AUDIT SCOTLAND

Bulletin..

Paying dividends

Local Healthcare Co-operatives bulletin

Local Healthcare Co-operatives are voluntary groupings of general practitioners and primary healthcare professionals, accountable to Primary Care Trusts.

There are 79 LHCCs in Scotland, covering all mainland health board areas except West Lothian.

Key findings are…

- size of the population covered by the LHCC, ranges from 4,000 to 172,000
- number of general medical practices involved, ranges from two to 31
- size does not have a significant effect on clinical governance activities or public and patient involvement
- involvement in the local planning process is limited in some LHCCs
- some boards may be too large to work effectively
- multi-disciplinary decision making is not being achieved in some LHCCs.

The Minister for Health and Community Care has identified three priority areas for action by LHCCs…

- increase patient and public involvement. This varies widely, but is taking place in the majority of LHCCs
- increase scale of partnership working with social work, the acute sector and voluntary agencies. This is underway in most LHCCs, although there is variation in the activities being undertaken
- tackling inequalities and improving access to primary care services. Some work on inequalities in access to health services is taking place in more than half of LHCCs.

In the future LHCCs will need to be able to demonstrate:

- effective corporate governance (financial regularity, probity and stewardship)
- improvements in patient care
- health improvement
- value for money in their use of resources.

Audit Scotland plans to gauge progress in these areas at a future date.

PREPARED BY AUDIT SCOTLAND APRIL 2001

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Audit Scotland

Audit Scotland is a statutory body set up in April 2000, under the Public Finance and Accountability (Scotland) Act 2000. It provides services to the Accounts Commission and the Auditor General for Scotland. Together they ensure that the Scottish Executive and public sector bodies in Scotland are held to account for the proper, efficient and effective use of public funds.

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Responsibility for the contents and conclusions rests solely with Audit Scotland.

Introduction

The creation of Primary Care Trusts (PCTs) and Local Healthcare Co-operatives (LHCCs) were key recommendations of '*Designed to Care*' (1997)[1]. PCTs came into being in April 1999 and include community health services, all mental health services, services for people with disabilities, and care of elderly people, as well as primary care services based in general practice. LHCCs are accountable to PCTs and comprise of voluntary groupings of general practitioners (GPs) and primary healthcare professionals. LHCCs can elect to take responsibility for general medical services, community health services and prescribing budgets administered by PCTs, although there have been calls for commissioning of secondary care in some form to be permitted[2].

The general principles for LHCC development were set out in MEL(1999)13, which stressed that "there is no single model" and that "the exact scope and functions of the LHCCs will be determined by discussion and agreement between member practices and the PCT".

The Minister for Health and Community Care set out her vision for LHCCs in the introduction to the report of the LHCCs development workshops held during 2000 to:

- increase patient involvement and satisfaction with the health and social care they receive
- increase the scale of partnership working with local authorities, the acute sector and voluntary agencies
- tackle inequalities and improve access to primary care services.

At the same time the Minister announced the establishment of a Best Practice Group to focus on identifying the opportunities to develop a common vision and to learn and share good practice.

The Health Plan reiterated the role of LHCCs as vehicles for the planning and delivery of health improvement and healthcare at local level[3]. The Health Department has stated it will take steps to enable LHCCs to carry out this role more effectively within agreed national and local standards.

Despite the high profile given to LHCCs, very little is known about the way in which LHCCs carry out the role. The limited research in this area has raised a number of areas of uncertainty and doubt, including effective engagement with the acute sector, the effectiveness of LHCCs in achieving health gain, and the effect on patient care[4].

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1 *'Designed to Care: Renewing the NHS in Scotland'*, The Scottish Office Department of Health, 1997.

2 *'Valuing Scottish general practice'*, Royal College of General Practitioners (Scotland) and Scottish General Practitioners Committee, BMA, 2000.

3 '*Our National Health: A plan for action, a plan for change'*, Scottish Executive Health Department, 2000.

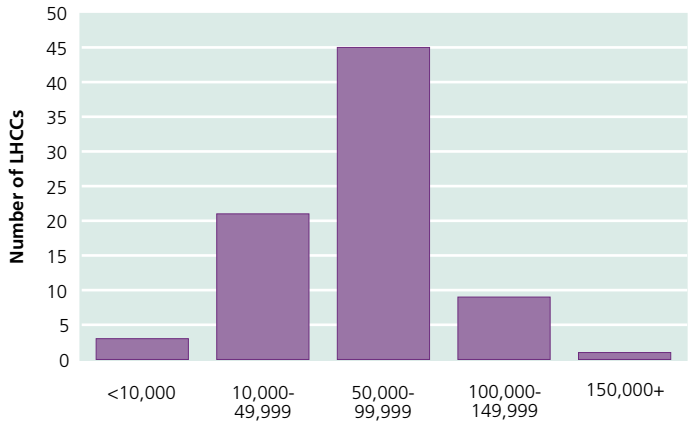
4 *'The development of local healthcare co-operatives in Scotland'*, Hopton J and Heaney D, BMJ 1999; 318: 1185-1187.

To inform the work of the Best Practice Group, a joint survey with Audit Scotland has been undertaken. The purpose of the survey was to obtain baseline information about the management structures, governance and activities of LHCCs to allow future evaluation of their effectiveness. This bulletin presents the responses of 61 of the 79 LHCCs (overall response rate 77%, range by trust 43% to 100%) to the joint Audit Scotland/Best Practice Group postal survey of LHCCs, conducted during August and September 2000. The results presented are based on the responses to this survey; these have not been independently verified.

Background

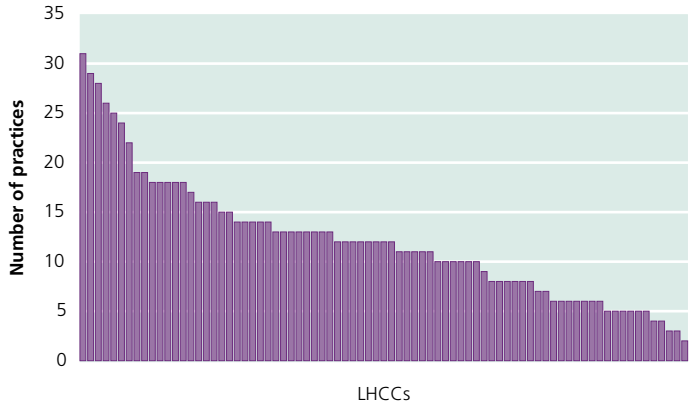
There are 79 LHCCs across Scotland, covering all mainland areas except West Lothian, which has chosen not to form LHCCs. LHCCs cover 952 general medical practices. Only 20 practices do not participate in LHCCs. There is wide variation in the population covered by each LHCC, ranging from 4,000 to 172,000 (Exhibit 1). Similarly the number of practices covered by each LHCC ranges widely, from two to 31 (Exhibit 2), and the number of GPs involved ranges from eight to 115.

Exhibit 1: Population covered by LHCCs



Source: Audit Scotland/BPG joint survey, 2000
Responses=79

Exhibit 2: Number of practices covered by LHCCs



Source: Audit Scotland/BPG joint survey, 2000
Responses=79

Governance, accountability and public involvement

LHCCs are not separate legal entities, but operate within the governance and accountability framework of the PCT. Within this framework all staff and members of LHCCs are accountable for their use of resources and quality of service. Despite this, the degree to which LHCCs have addressed governance and accountability issues varies. Methods used to involve the public and patients in LHCCs vary widely. Size does not appear to have a significant effect on clinical governance activities or public and patient involvement.

The majority (82%) of LHCCs have a formal constitution, including a statement on membership. Other issues in constitutions include: a statement on decision making or voting rights (80%), a mechanism for raising concerns (69%), a statement on communications (69%) and an accountability statement (64%).

Almost half of LHCCs (41%) have reviewed their constitution since it was first produced. The most common reason for review was to change the membership (20%). Twenty-one LHCCs have voted on issues at least once since they were constituted, including membership, budgets and resource allocation.

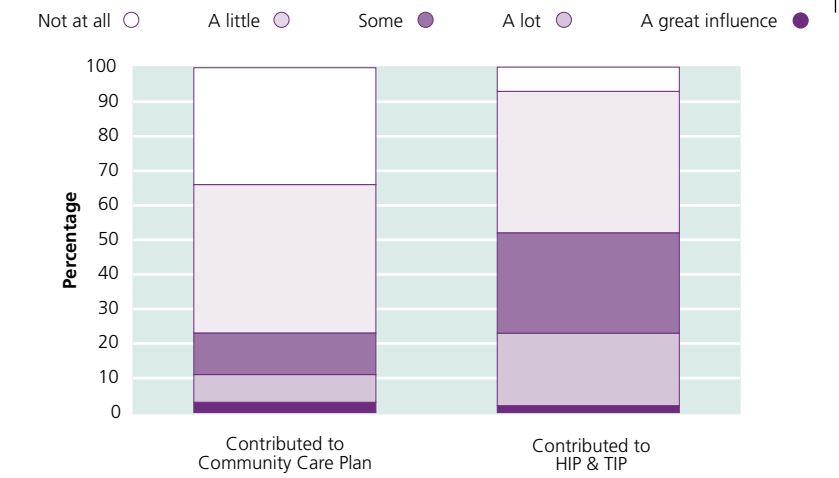
The organisational arrangements for links between the LHCC and senior management at the PCT fall into three main groups:

- regular meetings between LHCC staff and the trust (27%)
- clinical directors participation in formally constituted subgroups of the trust with a variety of names (61%)
- line management of the general manager (8%).

In line with the objective of identifying local health priorities and needs, 38 LHCCs (63%) have undertaken health needs assessments. These cover a wide range of issues including mental health, coronary heart disease and the elderly. The majority of LHCCs (78%) have collaborated with other LHCCs on specific projects, covering areas such as diabetes, care of the elderly and prescribing.

Fifty-five LHCCs (92%) have a development or local implementation plan. In almost all cases this was influenced by the Health Improvement Programme (HIP) and Trust Implementation Plan (TIP). The extent to which LHCCs feel they have contributed to the planning process is shown in Exhibit 3. The majority of LHCCs felt they had made at least some contribution to the HIP and TIP, compared with just 23% who felt they had made a contribution to the Community Care Plan.

Exhibit 3: Contribution to planning process



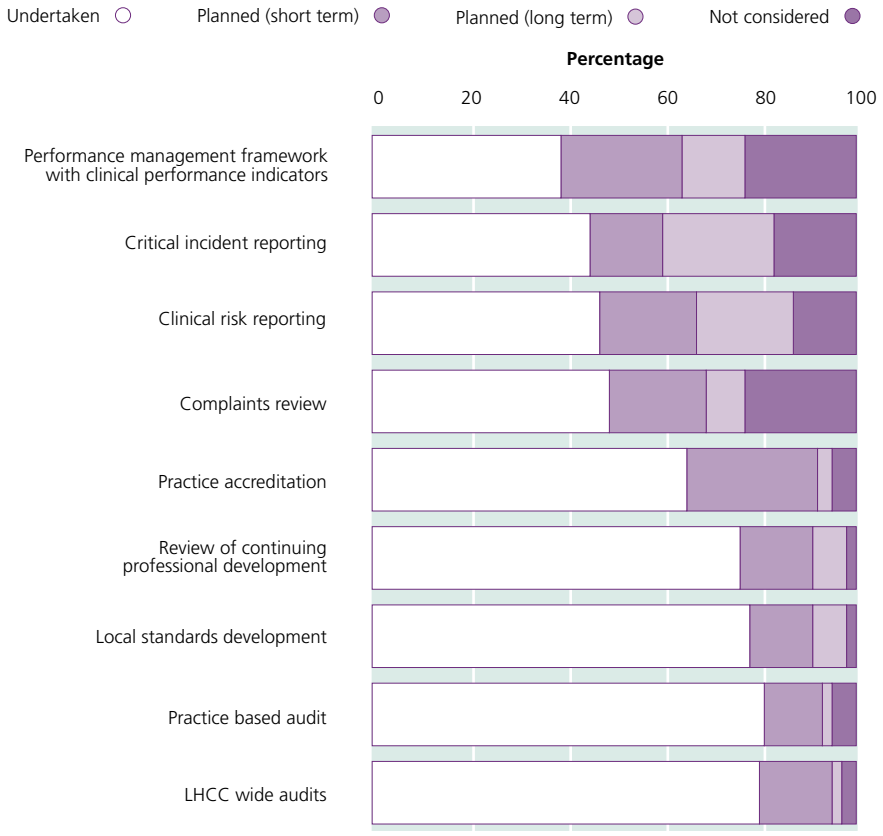
Source: Audit Scotland/BPG joint survey, 2000
Responses=60

In order to investigate if size, in terms of management and strategic capacity, has an effect on the activities undertaken, we have defined the 10 LHCCs with the lowest total management and administration budget as 'small' (budget ranging from £9,500 to £103,000) and the 10 LHCCs with the highest total management and administration budget as 'large' (range of budget from £282,000 to £600,000).

A clinical governance lead has been identified in 53 LHCCs (90%). Of these, 48 are GPs, two are physiotherapists and one is a nurse. In two LHCCs responsibility is shared between a GP and the lead nurse. In 10 LHCCs (18%) each practice has identified a clinical governance lead; in 22 (39%) no practices have identified such a lead. In six LHCCs (10%) there is no designated lead for clinical governance at either LHCC or practice level.

There has been a wide variation in the clinical governance activities undertaken by individual LHCCs (Exhibit 4), although some activity has taken place in each. There is no significant difference in the clinical governance activities undertaken by the largest and smallest LHCCs, except in the case of critical incident reporting where four of the large LHCCs have completed work compared with none of the small LHCCs.

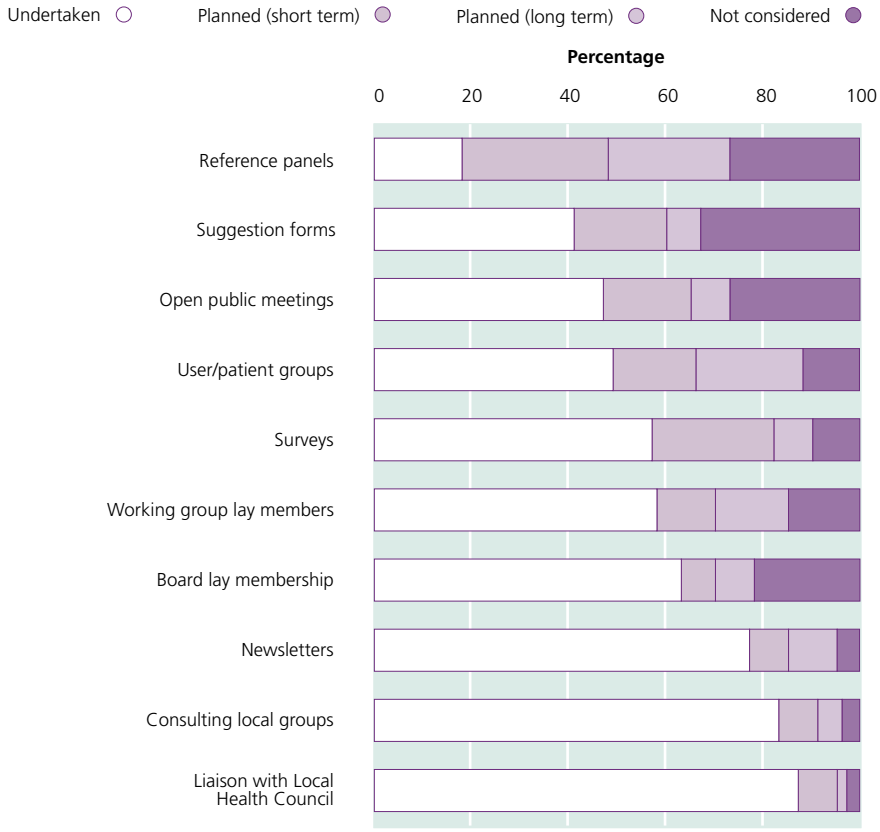
Exhibit 4: Clinical governance activities undertaken



Source: Audit Scotland/BPG joint survey, 2000
Responses=59

Throughout the NHS in Scotland, patient and public involvement is important. All LHCCs have carried out some work in this area, yet, like clinical governance, there is a wide variation in the range of activity (Exhibit 5). There is no difference between the smallest and largest LHCCs in the work completed on public and patient involvement, with the exception of provision of information about the LHCC through newsletters or notice boards, where larger LHCCs are more likely to provide such information.

Exhibit 5: Methods used to involve patients and the public



Source: Audit Scotland/BPG joint survey, 2000
Responses=57

Comparison with Primary Care Groups (PCGs) in England[5] and Local Health Groups (LHGs) in Wales[6] shows that LHCCs are undertaking more work in the area of public participation. In particular, 83% of LHCCs have consulted local groups, compared with 70% of PCGs and 65% of LHGs. Similarly, 57% of LHCCs have used surveys, compared with 25% of LHGs.

5 *'The PCG Agenda: Early progress of Primary Care Groups in the 'new NHS''*, Audit Commission, 2000.

6 *'Local Health Groups in Wales: The first year'*, Audit Commission, 2000.

Management arrangements

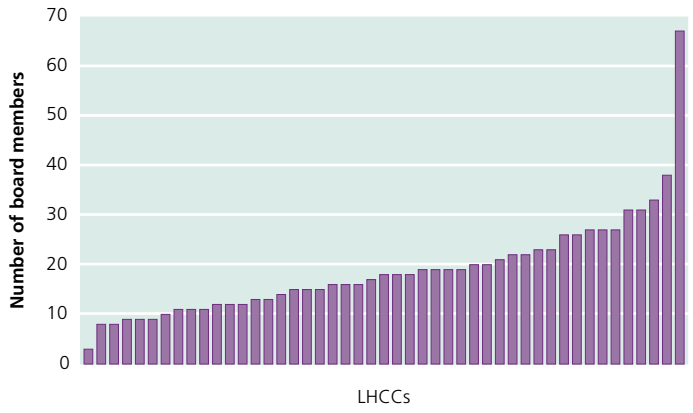
There is no centrally determined management structure for LHCCs; instead management arrangements have evolved on the basis of local priorities and decisions. The majority of LHCCs have a general manager, a core management team and a multi-disciplinary board which determines policy and direction. More than 70% of LHCCs directly manage at least one service.

Two LHCCs do not have a general manager; a further LHCC is currently recruiting a manager. Of the 23 LHCCs that stated a grade of manager, 13 were senior manager grades four to seven[7] and 10 were A&C grades seven to 10[8]. Most managers are full time (95%); three LHCCs have four, five and eight sessions per week respectively. The commitment of the LHCC chairs ranges from two to four sessions per week.

As expected, there is significant variation in the way in which LHCCs are organised. Most LHCCs (93%) have a core management team, responsible for day-to-day management and decision-making, ranging in size from two to 18 members. In all but five of these LHCCs, the core management team includes the general manager.

The majority (87%) of LHCCs have a board which sets direction and policy, with membership varying from three to 67 (Exhibit 6). Where the size of the board is very large this generally reflects the inclusion of all GPs within the LHCC. In another LHCC the 'board' takes the form of an open forum for those who wish to contribute; its last meeting attracted 80 people. Many boards may be too large to work effectively.

Exhibit 6: Membership of LHCC boards



Source: Audit Scotland/BPG joint survey, 2000
Responses=48

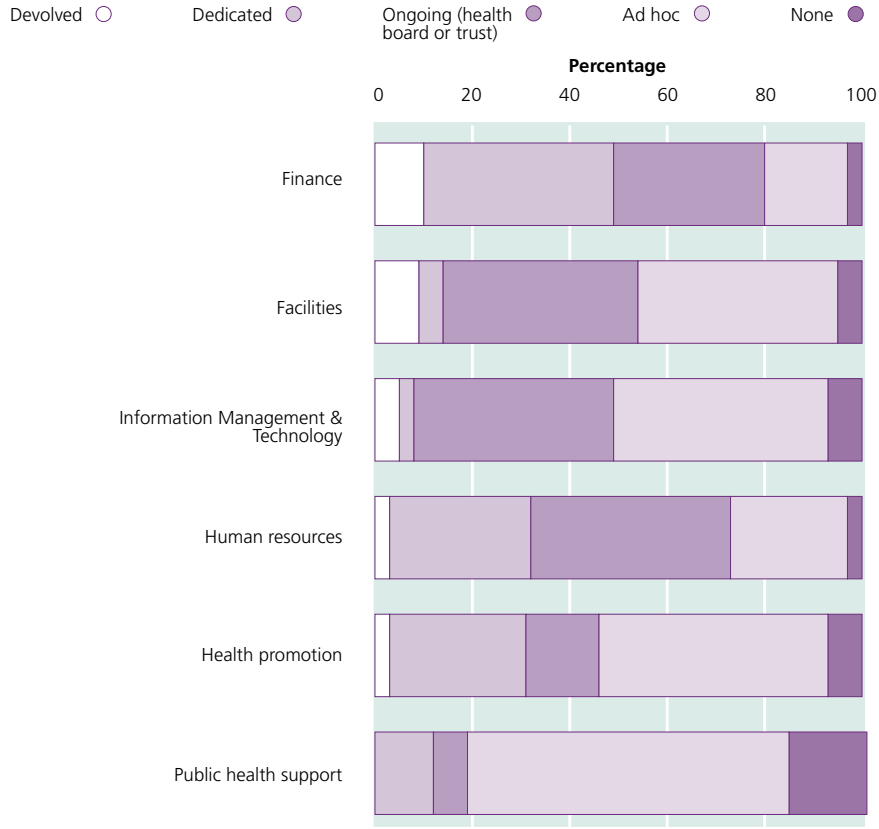
[7] Salary range £23,600 to £47,334.
[8] Salary range £21,491 to £40,251.

All boards are multidisciplinary; the number of disciplines ranges from three to 17, with an average of seven. The most commonly represented disciplines are general practice (all LHCCs), nursing (96%), professions allied to medicine (85%), LHCC managers (70%), public/patient representatives (68%) and pharmacists (62%). Social work is represented on 27 LHCC boards (57%). In 14 boards all members have full voting rights, in two only GPs can vote and in the remaining boards there is a variety of voting rights.

The relationship between the board and the core management team varies among LHCCs. In four cases there is a formal reporting mechanism, in one LHCC there is an informal relationship and in four the management group is a subgroup of the board. In the remaining LHCCs the management group is concerned with operational matters and implementation of strategy and policy set by the board.

There is wide variation in the provision of support functions to LHCCs (Exhibit 7) and few are fully devolved from the PCT to LHCCs. Only seven LHCCs (12%) have dedicated public health support and nine (16%) reported no public health support. For other LHCCs public health support is generally provided by dedicated sessions or ongoing departmental support from the health board. For health promotion the majority of LHCCs have either dedicated sessions or ad hoc arrangements with the local health promotion department.

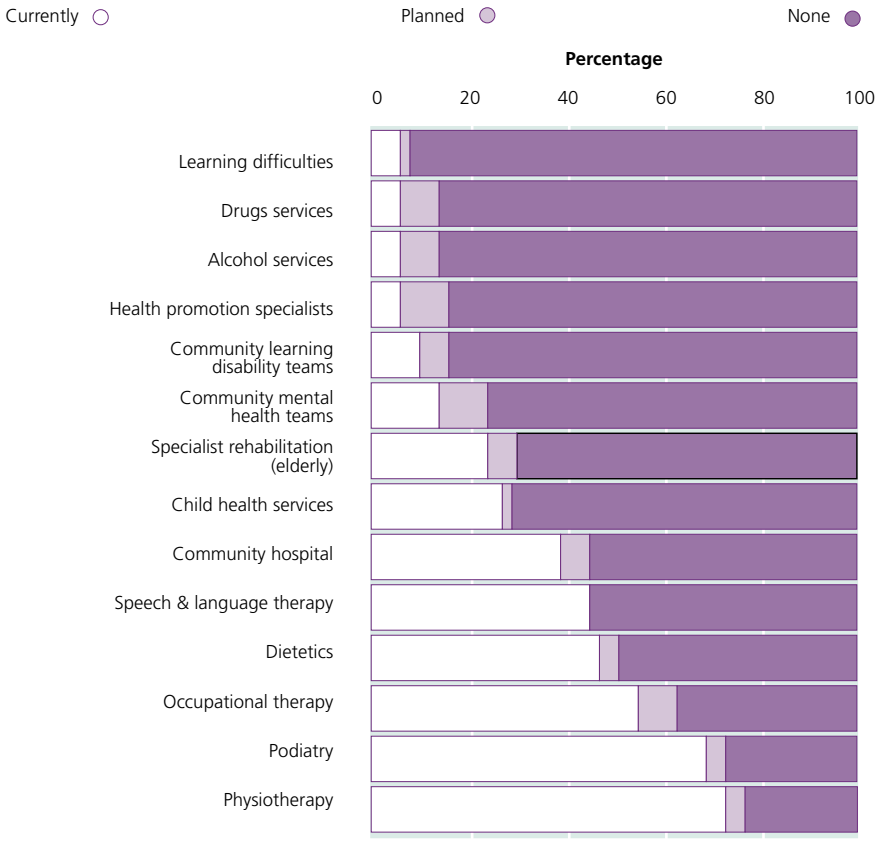
Exhibit 7: Provision of support functions to LHCCs



Source: Audit Scotland/BPG joint survey, 2000
Responses=58

More than 70% of LHCCs directly manage at least one service (Exhibit 8). The most common directly managed services are physiotherapy (73%), podiatry (69%) and occupational therapy (55%). Very few LHCCs manage community mental health services (14% currently, 10% planned).

Exhibit 8: Services directly managed by LHCCs



Source: Audit Scotland/BPG joint survey, 2000
Responses=58

Across the 31 LHCCs which provided information about their budgets, the average budget for management and administration was 1.3% of the total. This compares favourably with the 2.5% reported by the Audit Commission as the management allowance for general practice fundholding[9]. There is wide variation in management budget per head of population, with an average of £3.10, and a range from £1.30 to £7.77. A similar range of management budgets per participating general practitioner was found, from £1,188 to £8,696, with an average of £4,344.

[9] *'What the doctor ordered: A study of GP fundholders in England and Wales'*, Audit Commission, 1996.

Partnership working

LHCCs vary in the means by which they are working with partner organisations in the areas of community care, children's services and the acute sector. Most LHCCs have started to work with partner organisations, although larger LHCCs are more likely to have established relationships.

The Health Plan emphasised the role of LHCCs in working with partner organisations, particularly the acute sector. The plan clearly identifies that LHCCs have a pivotal role in children's services and community services. The development of child and adolescent mental health services was cited as a priority for action.

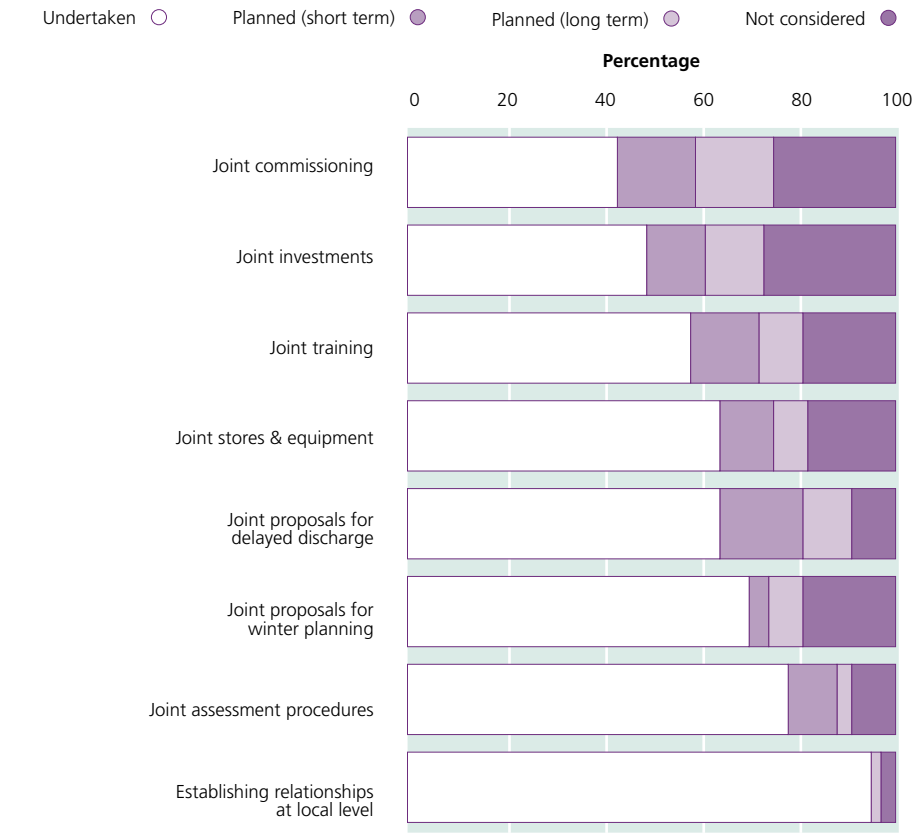
Working with local authorities

Few LHCCs are coterminous with local authority areas. The majority of LHCCs cover part of a single local authority area, with a few covering two local authorities. For local authorities, relationships may have to be established with up to 11 LHCCs. Likewise, a number of LHCCs may have to work with more than one acute trust. For these LHCCs joint working may prove more difficult. This is in contrast to LHGs in Wales where each LHG is coterminous with a local authority area[10].

LHCCs are involved in community care planning across a number of areas (Exhibit 9). Fifty-five LHCCs (95%) have undertaken some work in establishing relationships and structures at a local operational planning level to form the basis of future joint working. Forty-five LHCCs (78%) have undertaken work on joint or shared assessment procedures. Small LHCCs are less likely to have established relationships and structures for joint working.

[10] *'Local Health Groups in Wales: The first year'*, Audit Commission, 2000.

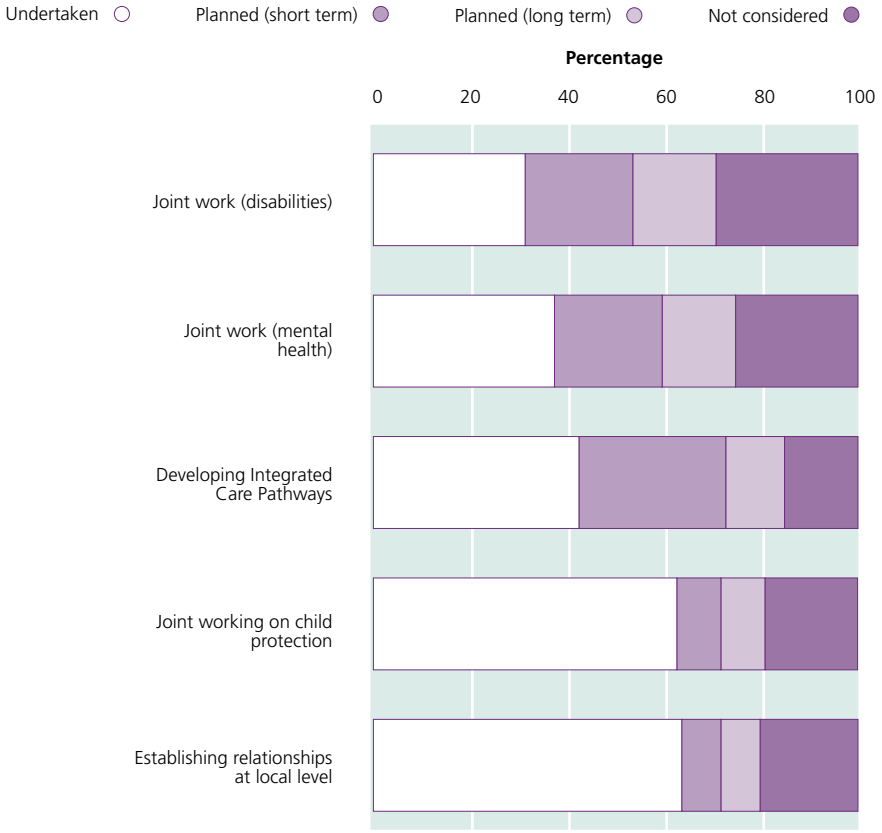
Exhibit 9: LHCC involvement in community care planning with social work



Source: Audit Scotland/BPG joint survey, 2000
Responses=56

A similar picture emerges with partnership working around children's services (Exhibit 10); 37 LHCCs (64%) have established relationships and structures with social work at a local operational planning level, and 36 LHCCs (62%) have undertaken joint work on child protection. The priority area of child and adolescent mental health services has not been considered in around a quarter of LHCCs, with only a third of LHCCs already undertaking joint work in this area.

Exhibit 10: LHCC involvement with social work in children's services

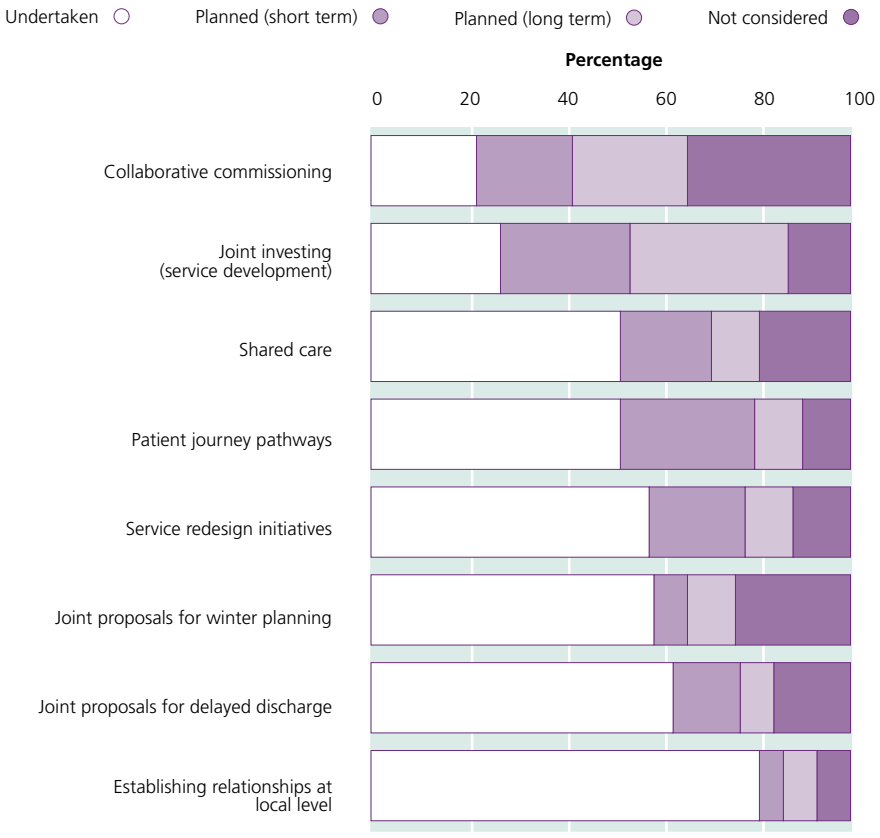


Source: Audit Scotland/BPG joint survey, 2000
Responses=57

Working with the acute sector

Exhibit 11 shows the degree to which LHCCs are working with the acute sector. As with social work, the majority of LHCCs (81%) are establishing relationships and structures at a local operational planning level. Thirty-six LHCCs (63%) have done some joint work on developing proposals for specific projects in relation to delayed discharge. Fewer small LHCCs have established relationships and structures at an operational level, but there is little difference in work completed in other areas.

Exhibit 11: Joint working with the acute sector



Source: Audit Scotland/BPG joint survey, 2000
Responses=48

Tackling health inequalities

The Health Plan confirmed the role of LHCCs in tackling health inequalities. Exhibit 12 shows the work that is currently going on in this area. The majority of LHCCs (76%) are working with partner agencies to address wider social and economic determinants of health and 59% of LHCCs are undertaking some work to reduce inequalities in access to health services as a result of social-economic disadvantage. Smaller numbers of LHCCs are currently undertaking work to address inequalities resulting from different minority cultures or languages (22%).

Exhibit 12: Work on health inequalities

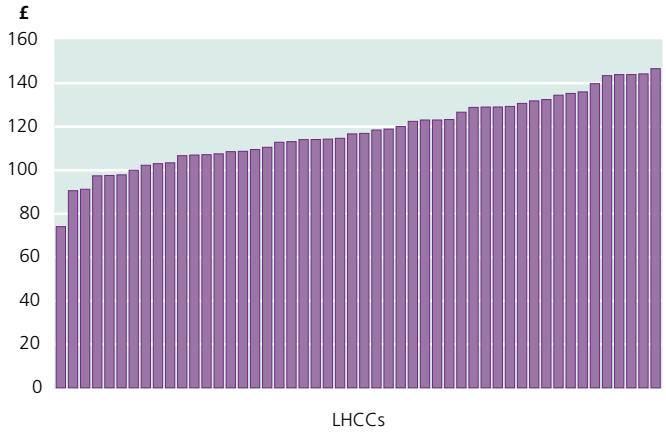
Source: Audit Scotland/BPG joint survey, 2000
Responses=57

Prescribing

Prescribing in primary care costs approximately £575 million per annum and makes up approximately 12% of the budget of the NHS in Scotland. Of the 26 LHCCs providing information on devolved budgets the average prescribing budget is 38% of total budget (range 23% to 68%). Previous work in this area has shown the scope to improve both the quality and cost effectiveness of prescribing, and this is an area where LHCCs can have a major impact[11].

There is a significant variation in the prescribing budget available to each LHCC (Exhibit 13).

Exhibit 13: Prescribing budget per head of population



Not standardised for age/sex distribution of population
Source: Audit Scotland/BPG joint survey, 2000
Responses=50

The basis of the allocation of prescribing budgets from the PCT to the LHCC varies, as shown in Exhibit 14. The majority of LHCCs have their prescribing allocation based on more than one indicator.

[11] *'Supporting prescribing in general practice'*, Accounts Commission for Scotland, 1999.

Exhibit 14: Basis of allocation of prescribing budgets

Basis of allocation	Number of LHCCs
Complex capitation (taking account of socio-economic status and or morbidity)	8
Simple capitation (based on age)	1
Clinical performance or quality indicators (CPI) and complex capitation	1
Historical practice	6
Historical practice and simple capitation	4
Historical practice and complex capitation	8
Historical practice and CPI	9
Historical practice, simple capitation and CPI	5
Historical practice, complex capitation and CPI	14

Source: Audit Scotland/BPG joint survey, 2000
Responses=56

The way in which under and overspends are managed also varies across LHCCs, as shown in Exhibit 15. The most common management structure is where practices and the LHCC keep a proportion of underspend and the overspend is managed by the PCT.

Exhibit 15: Risk management/incentive structure

Risk management or incentive structure	Number of LHCCs
Practices and LHCC keep proportion of underspend, overspend managed by PCT	24
LHCC keeps underspend, PCT manages overspend	2
Over and underspends managed by LHCC	10
Over and underspends managed at practice levels	2
Over and underspends managed by PCT	11
Practice keeps proportion of underspend, LHCC keeps remainder and LHCC manages overspend	4

Source: Audit Scotland/BPG joint survey, 2000
Responses=53

Fifty-three LHCCs (88%) have dedicated pharmacist input. The number of dedicated sessions varies from one session per week in 11 LHCCs (26%) to 30 sessions per week in one LHCC. Again this compares favourably with PCGs and LHGs where only 80% and 70% respectively had dedicated pharmacy support.

Nineteen LHCCs (32%) use a formulary. In five cases this was developed by the LHCC; in three by the Area Drug and Therapeutics Committee; in three by the health board; in one by the trust; in four by a multi-disciplinary group; in two by a joint group and in one by the clinical governance lead.

Forty-four LHCCs (75%) are involved in specific prescribing projects. Examples of these projects include prescribing of proton pump inhibitors, repeat prescribing, Accounts Commission indicators, "brown bag" patient support schemes and coronary heart disease projects.

Future work

The variation among LHCCs reflects the imperative of taking account of local circumstances. At this early stage of their existence LHCCs have started to develop their management and governance arrangements and to forge links with local authorities and the acute sector, in line with the vision set out by the Minister. This progress needs to be maintained, with best practice shared among LHCCs to avoid duplication of effort. The findings of the Best Practice Group, due in May 2001, should inform this process.

The data presented in this bulletin suggest that:

- size does not have a significant effect on clinical governance activities or public and patient involvement
- involvement in the local planning process is limited in some LHCCs
- some boards may be too large to work effectively
- multi-disciplinary decision making is not being achieved in some LHCCs
- partnership working with other LHCCs, local authorities and the acute sector is developing, although larger LHCCs are more likely to have established relationships and structures
- work on inequalities in access to health services is developing
- there is significant work being undertaken on prescribing.

In the future LHCCs will need to be able to demonstrate:

- effective corporate governance (regularity, probity and financial stewardship)
- improvements in patient care
- health improvement, and
- value for money in their use of resources.

This bulletin has provided baseline information on the current structures, management arrangements and activities of LHCCs. Audit Scotland plans to evaluate progress of LHCCs in these areas at a future date.

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