PRACTICE OBSERVED

Family Practitioner Committees

Family practitioner committee independence: what will it mean?

NORMAN ELLIS

For many general practitioners the new status of family practitioner committees as autonomous authorities which starts on 1 April 1985 may seem to be just one more administrative change in the health service. Some may think that it is a thinly disguised return to the position of the Executive Councils before 1974. Though it may look like an administrative device to tidy up the anomalous position of the family practitioner committees (which were virtually forgotten during the turbulence of the 1982 reorganisation of the National Health Service), it has been generally welcomed by general practitioners as a unique opportunity to develop the contribution and the voice of primary care in the NHS.

A forgotten sector?

Several months after the guidelines for the 1982 reorganisation of the NHS were laid down in July 1980 the Department of Health and Social Security issued a consultative paper (HN(81/10)) outlining options for the future administration of family practitioner committees. Having been preoccupied with promulgating a new structure for the hospital services, the government was now left with the dilemma of how to slot in the family practitioner committees. Because the number of health authorities had increased from 90 to 192 the previous "continuity" between family practitioner committees and area health authorities had gone (table 1). It was conceivable that a new family practitioner committee structure might have been proposed, increasing their number to 192 to maintain a one to one relation with health authorities. But this would have greatly increased administrative costs (apart from the

turbulence caused by the transfer of records and staff) and would have been contrary to the main purpose of the reorganisation, which was to reduce the burden of administration.

TABLE 1—No. family practitioner committees presently relate to district health authorities

46 FPCs relate to 1 DHA
20 FPCs relate to 2 DHAs
12 FPCs relate to 3 DHAs
7 FPCs relate to 4 DHAs
2 FPCs relate to 5 DHAs

So this option was not floated. Instead, the discussion paper gave three options and left the interested parties 10 weeks to choose which they preferred. These options and the arguments for and against are summarised in table 2.

At the outset the debate about the future of family practitioner committees seemed to be couched in administrative and legislative terms. In the consultative paper the need to develop the contribution and voice of primary care in the NHS was given little prominence, though this view subsequently prevailed in official thinking after the case for independence had been won and the necessary legislation was enacted. This shows the shift of emphasis that occurred; this view fitted easily into current government policy once it was recognised that an expanding primary care sector might contribute directly to the overriding aim of containing the rising costs of the NHS.

Finally, the possibility of abolishing the family practitioner committees was not raised, though the royal commission on the NHS had recommended the "abolition of family practitioner committees in England and Wales and the assumption of their functions by health authorities (para 20.57).¹ The government did only two years previously (para 20.57).¹ The government did

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TABLE 2—Three options considered

For	Against
Keep present arrangements	Administrative costs up to six times those of local health authorities
Lower change and management costs	Agree to agency or consortium arrangements for family practitioner committees
No new legislation required	Agree to agency or consortium arrangements for family practitioner committees
Better for staff development and mobility	Agree to agency or consortium arrangements for family practitioner committees
One family practitioner committee per district health authority	Agree to agency or consortium arrangements for family practitioner committees
Prefer by contractor professions and the family practitioner committees	Agree to agency or consortium arrangements for family practitioner committees
Could make family practitioner committees more effective, they would discuss and work with district health authorities on basis of equal partnership	Agree to agency or consortium arrangements for family practitioner committees
Avoid administrative complexities	Agree to agency or consortium arrangements for family practitioner committees
Direct responsibility for administration and staffing	Agree to agency or consortium arrangements for family practitioner committees
Improve administrative efficiency by joint management arrangements for the purchase and provision of management services	Agree to agency or consortium arrangements for family practitioner committees
Relate family practitioner committees to regional health authorities	Agree to agency or consortium arrangements for family practitioner committees
For	Against
Administrative complexities of (i) one body would be concerned in revenue allocation—for example, management services and computers	Regional health authorities would be concerned in local matters—for example, staffing and accommodation, not consistent with their primary strategic role. Family practitioner committees would still be dependent on other health authorities. Could weaken family practitioner committees and district health authorities

HN(81/10) March 1981 (consultation completed by 31 May 1981)

not question the need for a distinct and separate body to administer the contracts of family practitioners. These contracts were recognised to be qualitatively different from those of health service employees, and the bodies responsible for their administration had to be based on different principles from those appertaining to employment contracts. Family practitioner committees are firmly wedded to the notion of partnership: they are composed of half lay and half professional members, their style of operation is consensual, and they are statutorily obliged to consult with each local representative committee (dental, medical, pharmaceutical, and optical) on all matters concerning their part of the family practitioner services. It was rightly assumed that these important and necessary arrangements could not be transferred to an employing authority.

Parliamentary opposition to independence

Independence was achieved against enormous odds; a wide range of influential and powerful bodies had to be neutralised or not persuaded. The General Medical Services Committee, and in particular the terms of its past chairman, Dr John Ball, played a crucial role in ensuring that the government did not falter in its commitment to legislate for family practitioner committee independence. Originally it was hoped that the 1983 Health and Social Services Bill would have achieved this. Unfortunately, as that Bill was being hastily enacted during the closing hours of parliament before the 1983 general election, the opposition party insisted that the specific clause giving independence to family practitioner committees should be withdrawn. In the customary hurried horse trading the government conceded the opposition's request. The Minister for Health, Mr Kenneth Clarke, however, gave an immediate undertaking:

"Only this afternoon, Dr John Ball, of the General Medical Services Committee, came to see me to express the British Medical Association's very strong concern about the way in which the provisions had been drafted. I gave Dr Ball and others an undertaking, which I gladly repeat to the House today, when the government return to office it is our intention at the earliest possible opportunity to reintroduce these provisions in a new Bill."

Harvard 1983 May 11; col 878.

The Minister added that the government remained convinced that the family practitioner services would benefit most from being administered by independent free standing committees whose main concern and objective was to develop the primary care services, the NHS's first line of contact with the public. Just over a year later this promise was fulfilled when the 1984 Health and Social Security Bill was enacted.

The opposition to this change had been considerable. Politicians of all parties (the policies of the Labour Party and SDP Liberal Alliance favoured integration with district health authorities) initially feared that family practitioner committee independence could work against cooperation between family practitioner committees and district health authorities. Others questioned whether independence would be sufficient "control" over the contractor professions, and some probably thought that this would create an untidy administrative arrangement, lacking clear lines of accountability. In particular, the National Association of Health Authorities argued strongly against giving family practitioner committees independence on the grounds that it would divide rather than integrate health care provision at the local level.

Those who favoured independence believed that the new status would be a crucial catalyst for change and development. It would enhance the standing of primary care in the health service, allowing family practitioner committees to stand on an equal footing to district health authorities. Though this new status was initially regarded as a convenient (if not the preferred) administrative and legal solution to the problem of fitting family practitioner committees into the new NHS structure, it acquired a momentum and importance of its own.

The aims of independence, as now perceived by ministers, are to improve primary care, the planning of local health care, and collaboration between family practitioner committees and other services provided by local government and also to increase the administrative efficiency of family practitioner committees and their accountability to the DHSS.

Framework for independence

The independence that family practitioner committees will shortly enjoy is delineated by a framework of statutory and administrative constraints; relations between them and the DHSS will be based on the principle of delegation with matching accountability. Family practitioner committees will obviously have to act in accordance with legislation; this includes the terms of service of general practitioners and the other contractor professions, the regulations governing family practitioner committee procedures, and the various NHS Acts. Family practitioner committees are also required to implement government policy—for example, the programme to transfer patients who need long term care to the community ("Care in the Community" (HC(83/6)). They are also required to obtain value for money in the provision of family practitioner services. Figure 1 illustrates this range of constraints within which family practitioner committees must work. The most specific constraints apply to the comparative small proportion of total expenditure on family practitioner services (less than 2% on average) allotted to the administration of the family practitioner committees themselves. Thus manpower targets and cash limits will be applied to this part of the family practitioner committees' spending. This is not surprising and is no different from their present position in relation to the district health authorities. The only change is that in future they will be directly accountable to the DHSS on these matters.

The new financial and accounting arrangements between family practitioner committees and the DHSS are analogous to those that exist for district health authorities. It is recognised that family practitioner committees, unlike district health authorities, do not have control over many of the factors that determine expenditure for the family practitioner services. The

FIG 1—Framework for independence of family practitioner committees

FIG 2—The accountability process

DHSS will therefore not hold them to account for the total volume of their expenditure. They will, however, expect to see family practitioner committees exercise such discretionary powers as they have to secure value for money, and they are required "to pay the utmost regard to public bodies to their responsibilities for the use of public funds" (HN(84/37), "Family practitioner committees: accountability arrangements").

Specifically, family practitioner committees will be required to satisfy the DHSS that they are: (i) administering arrangements for the family practitioner service correctly and efficiently; (ii) implementing government policy; (iii) remaining within administrative cash limits and manpower targets; (iv) playing their part in cooperation with health and local authorities; (v) providing the family practitioner service as part of the comprehensive district health authority plan; (vi) keeping the public informed of their activities.

On this last requirement family practitioner committees are exhorted to make information about their activities more widely known (after paying due regard to confidentiality) and required to involve community health councils in defining the aims and policies for the family practitioner services in their localities. This may encourage family practitioner committees to publish annual reports; several, such as Avon, Croydon,

Norfolk, and Surrey, already do so. Some seasoned observers may recall that the former Executive Councils published annual reports before they were brought within the health authority structure.

The accountability process for family practitioner committees will comprise annual scrutinies (which may be conducted by correspondence) and more detailed periodic performance reviews, undoubtedly similar to those already operating for district health authorities (see fig 2 for sequence and a summary of these reviews). These exercises will enable DHSS officials to analyse key documents, including the financial returns and accounts and annual programmes. The officials will review what progress has been made towards achieving agreed objectives during the past year and will assess proposals for two years ahead. Work is already in hand in establishing performance indicators to apply to family practitioner com-

mittee administration. The purpose of these is to provide a means of comparing one family practitioner committee's performance with that of family practitioner committees generally and to monitor changes over time in individual committees.

Every five years a more detailed and rigorous performance review will be undertaken, and this will be based on a family practitioner committee's "policy and strategy statement" (see below), together with the documents referred to above. These periodic reviews will be used to identify and promulgate good practices. Where there are particular local difficulties these performance reviews may be carried out more often than the five year cycle. In addition, ministers propose to meet family practitioner committee chairmen annually in three groups to review progress and policies relating to the provision of family practitioner services.

Some may be critical of the amount of information family practitioner committees will be required to assemble for these reviews; the DHSS retort is simply that the aim in compiling profiles and strategies, programmes, and other performance review documents is to use the information that family practitioner committees should already be using for their own management, consultation, and planning.

PASS: new acronym in NHS vocabulary

The family practitioner committee's "profile and strategy statement," or PASS as it will undoubtedly be known, will have a key role in making it directly accountable to government and more open to public scrutiny and help in developing cooperation with district health authorities and local authorities (see fig 3).

Note: Similar information is also included in a PASS for other practitioner services
Fig 3—The contents of a PASS.

In due course each family practitioner committee will be required to prepare a PASS every five years, which will give information about family practitioner services in its area, point to expected changes during the next five to 10 years, and explain its aims and policies and how it intends to achieve these in this time scale. The PASS will serve as the family practitioner committee's contribution to the district health plan and enable the family practitioner committee to carry its management, planning, and accountability responsibilities in an informed way. The likely contents of a PASS are summarised in figure 3. The DHSS has emphasised that the PASS is not intended to be a free standing plan; it should represent the direction in which the family practitioner committee has agreed with district health authorities and local representative committees—that is, the local medical committees—its services should develop. Any planning by district health authorities that has implications for family practitioner services should not be undertaken, or proposals finalised, without reference to the family practitioner committee and the local representative committees. Of course, there may be differences of view; a PASS may be at variance with the district health plan. If this was important it would be regarded as indicating a failure of collaboration, but differences will arise and these should be jointly recognised and proposals made as to how these will be tackled.

Relations between family practitioner committees and district health authorities

It is understandable that once the issue of independence had been settled in principle the future arrangements for collaboration between the district health authority and family practitioner committee became a major preoccupation. It still seems strange that the term collaboration rather than, say, cooperation should have been used. The conventional dictionary definition of the term offers the act of assisting or cooperating with the enemy occupier of one's own country or working jointly on an artistic or literary production. No doubt there are sound historical precedents for talking about collaboration between family

practitioner committees and district health authorities, and in any event it may convey a firmer and more prescriptive tone.

Apart from the need to ensure that there is effective cooperation between the family practitioner services and the hospital and community health services, the relative distribution of family practitioner committees to district health authorities (see table 1) meant that formal machinery had to be devised for this purpose. The report of the DHSS joint working group on collaboration between family practitioner committees and district health authorities makes detailed recommendations of how this should be achieved; it endorses both the strongest mutual understanding and respect, to identify and pursue common goals and policies, to share information, and to create formal and informal arrangements for cooperation. In addition, the report lists some specific topics on which the two authorities should work together (table III).

TABLE III—Family practitioner committees and district health authorities: examples of areas of collaboration

(i) The impact of the quality of family practitioner services on accident and emergency services
(ii) Open access for general medical practitioners to district health authorities
(iii) Diagnostic therapeutic services
(iv) General practitioners' financial needs
(v) Length of hospital stay
(vi) Length of hospital stay
(vii) Community nursing services

Wider implications: will the family practitioner committees acquire new teeth?

Their newly acquired independence not only affects the relations among the family practitioner committees, district health authorities, and the DHSS. Other changes are being introduced that could make family practitioner committees more assertive and independent. Firstly, their chairmen and members are now appointed directly by the Secretary of State, although those members from the professions are appointed from nominees of local representative committees (including local medical committees). Secondly, the DHSS will ensure that there is a balance between lay and professional members, and it will be expected that in each family practitioner committee the chairman and his or her deputy would not both be drawn from the lay public or the profession. A further change will affect the secretariat of some local medical committees. In future family practitioner committee staff will not be able to hold appointments as secretaries of local medical committees, although those staff already doing so will be allowed to continue.

Already some effects of these changes are apparent. The influence of professional representatives in the Society of FPC Administrators is becoming less pervasive, and in future it is likely to become a more assertive and independent body, a national voice of the family practitioner services that is not necessarily in accord with the views and policies of the contractor professions. A favour of what may lie round the corner is to be found in Mr John Williams's presidential address to the 1984 annual meeting of the society:

When I was a young administrator it was preached to me that it was always in our interests to be seen to go along with the policies of the General Medical Services Committee. This was the strongest ally and they had a right to expect us to be with them. This was trotted out time and again. Whilst it probably makes sound sense if we think in terms of protecting ourselves, I always questioned this policy. Whilst agreeing that the General Medical Services Committee is a powerful lobby and in the main our interests were mutual, there could come a time when their interests and ours were almost bound to clash. They quite rightly are interested in preserving and improving the lot of the general practitioner. Our interests are in running a good service and in doing so ensuring that the service is shared by their terms of service give the National Health Service value for money. . . . We want the GMC to be our friends, but surely friends can disagree

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without falling out. If not that friendship is not worth very much. What I find upsetting is that some family practitioner committees, in their anxiety not to rock the boat, tend to regard the wishes of the profession as having a degree of priority greater than their merits.

Journal of the Society of FPC Administrators 1984;11:195-8.

Mr Williams goes on to spell out the implications of this new assertiveness and warn of the dangers of a too cosy relationship with the profession.

There are also some more immediate problems to be resolved. Both family practitioner committees and local medical committees will soon have to absorb increased demands on their resources. The family practitioner committee will be required to deploy staff on collecting and analysing the data required for the scrutiny and review procedures. Concern has already been expressed that they lack sufficient middle management to

direct this work and the additional task of computerisation, and it appears that no extra funds will be available for this. Local medical committees are likely to face a similar problem; if their input into planning is to be at all effective they will also require additional professional and administrative resources. It is unclear how these will be found.

Finally, the long overdue Green Paper on the future of the family practitioner services casts an uncertain shadow over the family practitioner committees' newly acquired independence. Nobody knows what further duties and responsibilities may be subsequently delegated to the family practitioner committees.

Reference

1 Royal Commission on the National Health Service. Report. London: HMSO, 1979 (Cmd 7815) (Merrison report).

100 YEARS AGO

The rapid transit of troops up the Nile by boats, and along its banks on camels, still goes on. Somewhat more than half the entire number of boats have already passed up the river already, they are now over a considerable portion of their troubles, and have a fine stretch of smooth water before them, right up to Korti, which is the concentrating station just now, from which a dash across the desert is being attempted by a portion of the force, while an advance of another portion of the troops along the river towards Merawi is, I believe, intended, with a view of punishing Stewart's marauders. Every now and then the splendid spirit of pluck which keeps a man from giving in almost as a point of honour. Under conditions such as the above, we must, I fear, look for a high death-rate, and, in cases of recovery, a tardy and difficult convalescence. At all events, be the cause what it may, climate, field-service, or an unusually severe type of disease, from one or all combined, enteric fever will claim far more victims than the Mad's bullet or spear. So far, the climate is all in our favour. There is a powerful sunshine, no doubt, but it is generally tempered by a cool northerly breeze by day. The temperature by day, as a rule, is over 90°, some mornings, the temperature falls close to 50°; in fact, the early mornings are bitterly cold, and the dryness of the atmosphere is extreme. To sum up, the hospitals are well supplied, the sick are well cared for, the most capacious critic can find no fault, the medical staff are working like men, and whether at professional duty or hauling a boat, or in desert marching, in mending a hospital-bed, or in building a hospital kitchen, from morning to night, all day and every day, we are all hard at work, all honestly striving to help on the expedition. *British Medical Journal 1885;1:427.*

The concluding days of the Manchester Conference on Education under Health Conditions were taken up principally with a discussion on the subject of Physical Education. Mr Charles Roberts read a paper on the "Correlation of Mental and Physical Education." Miss M. A. Cherriman, of the Physical Training College, London, followed with a paper advocating the physical training of women. Mr John Hinton said the good average physique of the British race, for our prediction for active sports, had a retarding influence on the introduction of gymnastics. At the same time, he considered much of the apparatus now used in ordinary gymnastics, expressing the opinion that the parallel bars were most objectionable, sharing with clubs and dumb-bells the invidious distinction of producing the gymnast's stoop, combined with stiffness of the shoulders. His preference was for the Swedish system of gymnastics, which, if carried out in accordance with the teaching of Ling, was free from the弊端 of our system, while capable of fully developing the body. The discussion was taken part in by Dr. Shuttleworth of the Royal Albert Asylum for Idiots, Miss Blyth, Edinburgh, Dr. Watts, and Mr. Broadfield. In reply to the President, Dr. Watts said he did not believe there was any falling off in the health and strength of school-children in consequence of the vigorous application of the system of compulsory attendance. He thought it was pretty generally known that infant mortality was decreasing, and that adult life was lengthening. At the close of the conference, Lord Aberdeen expressed his belief that there was no serious foundation for the cry of overpopulation, and nothing of the requirements of the Code for seven for the scholars. He considered that the report of Dr. Crofton Browne was unnecessarily extravagant. They ought for the present to be content with the changes which had been made in the Code, and not tinker it any further until it had had a longer trial. *British Medical Journal 1885;1:436.*

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NATIONAL HEALTH SERVICE RECORD OF TREATMENT

Surgeon: _____ No. _____ Date of Birth: _____

Address: _____

Family Practitioner: _____

Medical and Dental Officer: _____ Name FPC: _____

To be completed by patient

1. I have been vaccinated against:

a) Smallpox (vaccinated) ☐ b) A general vaccination test to be carried out at the age of 15 ☐

2. I have been vaccinated against:

a) Tetanus ☐ b) Diphtheria ☐ c) Whooping cough ☐

3. I have been vaccinated against:

a) Typhoid ☐ b) Cholera ☐ c) Malaria ☐

4. I have been vaccinated against:

a) Polio ☐ b) Measles ☐ c) Rubella ☐

5. I have been vaccinated against:

a) Tuberculosis ☐ b) Syphilis ☐ c) Gonorrhoea ☐

6. I have been vaccinated against:

a) Malaria ☐ b) Typhoid ☐ c) Cholera ☐

7. I have been vaccinated against:

a) Polio ☐ b) Measles ☐ c) Rubella ☐

8. I have been vaccinated against:

a) Tuberculosis ☐ b) Syphilis ☐ c) Gonorrhoea ☐

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a) Malaria ☐ b) Typhoid ☐ c) Cholera ☐

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a) Polio ☐ b) Measles ☐ c) Rubella ☐

83. I have been vaccinated against:

a) Tuberculosis ☐ b) Syphilis ☐ c) Gonorrhoea ☐

84. I have been vaccinated against:

a) Malaria ☐ b) Typhoid ☐ c) Cholera ☐

85. I have been vaccinated against:

a) Polio ☐ b) Measles ☐ c) Rubella ☐

86. I have been vaccinated against:

a) Tuberculosis ☐ b) Syphilis ☐ c) Gonorrhoea ☐

87. I have been vaccinated against:

a) Malaria ☐ b) Typhoid ☐ c) Cholera ☐

88. I have been vaccinated against:

a) Polio ☐ b) Measles ☐ c) Rubella ☐

89. I have been vaccinated against:

a) Tuberculosis ☐ b) Syphilis ☐ c) Gonorrhoea ☐

90. I have been vaccinated against:

a) Malaria ☐ b) Typhoid ☐ c) Cholera ☐

91. I have been vaccinated against:

a) Polio ☐ b) Measles ☐ c) Rubella ☐

92. I have been vaccinated against:

a) Tuberculosis ☐ b) Syphilis ☐ c) Gonorrhoea ☐

93. I have been vaccinated against:

a) Malaria ☐ b) Typhoid ☐ c) Cholera ☐

94. I have been vaccinated against:

a) Polio ☐ b) Measles ☐ c) Rubella ☐

95. I have been vaccinated against:

a) Tuberculosis ☐ b) Syphilis ☐ c) Gonorrhoea ☐

96. I have been vaccinated against:

a) Malaria ☐ b) Typhoid ☐ c) Cholera ☐

97. I have been vaccinated against:

a) Polio ☐ b) Measles ☐ c) Rubella ☐

98. I have been vaccinated against:

a) Tuberculosis ☐ b) Syphilis ☐ c) Gonorrhoea ☐

99. I have been vaccinated against:

a) Malaria ☐ b) Typhoid ☐ c) Cholera ☐

100. I have been vaccinated against:

a) Polio ☐ b) Measles ☐ c) Rubella ☐

FIG 2—Universal claim form with the top sheet folded back to show duplication on back sheet.

EVALUATION

For the three months April to June 1981 all conventional forms were withdrawn from use in this department. The universal claim form was stocked in all consulting rooms, the treatment room, reception desks, and in the medical bags of eight principals and four trainee assistants. One week before starting the trial all the doctors and reception staff were instructed in the use of the form and provided with an instructional handout.

The completed forms were analysed for: (i) type of claim; (ii) omissions and errors in completion; (iii) validity by referring to the patient's records. The completed forms were then submitted to the family practitioner committee. These data were compared with similar data for the corresponding period 12 months earlier.

With the agreement of the Welsh Office the staff of the family practitioner committee agreed to process the form in two ways: (a) By sorting all the forms according to the category of the claim for processing by the relevant staff in each of the claim sections (the conventional method); (b) By arranging for a small group of the staff trained in dealing with the full range of claims to process all the forms without initial sorting. The time taken to process the claims was recorded together with the attitudes of the staff. A questionnaire was designed to measure the acceptability of the form by all the participating doctors and staff.

Results

Errors were noted in less than 2% of all forms completed. Omissions mainly concerned failure to record the date, the patient's date of birth, or failure of the patient and doctor to sign the form. Analysis

of omissions showed a problem in design, which was a legacy from the existing form. It was thought that the declaration on contraceptive services should be reworded as a negative statement so that it was deleted only if services had been obtained elsewhere in the preceding 12 months.

There was a considerable increase in the overall number of claims completed during the trial period compared with the same period 12 months previously (table 1). This increase was particularly in respect of claims for vaccination, contraception, cytology, and night visits. Retrospective analysis of the practice records showed that a similar number of these services had been performed but not claimed in the same period in the previous year. Using the 1981 rates of payment for both years, this showed an increase of nearly £100 per week during the trial period.

The universal claim form was used to record clinical details for all temporary residents and for immediately necessary and emergency treatment. It is customary in the practice for the patients' notes to be collected and taken on night visits so that most claim forms completed for night visits did not need clinical details (table 1).

The form was used to make multiple claims in roughly 5% of all claims: temporary resident and night visit, one; a course or more than one vaccination, four; contraceptive services plus cervical cytology, 10; and immediately necessary treatment plus vaccination, one.

The favourable comments received during the trial from both doctors and lay staff validated the questionnaire, which had been prepared for use at the end of the trial. No adverse comments were

FOR FPC USE ONLY

1) Vaccinations
DPT
Polio
Measles
Rubella
Other

2) Temporary Resident

3) Immediately Necessary Treatment

4) Dental Treatment

5) Cervical Cytology

6) Contraception
Contraceptive service
I.U.C.D.

7) Maternity
ANC
INC
PNC
Total

8) Emergency Treatment
Service

9) Night Visit

10) Other

Doctor

FIG 3—Universal claim form: reverse of top sheet used by family practitioner committee for payment.

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Practice Research

Universal claim form for items of service payments in general practice

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Abstract

A universal claim form of this kind was designed to replace 12 different forms currently in use by general practitioners in the National Health Service to claim payment for items of service. This form was evaluated over a period of three months in a group practice. It was acceptable to doctors, staff, and the staff of the family practitioner committee. Consistently single and multiple claims were made during the trial period than during the same period the previous year.

Introduction

Twelve different forms are used by general practitioners in the National Health Service to claim payment for items of service (FP1, FP101, FP102, FP103, FP106, FP107, FP108, FP123, FP124, FP131). Three of these—FP1, FP101, FP107—also serve as an encounter record because they record clinical data. Only the FP1 is of a size that will fit into the medical record envelope.

This paper reports the results of an evaluation of a universal claim form in a general practice over a period of three months.

Method

The universal claim form (fig 1) was designed by JRG to replace the existing 12 claim forms. It encompasses all the relevant data on the existing forms and complies with the relevant sections in the Statement of Fees and Allowances Payable to General Medical Practitioners in England and Wales. It was designed to fit into the traditional medical record envelope.

The thin front sheet of "no carbon required" paper, hinged onto a card back piece. Hence, by using a ball point pen information entered on the top sheet is duplicated on the front of the card back piece (fig 2). After separation the front sheet is forwarded to the family practitioner committee as a claim. The reverse of the top sheet (fig 3) was designed to help the family practitioner committee to process claims. Clinical details may be recorded on the reverse of the card back piece (fig 4) and subsequently transferred to or filed in the patient's notes, be forwarded to the family practitioner committee (FP101, FP106, FP107), or, in the case of vaccinations, be

forwarded to the area health authority to be entered on their computer file.

Once the details about the patient are completed (fig 1) the patient ticks off and signs for the services rendered in this section. The bottom section is used by the doctor to claim for the services stated but not listed in the patient's section of the form—for example, night visits, emergency treatment, or second person for anaesthetic service. Maternity claims are made by using the existing maternity claim sticker (FP24A), which is attached to the back of the top sheet after the form is completed.

NATIONAL HEALTH SERVICE RECORD OF TREATMENT

Surgeon: _____ No. _____ Date of Birth: _____

Address: _____

Family Practitioner: _____

Medical and Dental Officer: _____ Name FPC: _____

To be completed by patient

1. I have been vaccinated against:

a) Smallpox (vaccinated) ☐ b) A general vaccination test to be carried out at the age of 15 ☐

2. I have been vaccinated against:

a) Tetanus ☐ b) Diphtheria ☐ c) Whooping cough ☐

3. I have been vaccinated against:

a) Typhoid ☐ b) Cholera ☐ c) Malaria ☐

4. I have been vaccinated against:

a) Polio ☐ b) Measles ☐ c) Rubella ☐

5. I have been vaccinated against:

a) Tuberculosis ☐ b) Syphilis ☐ c) Gonorrhoea ☐

6. I have been vaccinated against:

a) Malaria ☐ b) Typhoid ☐ c) Cholera ☐

7. I have been vaccinated against:

a) Polio ☐ b) Measles ☐ c) Rubella ☐

8. I have been vaccinated against:

a) Tuberculosis ☐ b) Syphilis ☐ c) Gonorrhoea ☐

9. I have been vaccinated against:

a) Malaria ☐ b) Typhoid ☐ c) Cholera ☐

10. I have been vaccinated against:

a) Polio ☐ b) Measles ☐ c) Rubella ☐

11. I have been vaccinated against:

a) Tuberculosis ☐ b) Syphilis ☐ c) Gonorrhoea ☐

12. I have been vaccinated against:

a) Malaria ☐ b) Typhoid ☐ c) Cholera ☐

13. I have been vaccinated against:

a) Polio ☐ b) Measles ☐ c) Rubella ☐

14. I have been vaccinated against:

a) Tuberculosis ☐ b) Syphilis ☐ c) Gonorrhoea ☐

15. I have been vaccinated against:

a) Malaria ☐ b) Typhoid ☐ c) Cholera ☐

16. I have been vaccinated against:

a) Polio ☐ b) Measles ☐ c) Rubella ☐

17. I have been vaccinated against:

a) Tuberculosis ☐ b) Syphilis ☐ c) Gonorrhoea ☐

18. I have been vaccinated against:

a) Malaria ☐ b) Typhoid ☐ c) Cholera ☐

19. I have been vaccinated against:

a) Polio ☐ b) Measles ☐ c) Rubella ☐

20. I have been vaccinated against:

a) Tuberculosis ☐ b) Syphilis ☐ c) Gonorrhoea ☐

21. I have been vaccinated against:

a) Malaria ☐ b) Typhoid ☐ c) Cholera ☐

22. I have been vaccinated against:

a) Polio ☐ b) Measles ☐ c) Rubella ☐

23. I have been vaccinated against:

a) Tuberculosis ☐ b) Syphilis ☐ c) Gonorrhoea ☐

24. I have been vaccinated against:

a) Malaria ☐ b) Typhoid ☐ c) Cholera ☐

25. I have been vaccinated against:

a) Polio ☐ b) Measles ☐ c) Rubella ☐

26. I have been vaccinated against:

a) Tuberculosis ☐ b) Syphilis ☐ c) Gonorrhoea ☐

27. I have been vaccinated against:

a) Malaria ☐ b) Typhoid ☐ c) Cholera ☐

28. I have been vaccinated against:

a) Polio ☐ b) Measles ☐ c) Rubella ☐

29. I have been vaccinated against:

a) Tuberculosis ☐ b) Syphilis ☐ c) Gonorrhoea ☐

30. I have been vaccinated against:

a) Malaria ☐ b) Typhoid ☐ c) Cholera ☐

31. I have been vaccinated against:

a) Polio ☐ b) Measles ☐ c) Rubella ☐

32. I have been vaccinated against:

a) Tuberculosis ☐ b) Syphilis ☐ c) Gonorrhoea ☐

33. I have been vaccinated against:

a) Malaria ☐ b) Typhoid ☐ c) Cholera ☐

34. I have been vaccinated against:

a) Polio ☐ b) Measles ☐ c) Rubella ☐

35. I have been vaccinated against:

a) Tuberculosis ☐ b) Syphilis ☐ c) Gonorrhoea ☐

36. I have been vaccinated against:

a) Malaria ☐ b) Typhoid ☐ c) Cholera ☐

37. I have been vaccinated against:

a) Polio ☐ b) Measles ☐ c) Rubella ☐

38. I have been vaccinated against:

a) Tuberculosis ☐ b) Syphilis ☐ c) Gonorrhoea ☐

39. I have been vaccinated against:

a) Malaria ☐ b) Typhoid ☐ c) Cholera ☐

40. I have been vaccinated against:

a) Polio ☐ b) Measles ☐ c) Rubella ☐

41. I have been vaccinated against:

a) Tuberculosis ☐ b) Syphilis ☐ c) Gonorrhoea ☐

42. I have been vaccinated against:

a) Malaria ☐ b) Typhoid ☐ c) Cholera ☐

43. I have been vaccinated against:

a) Polio ☐ b) Measles ☐ c) Rubella ☐

44. I have been vaccinated against:

a) Tuberculosis ☐ b) Syphilis ☐ c) Gonorrhoea ☐

45. I have been vaccinated against:

a) Malaria ☐ b) Typhoid ☐ c) Cholera ☐

46. I have been vaccinated against:

a) Polio ☐ b) Measles ☐ c) Rubella ☐

47. I have been vaccinated against:

a) Tuberculosis ☐ b) Syphilis ☐ c) Gonorrhoea ☐

48. I have been vaccinated against:

a) Malaria ☐ b) Typhoid ☐ c) Cholera ☐

49. I have been vaccinated against:

a) Polio ☐ b) Measles ☐ c) Rubella ☐

50. I have been vaccinated against:

a) Tuberculosis ☐ b) Syphilis ☐ c) Gonorrhoea ☐

51. I have been vaccinated against:

a) Malaria ☐ b) Typhoid ☐ c) Cholera ☐

52. I have been vaccinated against:

a) Polio ☐ b) Measles ☐ c) Rubella ☐

53. I have been vaccinated against:

a) Tuberculosis ☐ b) Syphilis ☐ c) Gonorrhoea ☐

54. I have been vaccinated against:

a) Malaria ☐ b) Typhoid ☐ c) Cholera ☐

55. I have been vaccinated against:

a) Polio ☐ b) Measles ☐ c) Rubella ☐

56. I have been vaccinated against:

a) Tuberculosis ☐ b) Syphilis ☐ c) Gonorrhoea ☐

57. I have been vaccinated against:

a) Malaria ☐ b) Typhoid ☐ c) Cholera ☐

58. I have been vaccinated against:

a) Polio ☐ b) Measles ☐ c) Rubella ☐

59. I have been vaccinated against:

a) Tuberculosis ☐ b) Syphilis ☐ c) Gonorrhoea ☐

60. I have been vaccinated against:

a) Malaria ☐ b) Typhoid ☐