

# Health Service Circular

## Local Authority Circular

**Series Number:** HSC 1999/246 : LAC (99)40

**Issue Date:** 22 December 1999

**Review Date:** 22 December 2002

**Category:** General Management

**Status:** Action

*sets out a specific action on the part of the recipient with a deadline where appropriate*

---

## PRIMARY CARE GROUPS: TAKING THE NEXT STEPS

---

**For action by:** Health Authorities (England) - Chief Executive  
NHS Trusts - Chief Executives  
Social Services Directors - England  
Primary Care Groups - Chairs

**For information to:** Community Health Councils, Chief Officers  
Health Authorities (England)- Chairman  
Local Authorities - London Borough Councils Chief Executives  
Local Authorities - Metropolitan District Councils Chief Executives  
Local Authorities - Shire Unitary Authorities Chief Executives  
NHS Trusts - Chairman  
County Councils – Chief Executives  
Common Council of the City of London  
Council of the Isles of Scilly  
Community Health Service Councils - Chairs  
Primary Care Groups - Chief Executives  
Local Medical Committees  
Local Dental Committees  
Local Optical Committees  
Local Pharmaceutical Committees

---

**Further details from:** Ms Shain Clarke  
PC-GMS (PCG/T Implementation Team)  
Rm 7E01, Quarry House  
Quarry Hill, Leeds, LS2 7UE      Tel No: 0113 2546323

---

*Additional copies of this document can be obtained from:*

Department of Health  
PO Box 777  
London  
SE1 6XH

Fax 01623 724524

It is also available on the Department of Health web site at  
<http://www.doh.gov.uk/coinh.htm>

© Crown copyright

---

# PRIMARY CARE GROUPS: TAKING THE NEXT STEPS

## Summary

This HSC outlines the actions which should be taken to continue the development of Primary Care Groups (PCGs), which are at the heart of the Government's programme for developing primary care and ensuring accessible, convenient local services for patients. It includes action for those that wish to move to Primary Care Trust (PCT) status who are able to demonstrate benefits for, and the support of, local patients and the wider health community. It provides preliminary advice on the growing information requirements necessary to support PCG/Ts, and outlines documentation produced on the establishment, functions and operational aspects of PCTs. The guidance supports HSC 1999/244 [LAC(99)39] *Planning for Health and Health Care*.

## Action

### Health Authorities (HAs) should

- take continuing management action to support PCGs in their continued development so that they are able to take on the responsibilities for delivering better health care and better services for patients
- agree fair and equitable distribution of management resources
- assist those who wish to progress to PCT status to achieve that ambition
- support those approved by the Secretary of State as PCTs in their establishment and during their preparatory period

### PCGs should

- work with their HA to take the opportunity to play an active part in determining local priorities, targets and the use of resources, to deliver more accessible and convenient services for patients through participation in the production of a local Health Improvement Programme (HImP) and by taking on responsibilities for delivery of a programme of action to achieve the HImP
- agree and implement development plans which allow each PCG to take on the responsibilities for improving patient services and the health of its community
- work with NHS Trusts and HA partners to commission services and align clinical responsibilities with incentives to maximise resources and deliver effective, efficient and quality care
- work with local partners to take forward any local application to move to PCT status, and become a successful PCT as outlined in this HSC

### NHS Trusts should

- work with HAs and PCG/Ts to ensure that regular accurate and comprehensive data (covering out-patient activity, A&E attendance and waiting lists) is provided which supports Long Term Service Agreements (LTSAs), and that this information can be disaggregated to practice level
- work with local PCT proponents to support establishment of the PCT and to facilitate appropriate transfer of staff and premises
- work co-operatively with PCTs to enable effective commissioning and delivery of healthcare services
- discuss with local PCG/Ts and HA partners how HR and other management functions might best be utilised across the local health system to maximise NHS resources and skills in that area

### Local Authority Partners should

- work with PCG/Ts in considering Joint Investment Plans that deliver responsibilities agreed as part of the development of a local HImP

- work with those approved by the Secretary of State to become a PCT to provide appropriate SSD representation on the PCT Executive Committee so as to enable better integration of services for the local community

## **Associated Documentation**

Primary Care Trusts: A Guide to Estate and Facilities Matters

Primary Care Trusts: Establishment, the Preparatory period and their Functions

Primary Care Trusts: Financial Framework

Working Together: Human Resources guidance and requirements for Primary Care Trusts

---

## Introduction

1. HSC 1999/192, *Leadership for Health: the Health Authority Role* made clear the pivotal role that HAs have in the delivery of the Government's policy for the new NHS. NHS planning guidance (HSC 1999/244 *Planning for Health and Health Care*) makes clear that, through the development of the Health Improvement Programme (HImP), HAs should:
  - ensure that service improvements for local people are coherently planned and delivered
  - provide strategic leadership on improving health and tackling health inequalities.
2. To achieve this, HAs must ensure that:
  - all parts of the NHS locally work together and are properly equipped to take on the modernisation challenge
  - they are applying and sharing good practice and learning
  - they are held to account for achievement of agreed health improvement and service delivery targets.

Developing successful PCGs who, if they wish, are able to progress and become effective PCTs, is key to this agenda.

## Strengthening the role and influence of PCGs

3. Delivering efficient and effective PCGs and PCTs are at the centre of the programme of reforms to modernise the NHS. Increasingly, they will be the key players in ensuring local delivery of national targets and service objectives and need therefore to be engaged at the heart of NHS planning. HAs are expected to work with local PCGs, to ensure this is happening at a pace and in a way which is sustainable to the whole health system in that area but at its core is agreed with and determined by each PCG. NHS planning guidance (HSC 1999/244) makes clear that to achieve this, HAs should:
  - work with local stakeholders in developing the HImP, and related Service and Financial Framework (SaFF)
  - agree responsibilities for leading on the delivery of targets and objectives contained in the HImP and SaFF, along with monitoring and reporting arrangements, to be set out in an Annual Accountability Agreement (AAA) between the HA and individual PCG/Ts
  - agree distribution of management resources with each PCG/T to enable each organisation to properly discharge its responsibilities set out in the AAA
  - devolve fair and equitable resources from the unified budget in an open and transparent process
  - agree and implement an organisational development plan which supports each PCG/Ts development at a pace determined and agreed locally.
4. The existing PCG incentive framework (see paragraphs 78-89 of HSC 1998/228) provides PCG/Ts with the opportunity to make use of the flexibilities offered by the unified budget. In particular, this framework enables PCG/Ts to operate financial management arrangements across their unified budget with practices acting as cost centres. In addition, effective incentive schemes will generate surpluses for the PCG/T that can be reinvested to develop primary care infrastructure or service delivery targets.
5. Prescribing is one component of unified budgets and is included within cash limits for HAs and PCTs. However, GP practices will continue to operate within "indicative" prescribing budgets which are not subject to cash limits at practice level. All preparatory PCTs and PCGs should set prescribing resource shares for their constituent practices for 2000-01. These budgets should be used to support the development and operation of prescribing incentive schemes as part of the PCGs overall incentive package for improving the effectiveness and quality of prescribing. Recent experience suggests that the creation of large contingency reserves at a HA level may detract from local actions to create incentives for the better management of these resources.
6. Chief Executives of HAs, PCGs and preparatory PCTs are asked to ensure that local arrangements are in place for practices to be awarded realistic prescribing budgets. Detailed

guidance to inform local discussion between finance directors and prescribing advisers is being issued and is contained as an Annex to *PCTs: Financial Framework*.

7. For 2000-01 PCG/Ts should also extend practice resource shares and incentive schemes beyond prescribing to cover commissioning activities funded from the unified budget. Advice on how to develop resource shares for practices was set out in the working paper *Supporting Incentive Schemes by Developing Weighted Capitation Resource Shares for Practices*, issued in March 1999. This extension of indicative practice budgets depends crucially on NHS Trusts (and PCTs) providing activity data to PCGs (or to other PCTs) which identifies the referring practice. HSC 1999/244 emphasises the need for NHS Trusts to provide such data in 2000-01. Further planned IM&T guidance will reinforce this message but initial advice is set out at Annex A to this HSC.
8. HAs also have a crucial role in ensuring that PCG/Ts are appropriately resourced to fulfil their role. Within the first year of PCGs there have, however, been large variations in the distribution of management costs between PCGs and host HAs. Some of these variations appear inconsistent with the responsibilities delegated to PCGs. Ministers have made clear that HAs will be asked to explain the basis for their distribution of management costs in 1999-00 and to provide full involvement of PCGs and preparatory PCTs in the planning process for 2000-01. In addition, For 2000-01 both newly established PCTs and continuing PCGs will therefore need to be adequately resourced by their HAs to:
  - carry out their functions
  - to deliver the agreed targets in their Annual Accountability Agreements
  - to play their full part in the local HImP
  - and to deliver SaFF targets.
9. The transition to PCTs also provides an opportunity for organisations to review how best to deliver management functions so that cost-effective and sustainable structures are established. In particular, this will involve exploring the scope for sharing support services. The development of common services shared across organisations brings the potential for maximising management resources in a way that can ensure a consistent, high quality and efficient service can be provided for all organisations within that health economy.

## Establishing PCTs

10. As has been made clear in *Primary Care Trusts: Establishing Better Services*, PCTs will be new statutory local NHS bodies. They have new opportunities and greater flexibilities to shape services to provide better health and better care to their local community. The decision to develop a proposal to become a PCT is a local one and will be the subject of an open consultation (see HSC 1999/167). The decision to approve a proposal and establish a PCT is made by the Secretary of State. The first PCTs will be established in January 2000 to begin operating from 1 April 2000. Subsequently more will be established.
11. Guidance has been produced for those wishing to become a PCT. Summaries of the contents of these documents are contained at Annex B to this HSC. In outline, the guidance produced covers:
  - *The Establishment of PCTs, their Preparatory period and Functions*: This document explains the arrangements for establishing a PCT and sets out key tasks needs to undertake during its preparatory period and before its operational date of 1 April (or for 2000/01 only 1 October). It outlines the functions that must be delegated to PCTs, those which will not be delegated and those where there will be local flexibility.
  - *Working Together: HR guidance and requirements for PCTs*: This document establishes the HR principles against which prospective – and in time established - PCTs will be assessed. It also identifies the immediate steps PCTs will have to take upon establishment. The guidance also aims to provide information to prospective PCT employees about the standards it is expected PCTs will adopt.
  - *PCTs Financial Framework*: This document provides details of the financial framework which will apply to PCTs. PCTs which commission services (known as "level 3") will be formed from PCGs. PCTs which also provide services (known as "level 4") will be formed

---

from PCGs and NHS Trusts. PCTs will continue PCGs' responsibilities for improving health and developing primary care. The document also sets out PCG and PCT prescribing and budget setting for the financial year 2000/01.

- *PCTs: A guide to Estates and Facilities matters*: This document provides details of PCT powers and responsibilities in the acquisition and disposal of property in their estate portfolio. Advice is also given on the conduct of estate and facilities management. Of particular interest to level 4 PCTs, who are likely to own or lease significant estate portfolios, it will also be of interest to level 3 PCTs in respect of estate used for their administrative purposes as well as GP reimbursements.
12. Whilst substantive guidance on the IM&T Requirements to support PCGs and PCTs will be available in January, a summary of the actions and tasks that need to be undertaken to support PCGs in the planning and delivery of better services and health for their community for 2000/01 is contained at Annex A.

All the documentation are freely available on the internet (or *NHSnet*) at the Department of Health website: [www.doh.gov.uk/coinh.htm](http://www.doh.gov.uk/coinh.htm). Alternatively, copies can be ordered by contacting:

Department of Health  
PO Box 777  
London SE1 6XH

Fax 01623 724 524  
Email [doh@prologistics.co.uk](mailto:doh@prologistics.co.uk)

13. A summary of the contents of these documents are attached at Annex B.

### Further reference

HSC 1999/192 Primary Care Trusts – Developing Better Services  
HSC 1999/167 Leadership for Health: The Health Authority Role  
HSC 1999/167 Primary Care Trusts – Application Process  
HSC 1999/207 Primary Care Trusts – Consultation Process

# Annex A

## IM&T REQUIREMENTS TO SUPPORT PCGs and PCTs

### Actions

a) **HAs / NHS Trusts / PCGs** should:

- within the process of drawing up their Local Implementation Strategy (LIS), ensure that PCG/Ts have the opportunity to take an active part in determining priorities, targets and the use of funding or other resources
- put in place arrangements to safeguard and govern uses made of patient identifiable information, in accordance with the principles defined by the Caldicott report.

b) **HAs** should:

- lead the development of the LIS, establishing a Health Informatics Service (HIS) to pool scarce IM&T resources and ensure that it is responsive to the needs of PCG/Ts
- ensure appropriate data and skills are available to support PCG/Ts in developing Health Needs Assessments
- ensure information relating to individual practice budget allocations and expenditure is made available to PCG/Ts
- ensure PCGs have the necessary systems and support to enable them to manage and monitor expenditure and performance against service agreements.

c) **NHS Trusts**, including community and mental health Trusts, should:

- ensure reports on admitted patient care, disaggregated to practice level, are made available monthly via the Nation Wide Clearing Service (NWCS)
- work with HAs and PCG/Ts to provide regular reports, disaggregated to practice level, covering out-patient activity, A&E attendance and waiting lists, which are required to support Long Term Service Agreements (LTSAs)
- ensure accuracy, consistency and comprehensiveness of details within commissioner datasets.

d) **PCGs** should:

- consider with their practices how to provide information systems that supports integrated Primary and Community Health Care Teams
- plan over time how to increase the use and scope of clinical recording within existing practice systems, and identify a clinical lead to co-ordinate this work
- develop, within Primary Care Investment Plans (PCIPs), and through contributing to the LIS, plans to ensure that Modernisation Funds are appropriately deployed to:
  - Develop PHCT systems and provide training and support
  - Collect comparative data, e.g. using MIQUEST
  - Implement decision support systems, e.g. using PRODIGY
  - Respond to NHSnet targets
  - Utilise electronic prescribing aids, e.g. ePACT.net
  - Make available information systems to support standards, service models and performance measures specified within each National Service Framework (NSF).
- in addition, prospective PCTs should consider the options available to establish adequate systems that support financial management and monitoring requirements.

## Introduction

- 1 Accurate, timely and relevant information is essential for the modernisation of the NHS to support delivery of improved health and reduced health inequalities. This guidance outlines information requirements for PCG/Ts to support the HSC *Planning for Health and Health Care*.
- 2 All NHS organisation should be working together to develop Local Implementation Strategies (LISs). PCG/Ts should take an active part in determining priorities, targets and the use of these resources as investments to support the information requirements of PCG/Ts must be planned and implemented in the context of the LIS.
- 3 Because of the relatively high cost and scarcity of specialist IM&T skills, pooling and sharing arrangements should be considered, both for IM&T specialists and clinical staff employed to support informatics work through establishment of a Health Informatics Services (HIS). As PCG/Ts are new organisations, with few IM&T skills or resources under their control, their needs should be supported recognising they will need time to adapt their systems and working practices.

## Electronic Patient Records / NHSnet

- 4 *Information for Health*, whilst outlining an important role for fully integrated Electronic Patient Records (EPR) recognises the need for these to evolve over time; with the introduction of comprehensive EPRs and EHRs to be in place by 2005. One element of this is the development of fully integrated Electronic Patient Records covering both primary and community care services. A phased process taking account of the legal status of GP clinical records, cultural changes such as consistent coding, training and the availability of resources should be taken, as the pace of change must have clinical support.
- 5 Greater co-ordination of care requires clinical systems that support all Primary Health Care Team (PHCT) members, where data is entered once only. Local strategies should include plans to provide integrated systems that aids access to patient information by authorised users based on a need to know. In the short term much can be achieved with existing systems. Within the LIS, and through investment in primary care, it will be important to provide for training and support for PHCT members to make best use of existing systems, and to develop incentives to ensure consistent recording of data on all types of health event. This will support patient care by enabling data to be extracted in a standardised and anonymised way to support clinical governance.
- 6 Communication within and between PCGs, HAs and Trusts is crucial and will be facilitated by the implementation of NHSnet. Further information is available on [www.ppnet.nhsia.nhs.uk](http://www.ppnet.nhsia.nhs.uk)

## Clinical Governance

- 7 The introduction of clinical governance and evidence-based practice requires:
  - improving access for all NHS staff to information on effective clinical practice and service provision, e.g. the National Electronic Library for Health (NELH)
  - investment in clinical systems and information support services, which support staff in putting evidence into practice, e.g. using PRODIGY
  - the development of a range of service models and indicators
  - collection of comparative data from primary care systems.
- 8 National Service Frameworks (NSF) set national standards and outline service models for a defined service or care group. They put in place strategies to support implementation and delivery and establish performance measures against which progress will be measured and monitored. NSF standards, service models and indicators need to be supported by information systems that are developed to keep pace with progress in implementing key elements of each NSF. These systems, and associated recording procedures, must enable patients' details, treatment or care provided and health outcomes to be recorded consistently and comprehensively to support direct patient care.
- 9 The Collection of Health Data in General Practice (CHDGP) project has produced a set of guidelines and associated training materials on clinical data recording, data quality audit methods, and on data extraction and analysis for assessing data quality using MIQUEST and other tools. Details are available on [www.nhsia.nhs.uk](http://www.nhsia.nhs.uk).

## Health Needs Assessment

- 10 It is necessary to collect and collate data and information from a variety of sources (including population demographic estimates and forecasts, and birth and death registration data produced by ONS, public health data sets, cancer registration, and other social and environmental data) to inform health needs assessment. Much of this data is area rather than practice based, but various techniques can be employed to overcome this problem. PCG/Ts will therefore need to access specialist analytical and public health skills.

## Confidentiality

- 11 Each HA and PCG should have appointed a Caldicott 'Guardian' responsible for establishing procedures governing access to, and the use of, person identifiable information. HAs and PCG/Ts should together undertake a comprehensive audit of existing procedures to ensure compliance with Caldicott principles. Delivering better integrated health and social care will require some sharing of information relating to these patients and service users where the care is jointly provided. PCG/Ts and their Social Services partners will need to address the issues of confidentiality and security of personal information that arise from this requirement.
- 12 Information for use within PCG/Ts will require comparison of performance between practices and against local and national benchmarks. Although sharing of practice level information is encouraged, it is sensible to discuss with representatives of each practice beforehand the purpose for which comparative information is required, how it will be used, together with the intended methods of analysis and presentation.

## Empowering PCG/Ts and practices

- 13 Information relating to resource allocations; current and forecast expenditure; human resources and service capacity; as well as reference costs based on Healthcare Resource Groups will be required to support service planning. PCG/Ts will need to be able to attribute this data to practice level, so as to support development of a range of incentives that encourage the delivery of better services and better health care for patients.

## Commissioning and LTSAs

- 14 In developing their commissioning role and to support the implementation of Long Term Services Agreements (LTSAs), PCG/Ts will require access to detailed information on the care provided to their patients by NHS Trusts and other organisations. As a minimum PCGs should already be receiving from HAs regular reports on admitted patient care based on data exchanged via NWCS. This should:
- identify completed episodes, admissions and discharges by speciality;
  - separately report emergency and elective episodes, admissions and discharges, as well as day-cases;
  - identify the NHS Trusts providing treatments and the individual general practices with which patients are registered;
  - compare levels of activity with those for comparable time periods in previous years, and with those planned for in service agreements.
- 15 In addition HAs and NHS Trusts must work together to provide PCG/Ts with information on out-patient care, attendance at A&E departments, and on waiting lists and times, at the earliest possible date. NHS Trusts are responsible for the accuracy, consistency and comprehensiveness of clinical details within these datasets.

## Managing Prescribing

- 16 PCG/Ts have responsibility for managing the prescribing budget and developing appropriate, high quality prescribing behaviour among their constituent GPs. The Prescription Pricing Authority (PPA) already provide PCGs with electronic prescribing data (e.g. EPACT.net) and paper reports to enable them to monitor GP prescribing. Specialist prescribing advice will assist PCGs in this role. Advisers should be trained in the use of electronic systems and work with the Clinical Governance Lead in each PCG/T to promote high quality, cost effective prescribing.
- 17 Decision support systems will increasingly become an important element of good clinical practice.

PRODIGY is a decision support tool that works with practice clinical systems during consultations and is included within RFA99. There is a continuing programme to extend and update its clinical content, which will operate under the auspices of the National Institute of Clinical Excellence (NICE).

### Supporting Level 1 and Level 2 PCGs

18 As well as the information requirements outlined above, PCGs will need to take forward their primary care development role through the development of a Primary Care Investment Plan (PCIP). Often investment will need decisions based on comparative benchmarking of the use of the GMS CL element of unified allocations by individual practices so as to identify 'fair share' allocations ensuring invest in under resourced practices. This requires analysis of individual practice budget and expenditure information. Analysis should take account of variations in the size of practices and their patient profiles, and needs to be supported by information on staff hours, premises and equipment. HAs should ensure this information is available to PCGs.

### Supporting Level 3 Primary Care Trusts

19 The financial systems support required to support the commissioning and primary and community care development activities of Level 3 PCTs is similar to that for level 2 PCGs. In addition, they require information concerning numbers of staff employed by and capital assets deployed by the PCT. They may choose to implement their own systems or commission these from the HA or externally e.g. an acute or community NHS Trust. If an external option is selected, a defined service agreement will be required.

### Supporting Level 4 Primary Care Trusts

20 Level 4 PCTs will directly provide community health services. The range of services provided will vary according to local circumstances and may include community hospital based care. Level 4 PCTs will employ the necessary staff and own property in order to provide these services. Financial management and monitoring systems will need to enable these PCTs to clearly distinguish between expenditure on the commissioning of services and their expenditure on the provision of services.

21 Level 4 PCTs also need to implement systems to support the costing of the services they provide, and the management of service budgets and expenditure. In these circumstances it may be appropriate to consider if and how the systems (ledgers, accounts receivable and payable, etc) within existing NHS Trusts should be used on a 'bureau' basis. Systems may need to be enhanced to enable the PCT to:

- identify service budgets and expenditure at practice level, particularly where integrated PHCTs are practice attached
- support the calculation of standard reference costs for services provided by the PCT.

22 PCTs will also need to consider:

- Human Resources and Personnel systems
- payroll systems
- stock control and ordering
- Capital Asset and equipment management

In the majority of cases, existing NHS Trusts or HAs should be able to assist new PCTs by providing services or support in these areas.

### Further Information

More detailed advice and information on the developing information and IM&T requirements that stem from delivery of *GPnet* and the continued development of PCG/Ts will be available in the New Year.

# Annex B

## Establishment, the Preparatory Period and Functions Guidance Summary

The guidance sets out arrangements for establishing a PCT. It explains the key tasks which PCTs must undertake in their preparatory period and before the operational date. It outlines the functions of PCTs, including those functions that will be delegated and those where there is local flexibility for delegation.

### Key points

A PCT may be established by the Secretary of State following local consultation, organised by the appropriate HA. Each PCT will be established as a free-standing NHS body separate from, but accountable to, its local HA. HAs will be required to delegate responsibility for commissioning the majority of hospital and community health services to PCTs. A level 4 PCT will also be able to provide services, run hospitals and community health services, and employ the necessary staff. HAs have a statutory duty to consult with the Local Medical Committee, and where these functions are delegated to a PCT, then the duty to consult the LMC will pass to the PCT as well.

The period between the establishment and operational dates is the preparatory period. During this period the PCT is limited in its range of functions to those required to prepare to become operational and the HA to which it is accountable will fund it. The CE is the Accountable Officer for the PCT and in each case (s)he will be appointed as such from the operational date of the PCT.

The Government's preferred PCT governance arrangements are set out in the guidance, including the respective roles of the PCT Board and Executive Committee. It sets out arrangements which should govern appointments, and makes clear that PCTs will have the same overall functions as PCGs and will be given responsibility for the provision of services across the broad mass of HA functions. Appointments to PCTs should set a high standard by using the best HR practices and candidates should be selected from clear job and person specifications after open and fair competition.

PCTs will be major contributors to the delivery of national targets and service objectives and HAs will need to work closely with PCTs to ensure their full involvement in the local HImP. Each PCT should also prepare a PCIP that summarises their overall intentions for the development of primary care provision across its area.

To facilitate the high quality services for patients, PCTs should seek the best possible coterminosity with other bodies, in particular with the HA and LA. PCTs should consider a pooled budget with their Local Authority (LA) in order to facilitate partnership working and collaboration.

## Content

- An introduction
- Preparatory period details
- Governance arrangements
- Alternative governance arrangements
- Appointment of the Chief Executive & Director of Finance
- Appointments to the Executive Committee
- PCT Functions
- Developing community health services
- The PCT commissioning role
- Service provision
- Delegation of HA functions
- Personal Medical Services
- Human Resources
- Finance
- Management costs
- IM&T
- Boundaries/Organisational codes
- Miscellaneous matters

- Annex A – Board & Executive Committee composition
- Annex B – Board Chair & Lay Member job descriptions & competencies
- Annex C – Chief Executive competency framework
- Annex D – Executive Committee member competencies

## Estate and Facilities Matters Guidance Summary

Estates and facilities management absorb some 20% of the NHS running costs, so the importance of good quality management of these services cannot be over-emphasised. The attached document *Primary Care Trusts: A Guide to Estate and Facilities Matters* provides details of powers and responsibilities in the acquisition, management and disposal of property.

The guide is of particular significance to level 4 PCTs who will require premises for the delivery of high quality patient services, but will also be of interest to level 3 PCTs who occupy premises mainly for administrative purposes. PCT estate needs should be commensurate with service expectations, be efficient, effective, and maintained in an acceptable condition. It should be well located and contribute to the healthcare provision in the health economy within which the PCT operates.

PCTs will have responsibility for making payments in respect of GP premises in accordance with the Statement of Fees & Allowances (cost rent and improvement grants). Payments made under these arrangements, to modernise GP premises, will need to be in accordance with the PCIP agreed with the HA.

The PCT Board and the Executive will also need to understand their responsibilities and liabilities in respect of property they occupy, for example health and safety, fire safety, disability discrimination, environmental management of for example clinical waste and other regulatory and statutory requirements.

### Content

- An introduction to the establishment of PCTs
- PCT roles and responsibilities for estates issues
- PCT functions and property requirements
- Estates Strategies, Primary Care Investment Plans (PCIPs) and relation to Health Improvement Programmes (HimPS)
- Need for estates expertise and establishment of appropriate support
- Available professional advice
- Compliance with **CIM** and **Estatecode**
- Property transfer orders
- Arrangements for 'property sharing'
- Facilities management issues, including risk assessment
- Miscellaneous property matters

In addition, a Boardroom Briefing paper sets out the principles of best practice in facilities management, emphasising the need of Boards and their Executive to ensure that estates and facilities management issues are addressed, performance benchmarked and ensure that the estate makes a genuine contribution to the achievement of the PCT's objectives.

Further advice on estates issues can be obtained from NHS Estates Head of Estates and Facilities based at each Regional Office

## Financial Framework Guidance Summary

This document provides details of the financial framework which will apply to Primary Care Trusts (PCTs). It is aimed at officers and non-executives at board level within HAs/PCGs and NHS Trusts. The document provides the "headline" messages on PCT finance and is supported by a small number of more detailed annexes which include Directions for HAs and PCTs.

PCT Board and Executive Committee members will need to be familiar with the key elements of the financial framework in order to fulfil their responsibilities for financial control and probity.

A listing of the key sources of finance guidance for PCTs is provided at the end of the section. Further support will be provided for members and staff who do not have a finance background or who are new to the NHS as part of the PCT Development Programme (further details are provided in HSC 1999/167, *Primary Care Trusts: Application Process*, issued August 1999). The HSC will be supplemented by the PCT Corporate Governance Framework Pack (which will be issued on CD) and technical accounting manuals which will be posted on the NHS Executive finance web site in the new year.

### Content

- Introduction
- Statutory Basis for the Financial Framework
- Financial Accountability and Corporate Governance
- Financial Duties
- Audit Arrangements
- Financial Monitoring
- Resource Allocation and Funding
- Setting up PCTs – establishing opening balance sheets
- Manual for Accounts
- Capital Accounting Manual
- Annual Report
- Management Accounting
- Further Guidance

- Annex A – Accountability Arrangements
- Annex B – Revenue Resource Allocation and Funding Arrangements
- Annex C – Capital Allocation and Funding Arrangements
- Annex D – Prescribing and Budget Setting for 2000/01
- Annex E – Financial Duties

---

## Human Resources Guidance Summary

The object of the HR guidance is to ensure that HR standards are maintained during the preparatory period and establishment of PCTs. In order for PCTs to meet the targets set in the strategic framework approach to human resources set out in *Working Together* PCTs will need to follow the requirements laid out in the guidance.

The strategic emphasis of the guidance considers the scale of the HR agenda faced by PCTs and the abilities and capabilities that these new organisations will have to implement that agenda.

The guidance emphasises the need to involve staff at all stages of the birth of the PCT through the establishment or strengthening of the local HR forum.

The guidance also outlines that staff rights under transfer orders will be fully protected, which will address much of the concern raised by staff. The positive role that unions can play in PCTs and the importance of training and development in the process. Statutory and NHS employment requirements are also fully covered.

## Content

- Introduction
- Purpose of the guidance
- Development plans
- Working Together
- Clearing House guidance
- Agenda for change issues
- Pension entitlement
- PMS Pilots
- General Practitioners
- Board and Executive Committee issues
- Equal opportunities
- Racial Harassment
- Improving working Lives
- Training and development
- Employment requirements
- Joint Working
- Partnership issues
- Quality
- Employment legislation

## EXECUTIVE SUMMARY

As new free-standing statutory bodies, PCTs will have a unique opportunity to set high standards of Human Resources (HR) from the very beginning. Their effectiveness in delivering their objectives, to improve the health of their community and develop primary and secondary care services, will be dependent on a committed workforce. It is therefore important that they seek to consult and work closely with staff at all levels during the preparatory, establishment and organisational maturity stages of their development.

Like other NHS employers, they will be bound by requirements under employment law and normal NHS practice as set out in guidance. Additionally, the first ever national framework for the management of HR across the NHS, *Working Together to secure a quality workforce for the NHS* has brought HR management to centre stage. It reminds us that HR issues can no longer be seen as an add-on – peripheral to the main business of delivering patient care. This is particularly salient for PCTs. The emphasis is on learning, establishing what works and what does not and about continuous improvement, not censure. The overarching principles that will influence the HR decisions are fairness, openness, transparency and equality of opportunity for all staff. There is an important role here for organisational development

This guidance has been designed to establish the HR principles by which prospective PCTs will be able to judge for their readiness in HR terms and enable them to plan for the effective long-term measurement of their HR performance. It is also aimed at providing reassurance to prospective employees of PCTs about the standards they can expect of their future employers. It should be shared with all affected staff and their representatives, as well as other key stakeholders, to ensure that the strategic HR direction can be maintained throughout the change process.

There are a number of key aspects fully covered in the guidance:

The importance and scale of the HR agenda in the development of PCTs. Prospective PCTs will need to ensure that they are fully able to deliver the necessary HR agenda. The PCT's ability to deliver the necessary service changes will be crucially dependent on the staff working within them.

The necessary HR resources are available to enable PCTs to address the HR agenda. There are a number of ways that the overall HR guidance can be provided to the PCT and this will be determined by local circumstances and issues in relation to management costs. It is important to use available NHS expertise and knowledge to provide the necessary HR support.

Suitable consultation mechanisms that will engage and involve staff through all stages of PCT development, from application to representation in the established organisation, are fully discussed including the important role that the HR forums will have in this process. As identified in HSC 1998/139 the HR forums developed by the HA must continue and should usefully include representatives from Community NHS Trusts, the HAs, staff side representative and PCGs and PCTs. It could also incorporate representation from acute or combined trusts. All decisions with HR implications should be discussed within the Forum thus allowing learning and good practice to be spread more widely. Union representation in PCTs will continue as in other NHS organisations and staff involvement as outlined in the report of the NHS taskforce on staff involvement is to be encouraged. PCTs will need to ensure suitable and agreed availability of the required resources in order to represent fully staff in these new organisations. However, it may be necessary for arrangements to be reviewed in light of local reorganisations. In all cases this will be a matter for local discussion and agreement with all the interested parties including the Trade Unions.

Guidance on issues surrounding employment policies and procedures. Staff who transfer into the PCT will bring with them a comprehensive package of terms and conditions of employment. There will however be no urgent need to harmonise most policies and procedures with one exception. It is important that disciplinary and grievance procedures are standardised in order to reflect the management arrangements in the new organisation and provide a level playing field for all staff. In relation to pay, PCTs, like other NHS organisations, are strongly advised to wait for the implementation of the new national pay system which is currently under discussion. Implementation may start from April 2001 and it is likely to be spread over several years. In the meantime it is recommended that any new staff appointed are put on similar terms and conditions to one of the organisations from which staff are transferring in. There must be clear unambiguous policies on equal opportunities and racial and sexual harassment. The "Improving Working Lives" agenda encourages the sharing of good practice on both flexible and family friendly ways of working. Health and safety

aspects remain similar to other NHS organisations, but PCTs can purchase the advice of a health and safety manager from a neighbouring PCT or lead NHS organisation. The responsibility for health and safety will continue to rest with the PCT CE.

The relevance of organisational development issues to HR including the development plans, HImP and joint working aspects. PCTs will be expected to work closely with the Health Authority to put together their development plan. The plan should identify the strengths and weaknesses of the emerging new organisations and clarify what resources and development support are needed for the PCTs to become operational. It will also identify the personal, managerial and organisational support needed by the PCTs after they become operational to ensure they remain fit for purpose and successful organisations. The development plan will link strongly with the whole system development plan including other public sector organisations. Possible joint working arrangements, under the new duty of partnership, need to be thought through. This stems from section 31 of the *Health Act 1999* and looks at shared budget and management between PCTs and other employers, particularly social services. This will be developed collectively through the HImP that starts by identifying the health needs and then setting appropriate priorities, objectives and measurable targets involving LAs, all NHS Trusts, PCGs and PCTS, education consortia and both the voluntary and community sectors.

The current agenda for Clinical Governance and staff training and development. All staff will need to have access to suitable training opportunities. This will include a fair and objective method of identifying training needs, most likely through Personal Development Plans (PDPs), linking with equal opportunities policies and by creating an organisational environment that will enable staff to be released for training and, where necessary provide cover in their absence. Influencing the Education Consortia at an early stage will support the workforce planning programme and ensure that the investment plans are able to develop the local health economy as a whole including primary care requirements. This will need to include smaller professional groups such as therapists as well as larger groups such as nurses and midwives. The PCT will also be responsible for locally managed systems of Continuing Professional Development (CPD) as one of the cornerstones for implementing clinical governance. A fair and objective appraisal system is the starting point for identifying the learning needs of individuals and teams. This will be further supported through the PDP process which will reflect local service objectives, and clinical governance objectives as well as individual career aspirations.

Implications for General Practitioners. GPs remain as independent, self-employed GMS contractors providing specified services to the NHS. They will also retain the right to employ their own staff to support this service delivery. But PCTs will provide the opportunity for the sharing of good practices in all arenas and this will include HR. Those staff who work in General Practice but who are employed by NHS Trusts will continue to be unchanged by their current employer or the PCT if that part of the organisation not transferring to the PCT.

Implications for PMS pilots Staff participation in PMS pilots was based on voluntary secondments rather than transfers of employment and there must be clear arrangements for secondees to return to their original NHS employer. In circumstances where a PCT is established alongside PMS pilots the contractual arrangements for PMS staff need to remain clear. In the event of the original NHS employer being dissolved or the service transferred to other NHS organisations, the secondees will become the responsibility of the most appropriate NHS organisation.

The guidance is aimed at facilitating local development and innovation that will be necessary to deliver Primary Care in the new millennium.

*This Circular has been issued by:*

*Alasdair Liddell*  
**Director of Planning**

