.

1.18 The programme of action is reviewed at agreed intervals.

Guidance

This should be done at organisational, practice and personal levels.

1.19 The programme of action is developed in conjunction with:

1.19.1 the primary care group board

1.19.2 representatives of other primary care group members

Notes

Notes

1.19.3 Stakeholders

Guidance

These include, for example:

- *local medical, dental, optometry and pharmaceutical committees*
- *social services*
- *other local authority departments, for example housing and environmental health*
- *education departments*
- *NHS trusts*
- *Community Health Councils*
- *voluntary organisations*
- *nursing/residential homes.*

1.19.4 representatives of patients and carers

1.19.5 the local population.

1.20 There is an individual training and development strategy for the primary care group.

1.21 There is a training and development plan for all members of staff.

Guidance

These include, for example:

- *general practitioners*
- *practice management and administrative staff*
- *community and practice nurses*
- *professions allied to medicine.*

1.22 Training and development plans:

1.22.1 include regular appraisal

1.22.2 promote continuing professional development

1.22.3 reflect individual needs

1.22.4 reflect local needs, both at practice and primary care group level

Guidance

Examples of education plans include personal portfolios, practice based learning plans and personal development plans.

1.22.5 are linked to educational consortia strategies

1.22.6 are linked to the education strategies of relevant employing organisations.

Guidance

Relevant organisations include, for example:

- *NHS trusts*
- *health authorities*
- *social services.*

Notes

Communication

1.23 There is a communications strategy for the primary care group.

1.24 This includes:

1.24.1 what it is trying to achieve

1.24.2 the range of media to be used

1.24.3 the target audience.

1.25 The primary care group uses existing communications networks.

Guidance

The health authority should be able to advise on existing networks of practice nurses, young principals and practice managers, amongst others.

Community trusts should be able to advise on existing networks of community nurses and professions allied to medicine, amongst others.

1.26 Gaps in existing communications networks are identified.

1.27 New communications networks are developed to fill identified gaps.

1.28 There is on-going audit of the communications strategy.

Guidance

This includes, for example, assessing how well information is disseminated and understood.

Information management and technology

1.29 There is a documented information management and technology strategy for the primary care group.

Guidance

This includes, for example:

- *computerisation of practices*
- *how information will be used to support business processes*
- *information flows with health authorities and NHS trusts*
- *the development of minimum data sets*
- *common data collection processes.*

1.30 The information management and technology strategy:

1.30.1 Reflects the national information management and technology strategy

1.30.2 Supports the primary care group's programme of action

1.30.3 Reflects the priorities of the health improvement programme

Notes

1.30.4 reflects the priorities of the primary care investment plan.

1.31 To support clinical governance, the information management and technology strategy includes:

1.31.1 a core clinical data set for the priorities in the health improvement programme

Guidance

This includes, for example:
- *what information is required*
- *who it is required from*
- *what it is required for.*

There is multidisciplinary input into the definition of the core clinical data set.

1.31.2 reference to the development of a common clinical database between all local health and social care organisations

Guidance

The participation of other agencies in the development of a core clinical database should be encouraged by the primary care group.

1.31.3 a definition of the minimum data recommended to be held on computer at practice level

1.31.4 a plan for the development of practice computer systems

Guidance

This should address Year 2000 compliance and compliance with Requirements for Accreditation, version 4.0. Reference: HSC (98) 228: paragraph 97.

Links to the NHS net should also be considered.

1.31.5 identification of resources to implement the strategy.

Guidance

This should reflect the primary care investment plan.

1.32 There is a policy on confidentiality, which is in accordance with current legislation.

Guidance

This includes the Data Protection Act (1998) and codes of professional conduct on disclosing patient information. Discussions need to take place as to where the boundaries of confidentiality begin and end. There needs to be a clear distinction between clinical audit and research and clinical audit should be under the same scrutiny as research if patient identifiable data is involved.

1.33 The policy reinforces confidentiality:

1.33.1 within the primary care group board and sub-groups

1.33.2 within the primary care group

1.33.3 with external agencies.

1.34 There is a code of practice in line with the Data Protection Act (1998) covering:

1.34.1 access to information

1.34.2 use of information.

1.35 There are inter-agency agreements on:

1.35.1 common formats for information sharing

1.35.2 common access to information systems.

1.36 There is on-going audit of:

1.36.1 the quality of information

1.36.2 the appropriateness of information

1.36.3 how information is used.

Guidance

Audit should be at practice level to ensure consistency.

Sources of guidance may be local audit advisory groups, public health advisors and GP computing facilitators.

1.37 The primary care group is registered under the Data Protection Act (1998).

1.38 There are written procedures for internal financial management which include:

1.38.1 financial accountability for all elements of the devolved unified budget at primary care group and practice level

1.38.2 allocation of resources

1.38.3 the format for monthly budget reports

1.38.4 reporting arrangements

1.38.5 the use of practice incentives

1.38.6 the use of practice savings

1.38.7 assessment and management of financial risk

1.38.8 the management of adverse financial results.

1.39 The primary care group produces a written annual report.

Prescribing

1.40 There is a documented plan on how to manage the primary care drugs budget.

1.41 The plan includes:

Notes

Notes

1.41.1 targets to be reached

Guidance

This will include, for example, percentage reduction in spending, percentage increase in the use of generic drugs.

1.41.2 how information regarding prescribing is collected

1.41.3 how information regarding prescribing is disseminated to primary care group members

1.41.4 monitoring arrangements.

1.42 There is a primary care group prescribing formulary.

The issue of clinical governance is already transforming the way individuals and health care organisations view their approach to quality.

This standard was written to provide primary care groups with a starting point or a framework in which to develop clinical governance. It will be essential that each primary care group establishes how it will work with each practice in order to deliver the quality agenda.

Primary care groups at level one and two will need to work through these issues.

Standard 2 : Clinical governance

Notes

There is an integrated and inclusive approach to clinical governance, which is supported at all levels of the primary care group, enabling continuous improvement of the quality of services and safeguarding high standards of care.

The framework for clinical governance

2.1 There is a senior health professional with responsibility for clinical governance at board level.

2.2 Administrative support is identified for the person with responsibility for clinical governance.

2.3 There is a personal development plan to support the person with responsibility for clinical governance in the role.

Guidance

Development plans should be sensitive to individual circumstances and educational needs.

It could include identification of professional support, for example, public health expertise and primary care group clinical teams.

2.4 The appointed person takes responsibility for the formulation of a programme for clinical governance.

2.5 All primary health care teams in the primary care group are encouraged to contribute to the development of the clinical governance programme.

Guidance

This could be achieved through the identification of a clinical governance lead in each practice.

Contributions should be sought from the range of health professionals working in primary care.

2.6 The clinical governance programme is developed using local, multiprofessional expertise.

Notes

Guidance

This may be through, for example:

- *local clinical audit groups*
- *academic institutions*
- *local clinical governance groups*
- *continuing professional development*
- *multiprofessional education and training*
- *evidence based care*
- *organisational development expertise*
- *information and technology*
- *public health.*

2.7 The clinical governance programme is agreed by the primary care group board.

2.8 The clinical governance programme reflects:

2.8.1 the health improvement programme

2.8.2 national priorities

2.8.3 local priorities

Guidance

These are at the discretion of the primary care group but should not conflict with the health improvement programme.

2.8.4 public involvement.

2.9 The clinical governance programme includes:

2.9.1 the action to be taken to improve care

2.9.2 a timetable for action

2.9.3 targets to be met

2.9.4 agreed clinical audits

2.9.5 definitions of information fields to carry out audits and reviews

Guidance

This includes standards to measure quality and to measure changes effected through clinical governance.

2.9.6 the contribution each primary health care team is expected to make

2.9.7 arrangements for reporting clinical governance objectives and results.

2.10 The appointed person ensures that the clinical governance programme:

2.10.1 is communicated to all key stakeholders

Notes

Guidance

These include, for example, practices within the primary care group, health authority, secondary care providers, community trusts, local authority, social services, patients, users and other primary care groups.

2.10.2 informs the annual accountability agreement.

2.11 There is communication with other clinical governance leads to share good practice and ensure best use of available resources.

Guidance

This includes clinical governance leads in other primary care groups and in NHS trusts.

This may be through clinical governance networks, for example in:

- *post-graduate education centres*
- *local, regional and national groups*
- *health authorities.*

2.12 The clinical governance programme is integrated with that of the local community services provider, where appropriate.

Quality

2.13 Training and development for clinical staff is in line with the primary care group's training and development strategy. (See standard 1 - criterion 1.20)

2.14 There is a framework to support access to clinical supervision/support.

Guidance

This may be through a uni or multidisciplinary process.

2.15 There is a programme to implement clinical guidelines.

Guidance

These may be developed:

- *nationally, for example by the National Institute for Clinical Excellence or within national service frameworks*
- *regionally, via research and development departments*
- *locally, in conjunction with:*
  - *professionals involved in primary care*
  - *health authorities*
  - *local authority services*
  - *other statutory services, for example police/probation*
  - *voluntary organisations*
  - *service users*
  - *NHS Trusts.*

Clinical guidelines should be accessible to all members of the primary care group. This may be achieved by:

- *wide dissemination*
- *a central source for the storage and retrieval of information.*

2.16 The primary care group has a process:

Notes

2.16.1 to assess the quality of primary care services provided by primary health care teams

2.16.2 for addressing identified deficiencies.

2.17 Clinical guidelines reflect evidence based practice.

2.18 All clinical guidelines are reviewed as part of the clinical governance programme.

Guidance

This may be annually or more regularly if appropriate. The perspective of patients/users should be part of the review process.

2.19 Good practice and innovation is shared across all primary care teams.

Guidance

This may be through, for example:

- *newsletters*
- *help sheets*
- *inter-site visits*
- *educational activities*
- *mentoring.*

Clinical risk management

2.20 There are policies aimed at managing clinical risk which:

2.20.1 systematically assess clinical risk

2.20.2 report identified risk

2.20.3 aim to reduce clinical risk.

2.21 There is a proactive approach to clinical risk management throughout the primary care group which includes:

2.21.1 employment of suitably accredited, qualified clinicians

Guidance

The primary care group needs to ensure that employing organisations check qualifications prior to employment. Records should be kept of professional qualifications, registration and updating requirements, for example, PREP for nurses.

2.21.2 adherence to policies, procedures, protocols and guidelines adopted by the primary care group

2.21.3 monitoring of risk through clinical and management audit.

2.22 There are procedures aimed at identifying and remedying problems related to clinical performance, which include:

2.22.1 adverse event reporting

Guidance

For example:

- *falls in surgeries*
- *drug reactions*
- *unexpected deaths*
- *failure to visit.*

2.22.2 audit and investigation of patients' complaints

Guidance

There should be a link with patient complaints systems of other stakeholders, for example community trusts, in order to identify those common elements that have an impact on the quality of clinical care.

2.22.3 arrangements for reporting and acting on the concerns of staff regarding the performance of their colleagues

Guidance

This may be through a Whistle Blowers' Charter. Reference should also be made to the GMC guidelines on unfitness to practice.

2.22.4 identifying training and support needs.

Guidance

These may be developed with the LMC, HA, ENB or continuing medical education departments.

Conciliation services may also be used.

2.23 The primary care group agrees standards for clinical records.

Guidance

These should:

- *include compliance with individual professional standards on record keeping, for example UKCC guidelines for records and record keeping 1998*
- *reflect HSG(96)31*
- *include standards on the retention of health records*
- *include recommendations made by the Caldicott Report.*

2.24 There is ongoing audit of clinical records against the agreed standards.

Notes

This standard was developed with the summer guidance (HSC 1998/139) in mind. It clearly defines issues which will need to be developed as primary care groups at all levels perform their functions.

The degree to which level one primary care groups develop these functions will depend on the level of responsibility that they take on from the health authority. This will particularly impact on the sections on developing primary and community services and commissioning secondary care. This level of responsibility should have already been determined by working through Standard One: The Organisation of the Primary Care Group.

Standard 3 : The functions of the primary care group

The primary care group acts in collaboration with others to improve the health of the population through the health improvement programme, develop primary and community services and commission secondary care.

Assessment of health needs

Notes

3.1 The primary care group clearly defines its population.

3.2 The population profile of the primary care group :

3.2.1 includes a summation of the practice populations within the primary care group

3.2.2 includes a summation of the ward populations within the boundaries of the primary care group

Guidance

This allows the application of local authority and census data to the primary care group population.

3.2.3 takes account of temporary residents

3.2.4 takes account of individuals who are not registered with a general practitioner but living within the geographical boundary of the primary care group

3.2.5 takes account of those in residential care

3.2.6 takes account of those in educational institutions.

3.3 There is a comprehensive analysis of the demographic features of the population.

Notes

Guidance

This includes, for example:

- *age structure*
- *gender*
- *ethnicity*
- *distribution*
- *deprivation, including nationally and locally developed indices of deprivation*
- *socio-economic status*
- *special features*
  For example:
  - *transient populations*
  - *travellers*
  - *armed forces*
  - *refugees*
  - *tourists.*

3.4 This information is available at:

3.4.1 Primary Care Group level

3.4.2 practice level.

3.5 There is a comprehensive analysis of the morbidity and mortality of the population.

Guidance

This includes, for example:

- *morbidity and mortality data from practices*
- *national data sets on death and illness*
- *public health common data sets*
- *Our Healthier Nation data sets*
- *local authority data sets*
- *local research and surveys.*

3.6 The primary care group is aware of how it compares to Our Healthier Nation targets for:

3.6.1 coronary heart disease and stroke

3.6.2 mental health

3.6.3 cancers

3.6.4 accidents.

3.7 The primary care group is aware of how it compares with targets set out in:

3.7.1 national service frameworks

3.7.2 national priorities guidance

3.7.3 national/high level performance indicators.

3.8 The primary care group uses its data analysis to identify significant health inequalities in its population.

3.9 The primary care group identifies the locally available services that can contribute to health improvement.

Guidance

These include, for example, services provided by:

- *health promotion services*
- *primary care*
- *community/combined trusts*
- *acute trusts*
- *other health organisations*
- *local authorities*
- *training and enterprise councils*
- *non-statutory and voluntary organisations*
- *users and user groups.*

3.10 The primary care group assesses its current use of existing services, and those being developed and/or considered, against the following criteria:

3.10.1 fair access

3.10.2 effective delivery of appropriate care

3.10.3 health improvement

3.10.4 efficiency

3.10.5 the patient experience

3.10.6 health outcomes.

Guidance

These are the headings included in the national performance framework.

3.11 The primary care group assesses its capacity to function through assessment of:

3.11.1 human resources

3.11.2 available skills

Guidance:

This should include an assessment of professional development needs of primary care staff. (See also Standard 1, criterion 1.20)

3.11.3 information technology systems

3.11.4 premises and equipment

3.11.5 financial resources

3.11.6 resource inequities between practices.

Planning for improving the health of the population

3.12 The primary care group identifies its health improvement priorities in line with the health improvement programme.

Notes

Notes

3.13 The process for agreeing the priorities of the primary care group is:

3.13.1 agreed

3.13.2 documented

3.13.3 reviewed.

Guidance

This is reviewed on an annual or more frequent basis.

3.14 The primary care group works with other agencies to determine local priorities.

Guidance

Priorities will include local priorities specific to each PCG as well as the local interpretation of national guidance.

This may be through, for example:

- *inter-agency workshops*
- *focus groups*
- *local consultative committees*
- *local development teams, for example drug action teams.*

3.15 The primary care group involves the local population in determining local priorities.

Guidance

The primary care group should seek truly representative views from the population including those of:

- *users*
- *carers*
- *the voluntary sector.*

Methods include, for example:

- *patient/user panels*
- *patient participation groups*
- *the community health council*
- *focus groups*
- *citizens' juries.*

3.16 The agreed priorities are documented.

3.17 The agreed priorities are used to inform the:

3.17.1 health improvement programme

3.17.2 primary care investment plan

3.17.3 commissioning plans.

3.18 The primary care group agrees the allocation of resources.

3.19 Representatives of all professions within the primary care group are involved in the planning process.

Notes

Guidance

This includes those professions not represented on the primary care group board.

It may be done using inter-professional and specialist sub-groups feeding into the board.

Health improvement programme

3.20 The primary care group contributes to the development of the health improvement programme taking account of:

3.20.1 national priorities

Guidance

These include, for example:

- *Our Healthier Nation priorities*
- *priorities identified by the Department of Health*
- *national priorities guidance*
- *national service frameworks*
- *national performance indicators.*

3.20.2 agreed local priorities.

3.21 The primary care group develops a programme of action to achieve its agreed targets in the health improvement programme.

Guidance
This should contain achievable and measurable objectives.

Developing primary and community health care services

3.22 The primary care investment plan:

3.22.1 is linked to and consistent with the health improvement programme

3.22.2 is linked to identifiable improvements in patient care

3.22.3 is shaped by locally agreed priorities

3.22.4 reflects the needs of constituent practices

3.22.5 is developed in consultation with all representative stakeholders

Guidance

This will include, for example, local medical committees, NHS trusts, and the larger community.

3.22.6 is co-ordinated with other local primary care groups (collegiate working)

3.22.7 is costed

Notes

3.22.8 considers the distribution of total resources

Guidance

For example, secondary and tertiary health services, local authority services, non-statutory and voluntary agencies.

3.22.9 reflects the training and development needs of staff

3.22.10 is linked to a review process

3.22.11 is available to other agencies and the wider community.

3.23 The primary care group contributes to the plans of other agencies.

Guidance

This may be through involvement in local teams run by the local authority, health authority, social services, community trusts and non-statutory and voluntary organisations.

Examples of plans include:

- *joint investment plan*
- *community development plans*
- *housing investment plan*
- *children's services plans*
- *early years development plan*
- *Agenda 21 (addressing social responsibility).*

3.24 The primary care group monitors the development of primary care against:

3.24.1 the objectives of the primary care investment plan

3.24.2 the national performance framework

3.24.3 local priorities

3.24.4 the health improvement plan.

3.25 This will include analysis of:

3.25.1 PACT data

3.25.2 referrals

3.25.3 waiting times

3.25.4 service provision within primary care

3.25.5 professional development of primary care staff.

Commissioning secondary care

3.26 A commissioning plan is prepared, which:

3.26.1 reflects the health improvement programme

Notes

3.26.2 reflects a balance of health service provision between primary, community and secondary care services

3.26.3 reflects locally agreed priorities

3.26.4 makes the changing responsibility for commissioning between the primary care group and health authority explicit

Guidance

HSC 1998/198 and HSC 1998/228 provide guidance on the respective roles of primary care groups and health authorities in the commissioning of services and how these may change over time.

3.26.5 where appropriate, reflects collaborative commissioning arrangements with other primary care groups (collegiate working).

3.27 The commissioning plan is developed in partnership with appropriate stakeholders which include:

3.27.1 other local primary care groups

3.27.2 health authority commissioners

3.27.3 public health departments

3.27.4 the local population

3.27.5 users and carers

3.27.6 service providers, such as trusts

Guidance

The strategic development plans of providers need to be taken into account, for example, Calman-Hine, Royal College plans, major reconfiguration.

3.27.7 voluntary organisations

3.27.8 local authorities.

3.28 Service level agreements are developed to implement the primary care group's commissioning objectives.

3.29 There is multi-disciplinary involvement in the development of service level agreements.

3.30 There are named individuals with responsibility for the development of service level agreements.

3.31 Service level agreements include the following dimensions:

3.31.1 quality (clinical and non-clinical)

3.31.2 cost

3.31.3 volume/activity.

3.32 The service to be provided is clearly defined in the service level agreement and includes:

Notes

3.32.1 a description of the service to be provided

3.32.2 evidence that providers are appropriately qualified and can demonstrate continuing professional development

3.32.3 protocols of care indicating the different responsibilities of staff at all stages from referral to post discharge

3.32.4 specification of formal lines of communication between the primary care group and the provider of services

3.32.5 arrangements for monitoring and reviewing compliance with specifications

3.32.6 mechanisms for dealing with problems in service delivery

3.32.7 specification of arbitration procedures in case of dispute

3.32.8 policies for risk management.

3.33 There is access to the following information:

3.33.1 a list of providers with which service level agreements have been negotiated

3.33.2 contact names for the above

3.33.3 a full set of signed and dated agreements for all the services commissioned.

3.34 Service level agreements are reviewed at defined intervals.

3.35 Clinical indicator information is obtained from service providers.

Guidance

These include, for example:

- *clinical outcomes indicators (this may reflect local or nationally defined outcomes)*
- *infection rates*
- *readmission rates*
- *percentage of referrals responded to within two weeks*
- *pressure sore rates*
- *length of stay*
- *time between referral and consultation*
- *evidence that quality standards stated in service level agreements have been achieved.*

3.36 The information received from service providers is monitored against service level agreements.

3.37 Where service changes are made, the primary care group demonstrates a clear rationale for the changes.

Guidance

The following should be considered when changing services:

- *public consultation*
- *assessed need*
- *agreed priorities*
- *proposed developments*
- *provider performance, including outcomes*
- *best value*
- *clinical evidence of effectiveness*
- *the impact of change.*

Notes

Evaluation

3.38 The primary care group reviews progress against targets and objectives in the:

3.38.1 health improvement programme

3.38.2 primary care investment plan

3.38.3 service level agreements

3.38.4 national performance framework

3.38.5 national service frameworks

3.38.6 locally agreed priorities.

3.39 The primary care group evaluates its collaborative arrangements with other agencies and stakeholders.

3.40 The primary care group produces a written report to inform future development against the six criteria in the national performance framework.

This standard not only considers how primary care groups move towards pimary care trust status but also covers the developmental issues which any organisation should be considering. Primary care groups which do not want to take on more responsibilities should still work through these criteria.

Standard 4 : Future development

The primary care group and its constituent parties assess, plan and develop its capacity to take on further responsibilities.

Criteria

Notes

Milestones for transition to trust status

4.1 There is a framework to support the decision making process to move towards levels three and four.

Guidance

This includes, for example, dialogue between the health authority, the trusts and members of the primary care group to ensure agreement by all parties and the level of consultation required.

4.2 Where progression to trust status is being proposed, the mechanisms for full consultation are explicit.

4.3 There are agreed triggers/standards for progression to higher levels which are agreed between the primary care group and the health authority.

4.4 There is a proposed board structure that reflects the necessary skills to undertake the tasks of the primary care group operating at a higher level.

4.5 There is evidence of working across primary care group boundaries (collegiate working.)

Guidance

This includes, for example developing joint guidelines, strategies and commissioning plans with other primary care groups. For level four primay care trusts, this will take account of the local health economy; the most cost-effective configuration of services bearing in mind other primary care trusts in the area.

4.6 There are clear arrangements for risk management/risk sharing.

Developing capability

4.7 There is an organisational development plan for the primary care group which includes:

4.7.1 an assessment of current skills and resources

4.7.2 an assessment of future skills and resource requirements

Notes

Guidance

These include, for example:
- *time*
- *people*
- *skills*
- *systems*
- *structures.*

4.7.3 the process for recruiting people with the necessary skills required for the management of the primary care group operating at higher levels

4.7.4 the process for appraising and re-recruiting elected members of the board.

4.8 At each new level, the constitution is:

4.8.1 reviewed

4.8.2 amended as necessary.

4.9 There is a resource investment plan.

Guidance

This includes, for example:
- *human resources*
- *infrastructure*
- *information technology.*

4.10 There are plans to address:

4.10.1 how the primary care group will take on core functions previously provided by health authorities

Guidance

These include, for example:
- *commissioning*
- *public health*
- *primary care development*
- *prescribing advice.*

4.10.2 how support functions previously provided by the health authority are best provided.

Guidance

These include:
- *legal advice*
- *human resources*
- *information technology*
- *finance*
- *organisational development.*

4.10.3 how it will manage the services to be provided as a primary care trust.

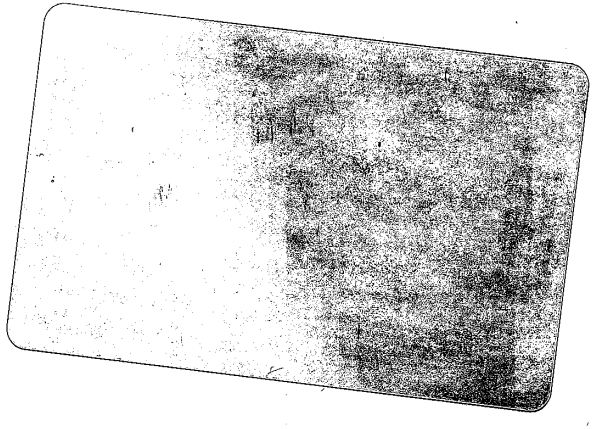
Feedback sheet

HQS needs the input of programme users to ensure that the standards and criteria are relevant and up-to-date.

Please use this sheet to record your comments on these standards, for example letting HQS know if criteria are difficult to interpret, if terminology used is incorrect, or if you know of more up-to-date references which should be included. Please return completed feedback sheets to the project manager in your organisation in the first instance, who will then forward to HQS.

Thank you

Criteria	Comment	Criteria	Comment



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