KING's FUND CENTRE

Changing Primary Care: The Role of Facilitators

Judith Allsop

KING'S FUND
CENTRE FOR
HEALTH SERVICES
DEVELOPMENT

PRIMARY HEALTH
CARE GROUP

RE GROUP PUBLICATIONS

ased at the King's Fund Centre for Health Services Development. ommunity health services, particularly in inner London; to encourage experiments with new ways of working; to disseminate 'good practice'; and to contribute to debates about primary health care policy. The group provides information and advice about primary care developments; works with NHS managers to establish and evaluate demonstration projects; organises workshops and conferences; and publishes papers and reports.

A Brave Attempt. Team working between health visitors and social workers on an inner city estate.
Hessie Sachs *May 90*
ISBN 0 903060 76 1 £9.50
Chronicles the experie
ing in a team of social
workers on a problem
all those concerned wit
policies for community

**The Consumer's Viev
community health ser**
Cornwell J.
ISBN 0 903060 39 6
Looks at services from
discusses negative attit
they affect health care.
resources for action. C
and practitioners, and

The Future of Comm
Hughes J.
ISBN 0 903060 19 1
Describes improvemer
community health serv
threats to continued pr
concerned with implen
and community care.

**User Friendly Servic
managers of commu**
Winn E and Quick A.
ISBN 0 903060 36 1
Practical help on maki
Detailed case studies c
pitfalls and the particu
surveys.

**Breaking New Groun
munity Care Centre.**
Winn K.E and King C. *Nov 87*
KFC 87/138 £1.50
Describes a small, community-based, GP hospital in inner London with valuable lessons about patient autonomy, involving local users and the need to clarify and communicate objectives.

Cumberlege in Action.
Brown P and Gordon P. *Apr 87*
KFC 87/67 £2.50
A directory of good practice that influenced the Community Nursing Review Team.

The Management Response to Childhood Accidents.
Constantinides P. *June 87*
ISBN 0 900889 98 5 £3.50
A guide for managers to the effective use of NHS
dent in-

ices.
Nov 87
£2.50
e progress
health

vices In-

£1.50
nation is

Feb 89
£5.00
sed as
coherent
atives,
ician and

Health

March 89
£5.00
ringey
portunities
th care.
ibes pro-
escrip-
nities

policy.

Changing School Health Services.
Gordon P and Hughes J. *Jan 88*
ISBN 0 903060 03 5 £8.50
An information pack of particular interest to managers seeking to review and develop school health services. Includes policy reviews, case studies, objective setting, bibliography.

CONTINUED ON REAR INSIDE COVER

KING's FUND CENTRE

Changing Primary Care: The Role of Facilitators

Judith Allsop

Primary Health Care Group
King's Fund Centre for
Health Services Development
126 Albert Street
London NW1 7NF
Tel: 071 267 6111

1990
KFC 90/15

ACKNOWLEDGEMENTS

This study was commissioned by the King's Fund London Programme, which was coordinated by Jane Hughes and Pat Gordon, and is now known as the Primary Health Care Group. Jane Hughes, June Huntington, Annabelle May, Sheila Rodmell and particularly Pat Gordon and Pam Constantinides, made a number of contributions to this work and helped to polish the final draft. Sylvia Beck assisted in the data collection and analysis and provided crucial support in the early stages. The text was edited by Catherine Dawson; and Helen Landsman undertook various stages of the word processing with great efficiency and goodwill. I am grateful to all of them and for the time given by the facilitators and general managers who talked to me about their work, especially Rosemary Beardow, Nancy Dennis, Tyrrell Evans, Roger Higgs, Ginny Morley and Michael Rope.

Judith Allsop

ISBN 0 903060 73 6

Published by the King's Fund Centre, 126 Albert Street, London, NW1 7NF
Designed and typeset by Hyphen Electronic Composition Limited, London, 071 403 9608
Printed by Jay Printers Limited, London

CONTENTS

INTRODUCTION

'Whilst the post will be challenging and offer a unique opportunity for the worker to make a positive impact, the job is likely to be a lonely one.'

The above quotation is from the job description for one of the early facilitator posts, a primary health care development worker in Tower Hamlets in 1983. It captures both the expectations of those who appoint facilitators and some of the difficulties facing post holders. Since then, the term 'facilitator' has come into general usage in primary care and the community health services. District health authorities (DHAs), family practitioner committees (FPCs) and even local authorities have advertised for facilitators in a variety of roles. In 1988 the King's Fund commissioned this study. The purpose was to describe the range of activities carried out by facilitators in order to clarify their role.

In approaching the task a number of questions arose to which there was no ready answer and which the study therefore attempts to address. What is a facilitator? How many facilitators are there? What kind of work do they do? How do they relate to the people who actually provide services – the GPs and other members of the primary care team – and to the managers in the DHAs and FPCs? What do they achieve and what factors help or hinder progress? Are they good value for money? There are also more general questions. Why were there increasing numbers of facilitator appointments in the 1980s? How have post holders contributed to implementing government policies for primary care?

During the 1980s, after years of neglect, primary health care became a major focus in government health policy. As the front line of the NHS, general practice and the community health services between them deal with nine out of ten health care consultations and consume 30 per cent of NHS expenditure.[1] Primary care can play a critical role in improving the health of the nation. The quality of life of everyone, and particularly children, elderly and chronically ill people can be enhanced by good, well coordinated primary care. Obstacles to change have been the lack of accountability of GPs and of FPCs as well as a lack of resources.

Mechanisms to ensure that all primary care reaches the level of the best have been inadequate. While government policies have identified areas which need development, managerial powers and the capacity to implement these changes have lagged behind. General practice and the FPCs have remained relatively isolated from the changes sweeping through the rest of the NHS. In 1989, publication of the terms of the new GP contract[2] and the proposals in the Prime Minister's review *Working for Patients*,[3] brought FPCs and general practice, albeit protesting vehemently, into the mainstream of the NHS. In future, FPCs will have to plan health services for their populations; secure value for money; actively manage resources and ensure quality of service through medical audit or other form of performance appraisal.

The thesis of this study is that facilitators have been part of the vanguard of

1. Department of Health and Social Security. *Performance indicators for FPCs for 1984*, 1986.

2. Department of Health. *General practice in the National Health Service. A new contract*, 1989.

3. Secretaries of State for Health. *Working for patients* (Cm 555), 1989.

change – the sappers pushing forward, the front line helping to create a policy agenda at the local level. The first facilitators were appointed in the early 1980s, prior to the 1985 Health Services Act. This made FPCs independent of DHAs and extended their role into planning for primary care. These early post holders identified some stumbling blocks to improving primary care in inner cities where the problems facing general practice were most acute. Nurse facilitators were appointed to develop health promotion prior to the publication of the White Paper *Promoting Better Health.*[4] Finally, some facilitators assisted with FPC/DHA inter-agency service development. Proposals in the NHS and Community Care Bill[5] are intended to create incentives for such collaboration.

4. Secretaries of State for Health. *Promoting better health: the Government's programme for improving primary health care* (Cm 249), 1987.

5. NHS and Community Care Bill (1990).

THE SCOPE AND ORGANISATION OF THE STUDY

In order to begin the study, decisions had to be made about the definition of 'a facilitator' and about the boundaries and methods of investigation. *The Shorter Oxford Dictionary* defines the verb 'to facilitate' as follows: 'to make easier; to promote; to help forward; to lessen the labour of'. Facilitators in primary care have been appointed to help forward changes and lessen the labour of the professionals and managers. The study focuses on their work in general practice and with FPCs. It is the FPCs' own definition of 'a facilitator' which provided the data for the study. Questionnaires were sent to all FPCs and later interviews were carried out with selected post holders and FPC managers. The methods of data collection and analysis are described in more detail in Appendix 1. Due to constraints of time and funding, questionnaires were not sent to DHAs, and so facilitators who worked exclusively from the DHA with no reference to the FPC were therefore omitted from the study. They warrant a separate investigation.

6. Handy, C. *The future of work*, 1985.

The book is organised on the basis of the professional background and training of the facilitator. Chapter one sets the scene and is in two parts. The first gives a more detailed account of the context of change in primary care policy. It can be omitted by those familiar with this history. The second part of the chapter describes questionnaire results on the numbers and type of facilitators. Chapter 2 discusses how nurses, the largest single group, have worked as facilitators. Chapter 3 examines the work of doctors, community development and research workers. It draws out the differences and similarities between projects, first in supporting changes in general practice, and second in encouraging FPC/DHA service development. Chapter 4 discusses the work of the Camberwell Primary Care Development Project which consisted of a team of facilitators. A final chapter sums up the contribution of facilitators and speculates about their role in the future.

A major theme in this book is diversity. Facilitators have carried out diverse tasks in a variety of contexts. There are some common threads. They have worked in three main arenas: in general practice itself; at the interface between GPs and the FPC and that between FPCs and DHAs. Facilitators have some shared characteristics. Virtually all held part-time or short term contracts, often outside the bounds of existing salary structures and conditions of service. Most were women or retired men and not what Handy[6] in his classification of types of worker calls 'organisation people' – full-time workers aged between 25 and 45 on secure career pathways. Apart from these, the kind of tasks facilitators took on – their relationships with others working in primary care, and the kind of interventions they made, differed widely.

Each chapter covers a number of separate projects. Where possible, the aim has been to describe each project in its local context; the content of the

facilitator's work and the processes used to bring about change. This is a framework for analysing change in health care organisations recommended by Pettigrew *et al.*[7] However the amount of detail available is uneven and the study does not claim to be able to compare projects and evaluate approaches. Bulmer[8] and Smith and Cantley[9] point out that it is necessary to set clear objectives in order to evaluate outcomes. This did not occur in the case of most facilitators. They were plunged in at the deep end with a general brief and little guidance. They achieved what they could, where they could, identifying blockages to change and trying to do something about them. Some worked in a difficult and hostile environment and, with limited resources, achieved little. It is nevertheless as important to identify the reasons for failure as for success.

Another factor to be borne in mind when reading the accounts of facilitators' work is that national and local policy in primary care changed rapidly during the 1980s. These changes affected what facilitators were expected to do, and influenced their own interpretation of their role. There is evidence that they learnt from each other through informal networks and where they were in post for some years, or where one facilitator was succeeded by another, the learning was cumulative.

The main objective of this book is to describe what facilitators have done and to extend knowledge about their work to a wider audience. If there is one single message it is that facilitators need political and managerial skills as well as professional knowledge to achieve change. Surprisingly, in view of the emphasis on management throughout the decade, facilitators with formal qualifications or experience in senior management were not appointed, except possibly in one case. Effective facilitators have tended to develop the skills as they carried out the job.

7. Pettigrew, A, McKee, L and Ferlie, E. Understanding change in the NHS. *Public Administration*, 1988, **66**, part 3, 297–317.

8. Bulmer, M. *The uses of social research*, 1977.

9. Smith, G and Cantley, C. *Assessing health care: a study in organisational change*, 1985.

1 POLICIES FOR PRIMARY HEALTH CARE

The decade of the 1980s was a period of unprecedented activity in primary health care. The 1985 Health and Social Security Act established family practitioner committees as free standing health authorities. In 1986, a Green Paper opened a debate about improving primary care.[10] It was published simultaneously with the Cumberlege review of community nursing.[11] In 1987, the Social Services Select Committee Report[12] on primary health care urged the government to take action on promoting change and to find the necessary resources. In 1987, the White Paper *Promoting Better Health*[4] made a large number of proposals to improve standards. A summary and critique of these documents may be found in two King's Fund Institute Papers.[13, 14]

This chapter addresses three related questions – Why has there been a focus on policies for primary health care? What difficulties have arisen in implementing policy change and what assumptions have been made in the appointment of facilitators as change agents? The second part of the chapter presents the questionnaire findings on the numbers and types of facilitators in early 1989 and the methods of funding these posts.

10. Secretaries of State for Health. *Green paper on improving primary health care*, 1986.

11. Department of Health and Social Security. *Neighbourhood nursing: a focus for care* (Chair Mrs Julia Cumberlege), 1986.

12. Select Committee on the Social Services, House of Commons. *First report 1986–7 primary health care.*

13. Marks, L. *Promoting better health?* An analysis of the government's programme for primary care (King's Fund Institute, Briefing Paper 7), 1988.

14. Marks, L. *Collaboration between FPCs and DHAs.* The FPC/DHA demonstration projects, Final Report vol 1. Primary Care Group. King's Fund Centre, 1989.

POLICY CHANGE
The prevention of ill health

In part, primary care has assumed greater importance as a consequence of changes in the population structure and in the pattern of disease and illness. There are more elderly people in the population who require care and treatment for chronic illness and there has been a relative increase in the incidence of illnesses which are caused by environmental or behavioural factors. In theory at least, the latter are preventable. There is strong evidence to suggest that the incidence of diseases of the circulatory system and the cancers could be reduced by a change in behaviour, by not smoking, for example.[15] Moreover, it is argued that susceptibility to diseases, such as coronary heart disease, can be detected by the identification of risk factors. Some forms of cancer can be identified through screening, and then treated. Although there are critics of over-enthusiastic screening for both cancer and heart disease,[16] anticipatory care can prevent, or ameliorate the effects of disease. General practice as the first line service has a key role to play in providing this care.

The Royal College of General Practitioners has supported the approach arguing that: 'For the general practitioner, prevention has become a real option in certain contexts and is gaining in importance in relation to caring and curing.'[17] The 1987 White Paper, *Promoting Better Health*, identified the issue as one of its main objectives. Quoting a Social Service Committee Report, it declared on page 13 that '. . . the next big challenge for the NHS, and one especially for primary care, is to shift the emphasis from an illness service to a health service offering help to prevent disease and disability'.[4] Family doctors and the primary health care team, it suggested, can contribute to promoting good health by giving advice on life-style and by screening for

15. Doll, R. Major epidemics of the 20th century, from coronary thrombosis to AIDS. *Social Trends*, **18**, 13–21.

16. McCormick, J.S. Cervical smears: a questionable practice? *The Lancet*, 22 July 1989, 207.

17. Royal College of General Practitioners. *Prevention of arterial disease in general practice.* (Report for general practice 19), 1981, 4.

early signs of disease. GPs provide continuous care so they can play a key role in the following areas: cervical and breast cancer screening; screening for high blood pressure; improving the uptake of vaccination and immunisation; providing health surveillance for the under fives and regular assessment of their elderly patients, particularly those with special needs. The proposed new GP contract carried this policy forward by proposing protocols for screening and targets for uptake.[2]

Rising Costs

A second reason for a focus on primary care has been rising costs in the acute sector and a 'clinical drift' towards hospital medicine.[18] In 1983, the General Medical Services Committee argued that: 'too many medical skills and aptitudes are laid to rest when doctors enter general practice. If general practitioners are given the opportunities and resources to use these wasted skills it would lead to a redistribution of work within the NHS.'[19] On the basis of commissioned research, the committee also argued that minor surgery, hypertension screening and child health surveillance could be carried out more cost effectively in general practice. These claims found a resonance with government concerns for value for money in public spending.

18. Honigsbaum, F. Reconstruction of general practice: failure of reform. *British Medical Journal*, 1985, **290**, 823–826.

19. General Medical Services Committee. *General Practice: a British success*. British Medical Association, 1983, 30.

Changes in general practice

During the 1970s and 1980s, the way in which many GPs work changed. In the period 1971 to 1985, the proportion of GPs in England and Wales receiving the group practice allowance rose from 58 per cent to nearly 80 per cent.[20] There has been an increase in resources to improve practice premises and to pay for additional practice staff. The introduction of computer technology into FPCs, and many GP surgeries, has begun to lay the foundation for the assessment of GPs' activity. It has also made screening for disease or 'population medicine' possible.[21] However, some general practices have not kept pace with these changes.[22] On the basis of their research, Leese and Bosanquet[23] suggest that general practice is becoming increasingly divided between high income practices with more staff and resources and those with low incomes and few resources. The former tend to be the innovators.

Huntington questions the extent to which the culture of general practice has kept pace with these developments, despite the move towards group practice. She comments that GP practices are typically isolated and closed organisations: 'Even in many so-called group practices, partners retain the sole trader mentality, much to the despair of staff and patients who remain confused by the variety ... of patterns of doctor availability, consultations times, prescribing and referral policies within the same practice.'[24] Further, she suggests that most GPs are more comfortable with one to one relationships with their patients, than with planning care for their practice population.

At the beginning of the decade, the London Health Planning Consortium[25] published the report of a study group chaired by Professor Donald Acheson, entitled *Primary Health Care in Inner London*. This demonstrated quite clearly that general practice in many parts of London was poor. There were many sub-standard premises, a high proportion of single-handed practitioners and some very elderly doctors still practising. Due to a complex set of interacting factors, practices in London had not followed the pattern in other parts of the country. The study group declared that action was urgently needed and it made a large number of recommendations. Subsequent studies indicate that some, though by no means all, large cities in Britain had similar sorts of problem. Wilkin, Hallam, Leavey and Metcalfe[26] review the evidence.

20. National Audit Office. *Report of the Comptroller and Auditor General: management of the family practitioner services*, 1988.

21. Tudor Hart, J. *A new kind of doctor: the GP's part in the health of the community*, 1988.

22. Irvine, D. Quality of care in general practice: our outstanding problem. *Journal of the Royal College of General Practitioners*, 1983, **33**, 521–523.

23. Leese, B and Bosanquet, N. High and low incomes in general practice. *British Medical Journal*, 1989, **298**, 932–934.

24. Huntington, J. Change at the grassroots. *Health Service Journal*, 1 March 1990, 324–325.

25. London Health Planning Consortium. *Primary Health Care in Inner London* (Acheson Report), 1981.

26. Wilkin, J, Hallam, L, Leavey, R and Metcalf, D. *Anatomy of urban general practice*, 1987, 39–43.

The government did not make an explicit response to the Acheson Report, although some funding was made available for small-scale projects. Rhodes, Prashar and Young[27] conclude that the response was not adequate: 'The projects constitute a piecemeal, uncoordinated approach to the problems of primary care in inner cities [and] they represent a short-term approach, a temporary stimulus rather than a continuing commitment.' A number of major difficulties stood in the way of improving standards in primary care besides low levels of investment. These relate to the lack of accountability of GPs, the inadequate powers and underdevelopment of the managerial capacity of FPCs and the organisational discontinuities between DHA services and general practice.

27. Rhodes, G, Prashar, U and Young, K. *Primary health care in the inner cities: after Acheson*. Policy Studies Institute, 1986, 94.

GPs are independent practitioners under contract to the FPC. They had considerable autonomy to practise how and where they liked. The contract was couched in terms of general availablity to be consulted by ill patients. FPCs had traditionally had an administrative role – paying practitioners and providing advice and assistance when requested. Since the early 1980s, they have been required to take a more active stance towards managing practitioners. In 1985, FPCs became self-employing authorities. They subsequently had a statutory duty to plan services jointly. They also had increased responsibilities for monitoring and inspecting GP premises and the deputising services. The White Paper, *Promoting Better Health*, reiterated the importance of GPs working with nurses and other primary health care staff in a team. FPCs were urged to encourage GPs to employ staff under the ancillary staff scheme.

FPCs and national policy

The 1987 White Paper, together with the new contract, presented a new vision for primary care in the 1990s. The implementation of *Working for Patients*[3] and the NHS and Community Services Bill[5] bring additional funding and powers to FPCs. Both are necessary in order to make the transition from largely administrative to management organisations. Huntington's report[28] for the National Health Service Training Authority outlines the training programme which must underpin a change in organisational culture to '. . . fill the current managerial vacuum in primary care'. However, FPCs, like their contractors, have valued their separateness from the NHS and indeed from each other.[29] Closer monitoring of their performance is necessary.

28. Huntington, J. *Report of a project to investigate the training and development needs of family practitioner committees with particular reference to their management development needs*. King's Fund College, 1987.

29. Allsop, J and May A. *The emperor's new clothes: family practitioner committees in the 1980s*, 1986.

In 1988, a National Audit Office (NAO) report was critical of the lack of direction given by the Department of Health (DoH) and expressed concern about the lack of improvement in general practice particularly in inner cities. The NAO had been asked to examine two aspects of FPC management. First, whether the family practitioner services were working satisfactorily and second, whether these arrangements had had a practical impact on five areas relating to GP services: the use of deputising services, the employment of ancillary staff; the health care of the homeless, the promotion of group practice and the improvement of practice premises. The report's conclusions were that the DoH had given insufficient guidance to FPCs in producing their planning strategies; that collaboration between health authorities had improved but there remained formidable obstacles; that resource constraints had hindered the assumption of the wider responsibilities envisaged. Good progress had been made with computerisation.

It is worth repeating the comments of the NAO as they reveal FPC management problems in the late 1980s. In relation to deputising services, FPCs experienced difficulty in monitoring and influencing the extent of use. Most of the FPCs visited by the NAO had not reviewed their policies for

monitoring these or increasing GPs' employment of staff under the ancillary staff scheme. The DoH had not provided guidance in this respect, nor in relation to planning the balance between group and singlehanded practice. Despite the general trend towards group practice, the NAO said that in some inner city areas almost three-quarters of the GPs did not practise in groups. Furthermore, the standards of many GP premises in major cities remained unsatisfactory. FPC returns in 1986 had shown that 20 per cent of premises nationally were unsatisfactory, whilst the proportion in inner cities was almost 40 per cent.

The NAO noted a number of barriers to change. These included the large number of agencies with which the FPC had to relate; the different priorities of DHAs and FPCs; the lack of planning guidance from the DoH; an absence of middle managers in FPCs; the lack of powers which FPCs had to direct practitioners; the high cost of improving premises in the inner city and the inadequate level of financial assistance available from central government.

A number of studies have demonstrated the problems for health authorities in planning and delivering services jointly.[14, 29, 30] In 1984, the Joint Working Group on collaboration between FPCs and DHAs[31] recommended that the health authorities, the FPC and the committees representing each group of practitioners should work more closely together, especially in areas such as child health, family planning, screening and community nursing. The group suggested that joint working was also inhibited by a poor database on general practice and an inadequate flow of information between authorities.

In summary, although the reasons for a policy focus on primary care are clear, there have been serious implementation problems. These difficulties have not been helped by problems which often arise in relationships between nursing and general practice.

30. Williams, S. Case Studies in collaboration. *The Family Practitioner Services Journal*, 1986, **13**, part 3, 39–43.

31. Department of Health and Social Security. *Report of the Joint Working Group on Collaboration between Family Practitioner Committees and District Health Authorities*, 1984.

Nurses in primary health care

The services provided by nurses, and their professional skills, are critically important to general practice, particularly in providing anticipatory care. Either practice nurses or community nurses or both may deal with a GP's patients. Practice nurses are employed directly by the GP and, until April 1990, 70 per cent of the costs were automatically reimbursed under the ancillary staff scheme providing that this came within the limit of not more than two additional practice staff per GP.

Practice nurses carry out a wide variety of tasks.[32, 33] Some are largely autonomous 'nurse practitioners' who undertake clinical tasks and manage health promotion systems. At the other end of the spectrum, others act as receptionists and general helpers in the surgery. Qualifications vary and it is the GP who appoints practice nurses and decides how they are to be deployed.

The number of practice nurses is relatively low compared to the largest group of community nurses – district nurses. In 1987, there was less than one practice nurse to every 1,000 people compared to two or three district nurses to every 1,000. Moreover, there were substantial regional variations in the ratio of practice nurses to patients.[34] In recent years, the numbers of practice nurses have increased rapidly. In 1984, there were 2,015 in England and Wales (WTEs); in 1988, 3,711 (DoH personal communication 1990). Numbers are also likely to have increased substantially in 1989 as GPs appointed nurses to avoid the cash-limited budgets for ancillary staff introduced in April 1990. This increase in practice nurses should be welcomed as the NAO[20] found that only 15 per cent of all practices took up their full quota under the reimbursement scheme.

In the past, the employment of practice nurses has been held back by

32. Bowling, A. *Delegation in general practice: a study of doctors and nurses*, 1981.

33. Bowling, A and Stilwell, B (eds) *The nurse in family practice*, 1988.

34. Bowling, A. The changing role of the nurse in the UK. In: Bowling, A and Stilwell B (eds) *The nurse in family practice*, 1988.

practice structure and organisation and also by the absence of a proper definition of practice nurse qualifications and training. In 1989, the English National Board laid down guidelines for training and the 1990 *Statement of Fees and Allowances* for GPs, states that practice nurses should have General Registered Nurse qualifications with additional specialist qualifications in health visiting and midwifery if they intend to carry out these tasks.[35]

35. Department of Health. *Statement of Fees and Allowances* 52.22/3 1990.

Community nurses, that is district nurses, health visitors, midwives and other specialist nurses, are managed by a senior nurse within the DHA. In some areas, they are attached to practices and work as part of a primary care team. This way of working has been supported in most government reports as the best way to develop good collegiate relationships and achieve continuity in patient care. However, in the inner city, because GPs draw their patients from wide and overlapping catchment areas, formal attachment may make excessive demands on nurse time. Many DHAs have therefore organised community nurses within a geographical area covering a number of practices to which they are aligned. Following the Cumberlege Report,[11] nurses are more likely to be grouped and managed on a locality basis. However, there remains considerable diversity.

FACILITATORS AS CHANGE AGENTS

It has been important to consider the aims of government policy as well as some of the stumbling blocks to implementation. The major problem has been that FPCs have lacked the resources and powers to 'manage' practitioners directly. Rather, as one FPC Annual Report put it, they have relied on: 'Working with them, discussing, persuading and informing them . . . about services as they develop'.[36] In order to work successfully, this requires clear local policies and a good knowledge of what GPs do and what they want to do in the future. In some FPCs, relationships have been poorly developed while GPs may face insuperable problems in developing their practice. The Royal College of General Practitioners has vigorously promoted good practice, but in the 1980s less than half of GPs were members.

36. Ealing Hammersmith and Hounslow FPC. *Annual Programme for 1985–86*, 1986.

37. Schulz, R and Harrison, S. *Teams and top managers in the NHS*. (King's Fund Project Paper 41) 1983.

Facilitators have been appointed to bridge that gap and act as a catalyst for change. Someone who could on the one hand identify problems and act as a source of support and advice for GPs and on the other build bridges between GPs and the FPC. Some FPCs have themselves needed an outside influence to generate a change of culture. Indeed, Pettigrew argues that public sector managers tend to be policy maintainers rather than innovators, locked into sets of relationships with their practitioners: '. . . with some notable exceptions, [they] emerge as reactive not proactive, as skilled in avoiding conflict or as risk averters capable of providing what service providers want with as few overt scandals or struggles as possible'.[37] Huntington's study of FPCs[28] found much evidence to support this view.

While subsequent chapters describe how facilitators fulfilled these roles, the remainder of this chapter reports on the survey findings on the numbers and types of facilitator in January 1989.

Numbers and funding

All FPCs were asked to fill in a simple questionnaire to establish how many employed facilitators or knew of facilitators working in their area; how the post was funded; whether the contract was full- or part-time and whether it was on a short term basis or was an established post. A brief statement about the aims of the appointment and the professional qualifications of the post holder were also asked for [Appendix I]. The results from the questionnaires were recorded on a matrix which allowed some simple counting and grouping under professional qualifications and funding. Where FPCs enclosed a job

description this provided more information on the intended scope of the facilitator's work and it is used in subsequent chapters.

The findings provide an overall picture of facilitator projects in England and Wales at the beginning of 1989. The questionnaire was sent to all FPCs in November 1988, with a follow-up request in January 1989. The final response rate was just over 90 per cent. Ninety of the 98 responded.

FPCs WITH FACILITATORS IN ENGLAND AND WALES 1989 **TABLE I**

FPCs with facilitators in post	49
with appointments pending	6
Total	55
FPCs considering appointing a facilitator	5
unable to appoint due to lack of funding	3
with no knowledge of facilitators in their area	27
Total questionnaire returns	90
Total number of FPCs in England and Wales	98

Source: Questionnaire returns 1989

Overall, 49 FPCs referred to facilitators working in their area. A further six said that appointments were pending in the very near future and gave details of funding. This made 55 FPCs in all – more than half of all FPCs. A further five FPCs said that they were currently considering appointments. Three FPCs, South Glamorgan, Sheffield and North Tyneside, said they had not been able to appoint facilitators due to either lack of support and/or funding. According to our data, there were 103 facilitators in post in early 1989, either full or part-time. The number of facilitator posts exceeds the number of FPCs because in some FPCs there is more than one facilitator.

FACILITATOR POSTS IN ENGLAND AND WALES BY SOURCE OF FUNDING 1989 **TABLE II**

Funded by DHA	33
DHA and FPC	43
joint finance	8
FPC* (with additional RHA or DoH support)	19 (9)
Total number of posts funded	103

* Some FPCs have raised additional resources from the private sector.

Source: Questionnaire returns 1989

Of the 103 posts referred to in the FPC questionnaires: 33 were funded by DHAs; 43 by a combination of the DHA and FPC; eight through some form of local authority-based finance and 19 by FPC funding. Of these, nine FPCs had supplementary funding from regional health authorities or from the DoH. The source of funding was a predictor of the professional background and task of the facilitator.

Virtually all the 33 DHA-funded posts were for nurse facilitators. Typically, they worked from health promotion, health education or community medicine departments of DHAs, and were concerned with developing some aspect of population screening or health education.

Only rarely did questionnaire returns refer to a joint steering group with the FPC to guide the work of these facilitators. The numbers recorded in the survey are only from FPC sources. It is likely therefore that the number of DHA-funded facilitators is higher than the figure given here. For example, we know from the Oxford Heart and Stroke Project (1989) that at least four further posts are funded by DHAs. Some facilitators therefore work with general practices entirely in isolation from the FPC. The Welsh Office and some regions have provided funding, generally for nurse facilitators.

There were considerable variations among the 43 posts funded jointly by the DHA and FPC. For example, two posts were funded almost wholly by the the district but the facilitator was seconded to the FPC. The FPC was thus used as a base from which to work with GPs. The FPC contributed only office space and administrative costs. In some cases, the arrangement was reversed. An example of a post largely funded by the FPC but with adminstrative support from the DHA is Enfield and Haringey FPC. Here, a social researcher was employed on a joint project to survey services provided by GPs and related health authority services.[38]

38. Constantinides, P. A review of GP services in Tottenham. Unpublished research report to the Enfield and Haringey FPC and Haringey DHA, 1989.

In some areas, the costs of employing a facilitator were shared more equally. The most common arrangement was funding through the ancillary staff scheme which allowed (until April 1990) automatic reimbursment to GPs of 70 per cent of the costs of the employment of certain categories of practice staff, including nurses, providing that this does not exceed a maximum of two full-time staff per family doctor. The GP pays the remaining 30 per cent. However, the DHA, the FPC, or the local medical committee may act as an agent for a group of GPs. They then pay 30 per cent of the cost. Facilitators employed in this way were usually nurses.

Joint consultative committees, composed of representatives from the health districts, the local authority, the FPC and local voluntary organisations, receive a funding allocation for joint projects. Joint finance is intended to provide short term funding for collaborative projects or for longer term schemes where one or other of the constituent bodies eventually takes over the funding into their mainstream budget. Special funding is also available to some local authorities with high levels of social deprivation through the Inner Urban Aid programme. In eight areas, these sources had been used to fund nurse facilitators, often in the context of a local health strategy. However, funding is short term and in a number of cases plans are already well advanced to move towards an alternative source of support, such as the ancillary staff scheme.

The remaining 19 posts were funded from or through the FPC administrative budget. These are the most varied projects in terms of the content of the work and professional background of the facilitator. The distinguishing characteristic of this group is that the facilitator works very closely with FPC managers and within the strategic planning framework of the FPC. Work with individual practices is therefore carried out overtly or covertly within a shared framework of knowledge about the circumstances, issues and problems likely to be facing particular practices. In these circumstances, the facilitator can be employed to develop the FPC's general strategy.

Additional funding has been provided by the Department of Health, the regions and the private sector. For example, South East Thames Regional Health Authority is funding a nurse facilitator in East Sussex FPC. North West Thames Regional Health Authority funded a GP, and then a nurse, facilitator in Kensington, Chelsea and Westminster. East Anglian Regional Health Authority funds a GP in Norfolk. The Department of Health has

funded six posts in FPCs. Private sector pharmaceutical companies have contributed to nurse facilitator posts in Stockport and in Cheshire.

To summarise, most facilitator posts are funded from more than one source. There is considerable variety in where the initiative comes from, and arrangements made for steering the facilitator's work. Generally, if there is shared funding, there is a steering group. Facilitators can thus encourage joint working between authorities. It was not possible to obtain from the questionnaire data the dimensions or quality of these collaborative relationships in terms of primary care development, but this is an important issue which deserves further investigation.

TABLE III

TYPES OF FACILITATOR POST BY PROFESSIONAL BACKGROUND 1989, ENGLAND AND WALES

Facilitators with a nursing background	88
medical background	13
community development background	2
Total	103

Source: questionnaire returns 1989

The questionnaire returns indicated that in early 1989, there were 13 facilitators with a medical background, two from a background in community development or research while 88 had a professional training in nursing [Table III]. Nurses were by far the most numerous group. The following chapters look in detail at the work of selected facilitators on the basis of their professional background. The data is drawn from interviews with, or from reports written by, facilitators both past and current.

2 NURSES AS FACILITATORS

Nursing is by far the most common background of facilitators. The questionnaire data indicated that in 1989 of the 103 facilitators, over four fifths were nurses. The growth in numbers of nurse facilitators has occured in the latter part of the 1980s and this chapter aims to describe some of the tasks they carry out. The concept of the nurse facilitator derives from the work of the Oxford Heart Attack and Stroke Project which pioneered a technique for helping GPs to screen their patients for risk factors in coronary heart disease (CHD). In 1983, a nurse facilitator, supported by the Community Medicine Department at Oxfordshire Health Authority, was appointed to work with practices in Oxfordshire. The method has been copied elsewhere and is referred to here as the Oxford model.

The rapid spread of the nurse facilitator was encouraged by the growing public health movement in the mid 1980s[39] and the government's support for health promotion in the 1987 White Paper, *Promoting Better Health*. However, the tasks carried out by nurses have diversified beyond the Oxford model and this chapter aims to describe both this model and subsequent developments.

The Oxford model focused on helping the general practices to introduce screening for CHD and then extended into other forms of screening, for example cervical cancer. Other nurse facilitators have focused on helping practices to meet the health needs of ethnic minority groups, particularly in inner cities where practices may be small or in poor premises. Yet others have assisted practices to develop services for patients with chronic illnesses such as diabetes, asthma or who are HIV positive.

Nurse facilitators were initially also appointed to work at a more strategic level within the DHAs. Sometimes this involved the nurse in working closely with FPC management. The link was important for two reasons. First, not all GP practices had the appropriate buildings, staff or practice organisation to support either screening for disease or a broader form of health promotion. The FPC was a channel for extra resources to the practice. Second, practice nurses who carried out health promotion often required training and support in developing their role. Practice nurses are a heterogeneous group for whom recognised national training courses are only now beginning to develop. Typically they have had neither the management support nor the training of district nurses or health visitors. Third, the nurse facilitator with management links to the FPC was in a better position to develop collaborative working with nurse managers in the DHA.

In the latter part of the 1980s, there was a move towards FPCs themselves appointing nurse facilitators. Sometimes the nurse became part of the FPC management structure. She or he thus gained a thorough knowledge of the needs of GP practices; and could work with public health departments, as well as provide leadership in health promotion. Examples of FPCs who have followed this route are given at the end of the chapter. The changes proposed

39. Ashton, J and Seymour, H. *The new public health: the Liverpool experience, Open University Press*, 1988.

in the NHS and Community Care Bill[5] make this the most likely direction for future development. To begin with, however, this chapter describes the Oxford model which remains a core technique.

SCREENING: THE OXFORD MODEL

The director of the Oxford Heart Attack and Stroke Project, Elaine Fullard, has described the work of the nurse facilitator as 'the White Paper in action'.[40] The approach is based on screening for coronary heart disease risk factors in patients between the ages of 35 and 64, when they visit their GP. The method does not depend on a call system but on tagging patient records for easy identification.

As most of the population is registered with a GP and 75 per cent will visit their doctor at least once a year, and 90 per cent within five years, the method is capable of reaching a large proportion of all patients.[41, 42, 43, 44] Age/sex registers are necessary to the process and good basic level record keeping is essential, but computerisation is not. However, computerised records simplify the task of identifying and checking levels of take-up.

When patients in the target category visit the surgery, they are offered an appointment for a general health check. This may be carried out by the GP, or more probably, the practice nurse or health visitor. The health check, or human MOT, as the Oxford Project calls it, is based on recording specific information about the patient such as blood pressure, smoking behaviour, weight, alcohol consumption, amount of exercise taken and, in the case of women, the date of the last smear test. The check provides an opportunity for treatment, advice and counselling. If recordings of basic measures indicate problems, then there may be further tests, or referral to the GP (if a nurse is carrying out the screening). The rationale of this approach is that people in middle age are most vulnerable to 'deaths before their time'. Britain has a high death rate from coronary heart disease and cancers compared to many other developed societies.[45, 46]

The belief is that early identification of signs (high blood pressure, overweight, smoking or excessive alcohol consumption) provides an opportunity for advice to be given. This may change behaviour, reduce risk factors and therefore prevent more serious illness or death. It is argued that in the case of cervical cancer, early detection via a smear test can save lives as the disease is susceptible to treatment.

The Oxford method is simple, low cost and amenable to quantification. Fullard[40] describes the steps taken by the nurse facilitator. First, she initiates a practice meeting to discuss workload, methods of screening and the appointment of practice nurses. Second, s/he audits the practice records to demonstrate the scope for improvement. This usually shows low levels of recording. In the average practice, blood pressure is recorded for approximately 50 per cent of patients; smoking behaviour for 25 per cent and weight for 10 per cent. Practices are invariably 'horrified' by these low levels of recording. This provides a spur to improve performance. A subsequent audit a year later typically shows a 30 per cent rise in the recording rate.

The third stage of the nurse facilitator's work is to offer training for the practice nurse. The fourth is to provide a support service for the practice. A variety of aids such as record cards may be supplied by the private sector. Fullard argues that the introduction of screening does not appreciably affect the workload of practice staff. Moreover, it can be carried out by practice nurses whose salary costs are considerably less than those of doctors. A practice nurse's salary can in any case be claimed from the FPC under the

40. Fullard, E. The facilitator is the White Paper in action. *The Family Practitioner Services*, 15 November 1988, 208.

41. Fullard, E, Fowler, G, Muir Gray, J. Facilitating prevention in primary care. *British Medical Journal*, 1984, **289**, 1585–1587.

42. Fullard, E, Fowler, G, Muir Gray, J. Promoting prevention in primary care: controlled trial of low technology, low-cost approach. *British Medical Journal*, 1987, **294**, 1080–1082.

43. Fullard, E, Fowler, G, Muir Gray, J. Unleashing the potential of primary care. *Health Trends*, 1987, **19**, part 2, 33.

44. Astrop, P. The birth of a new profession. *Health Visitor*, 1988, **61**, 311–2.

45. Health Education Education Authority. *Look after your heart campaign strategy*, 1987.

46. National Audit Office. Report of the Comptroller and Auditor General: *NHS coronary health*, 1989.

ancillary staff scheme and a practice may offset costs by enhanced claims for item of service payments.

The Oxford Prevention Project has not only pioneered the method of screening but has helped to create a support group through the Association of Primary Care Facilitators. The association has established a peer group network to counter the isolation of the nurse facilitator and to pass on good practice. Facilitators in turn support practice nurses. They aim to develop cohesion and establish a professional identity. They provide a training for practice nurses in the instrumental skills necessary for health screening and have underpinned this with a set of values, or expressive skills, about the distinct role of the nurse in health promotion. In doing so, they have filled a vacuum.[47]

47. Bowling, A. Emergence of the facilitator. *Primary Health Care*, March 1987, 12–13.

Association of Primary Care Facilitators,
c/o HEA Primary Health Care Unit,
Block 10, Churchill Hospital,
Oxford OX3 7LJ,
Tel: 0865 63283.

In the Oxford promotional literature, nurse facilitators are presented as catalysts who inspire others with their own confidence in this efficient and effective and above all, rational method. Fullard herself talks of nurse facilitators needing 'a charming ruthlessness' in order to overcome the many obstacles presented by the general practice system. GPs as independent practitioners decide how to run their practices and the nurse facilitator, with her package of equipment, must be persuasive in order to achieve cooperation within the practice. Astrop[44] suggests that facilitators also have a role as a 'cross-pollinator' of good ideas between practices. She comments: 'General practice tends to operate in isolation with practices in different parts of a town totally unaware of what happens in practices nearby'. The Oxford Heart and Stroke Project has made a significant contribution in developing a method and promoting its implementation. It has encouraged training and supported the growth of a new sub-specialism within nursing.

The Oxford method however has limitations and there are general practices where its use would be inappropriate. There are also some who are critical of the claims made for preventive health measures and believe there are other priorities. These issues are addressed in turn.

Limitations of the Oxford model

In interviews for this study, some health professionals commented that the Oxford method is too mechanistic. It is primarily concerned with increasing the level of recording on patient notes and telling the patients they are at risk. It can become an end in itself and detract from the importance of personal relationships in changing behaviour. Very little is known about why patients do, or do not, change their health behaviour on being told they are at risk. There are a number of competing theories about the effect of personality type and the effect of social roles, positions and networks on motivation, but little hard evidence.[48]

Two counter points may be made. If the introduction of a screening system encourages practices to be better at keeping full patient records, this in itself is of great value and can alter attitudes to patient care in the practice as a whole. Second, studies have indicated that GP counselling can change patient behaviour.[49] The effectiveness of GPs in tackling smoking and diet is recognized and validated in many research studies, although their role in the control of alcohol consumption is less developed.[50, 51] Furthermore, Bowling and Stilwell in a survey of the literature from the United States suggests that patients are equally satisfied with advice from a nurse or a doctor.[33] However this does not necessarily endorse the Oxford model. It simply underlines the importance of the professional/patient relationship.

Some respondents interviewed during the course of this study questioned the effectiveness of the Oxford approach in inner city practice where neither

48. Peterson, C and Stunkard, A. Personal control and health promotion. *Social Science and Medicine*, 1989, **28**, part 8, 819–828.

49. Russell, M, Wilson, C, Taylor, C *et al.* Effect of general practitioners' advice against smoking. *British Medical Journal*, 1979, **2**, part 6184, 231–235.

50. Richmond, R and Webster, I. Evaluating a general practitioner's use of a smoking intervention programme. *International Journal of Epidemiology*, 1985, **14**, 396–401.

51. Wallace, P.G *et al.* Are general practitioners doing enough to promote healthy lifestyle? *British Medical Journal*, 1987, **294**, 940.

the practice structure nor the patient population may be appropriate for systematic screening. Beardow, Oerton and Victor[52] have drawn attention to the difficulties of introducing a cervical cytology screening programme in an inner city health district and of the considerable effort necessary at FPC level to prepare practices to achieve anticipatory care. One GP facilitator commented that in his view there was little point in telling patients in adverse social circumstances to stop smoking or change their diet when they were unable to control vital aspects of their lives such as income and housing. Practice priorities, in his view, should be planned in the context of the lives of patients and existing facilities. The first task might be to improve inadequate premises in the light of future needs (interview).

Conversely, Marsh and Channing[53] demonstrate what can be achieved in a well-organised group practice despite high levels of patient need. In their practice in Stockton-on-Tees, the levels of take-up for cervical cytology, vaccination and immunisation on a large council estate were raised above those in a more middle class suburban district through active promotion. The key ingredients may have been the commitment of all practice members to health promotion; the existence of a team with a variety of skills; a research-based approach; and a stable patient population.

52. Beardow, R, Oerton, J and Victor, C. Evaluation of the cervical cytology screening programme in an inner city district. *British Medical Journal*, 1989, **299**, 98–100.

53. Marsh, G.N and Channing, P.M. Deprivation in health in one general practice. *British Medical Journal*, 1986, **292**, 1173–1176.

Reservations about screening

In recent years the extension of screening for disease in general practice has been rapid, although reservations have been expressed about some of the consequences. In the 1970s, Crawford, a social scientist in the US, wrote about the dangers of 'healthism'. He argues that there were costs as well as benefits to the policy emphasis on prevention.[54] One cost was the creation of 'the worried well', those people whose concern about their health had been raised by routine screening. In Britain, McCormick[16] has pointed to the difficulties and the high cost of surveying populations for cervical cancer. He questions the benefits, and draws attention to the problems in running efficient systems. Wilkinson, Jones and McBride[55] comment on anxiety caused by insensitive screening programmes.

The interviews carried out for this study indicate that not all GPs, or indeed GP facilitators, give a high priority to screening, particularly in the absence of proper counselling, and effective administrative and data processing systems.

There is, as yet, little clear evidence that screening reduces deaths from either CHD or cervical cancer. Recent figures suggest that the mortality rates for the former are beginning to fall, but the fall is significantly less than that achieved in North America.[46, 56] It would in any case be difficult to attribute the fall to screening as a number of intervening variables will be involved.[57] Despite these reservations, the new GP contract[2] creates powerful financial incentives for screening and indeed for other measures such as child health surveillance, vaccination and immunisation. In 1990, the number of facilitators concerned with these latter programmes has increased rapidly.

54. Crawford, R. You are dangerous to your health: the politics and ideology of victim blaming. *International Journal of Health Services*, 1977, **7**, part 4, 663–680.

55. Wilkinson, C, Jones, C and McBride, J. Anxiety caused by abnormal result of cervical smear test: a controlled trial. *British Medical Journal*, 1990, **300**, 440.

56. Wells, N. *Coronary heart disease: The scope for prevention*, 1982.

57. Oliver, M. Does control of risk factors prevent coronary heart disease? *British Medical Journal*, 1982, **281**, 1065–1066.

58. Brown, C. *Black and white in Britain: the Third Policy Studies Institute Survey*, 1984.

SERVICES FOR ETHNIC MINORITY PATIENTS

Asian communities are often concentrated in run-down inner city areas, where GP facilities may be poorly developed.[23] Women may be particularly affected by poor levels of service provision. A Policy Studies Institute survey[58] estimated that 70 per cent of all Pakistani and Bangladeshi women in Britain spoke little, or no, English. McAvoy[59] in a recent study in Leicester, found that there was a low take up rate for cervical cancer screening among Asian women. Further, it is estimated that the incidence of heart disease is twice as high in adult males from the Asian sub-continent as their equivalent

59. McAvoy, B.R. Asian women: i) contraceptive knowledge ii) contraceptive sources. *Health Trends*, 1988, **30**, 11–17.

British-born group.[60] The incidence of diabetes itself increases the risk of heart disease. Furthermore, there may be social and cultural reasons why treatment or prevention services are not sought out. The 1987 White Paper suggested that: 'Linkworkers who could communicate effectively with different communities could help to offset the problem that the areas where ethnic minorities had settled were also those where primary care problems were likely to be most intense'.

Southern Derbyshire Health Authority and the FPC jointly have developed a strategy to identify the main causes of ill health among the large Asian population in inner city Derby. There is a high incidence of diabetes and a community-based diabetic advisory clinic was set up with joint funding. A nurse facilitator was also appointed by the FPC to work with practices.[61] As some GPs wish to develop their own diabetic clinics, they are being helped to plan these and the FPC has used the ancillary staff scheme to appoint nurses shared between practices. Half of the ten practices in the area are single-handed GPs. The DHA has provided leaflets in English and a number of Asian languages and health promotion videos are widely used to reach those who do not read, or write well in any language. It is estimated that 70 per cent of the Asian population have access to a video recorder.[62] Other tapes are available for training health workers.

The importance of the Derbyshire initiative is that is has been introduced as part of a well researched and publicised initiative by the FPC and DHA. A report, *Raising the Issues; a review of service provision for ethnic minorities* describes the general issues, the local problem and the policy response.[62]

60. Whitehead, M. *The heath divide; inequality in health in the 1980s*. Health Education Council, 1987.

61. Guram, B. *Diabetic Linkworker Project Report*. Derbyshire FPC, 1989.

62. Derbyshire Family Practitioner Committee. *Raising the issues: a review of service provision for ethnic minorities*, 1989.

SERVICES FOR CHRONICALLY ILL PATIENTS

It has long been argued within the medical profession and by governments that more medical care could, and should, be undertaken in general practice (see chapter 1). There is some evidence to suggest that many hospital out patient visits are unnecessary. For example Marsh[63] carried out a study of 260 follow-up outpatient consultations in twelve GP practices and found that a large proportion appeared to be a waste of time. In some parts of the country, hospital clinicians and GPs have drawn up protocols to share care in the treatment of chronic conditions such as diabetes, asthma and AIDS.

Implementing shared-care schemes and ensuring their continuation is a complex process and one in which a nurse facilitator can play a vital role. Data from the questionnaires show, for example, that in Lincolnshire, having developed screening for heart disease, the nurse facilitator intends to extend her work into developing practice-based clinics for diabetics. This is an important step as one and a half per cent of the population have a form of diabetes. She has also developed an AIDS health promotion programme involving pharmacists as well as GPs.

Hampshire FPC has a primary care adviser who aims to develop shared care schemes between hospital and general practice for patients with chronic disorders, particularly diabetes. The development of a shared-care scheme was one of the major activities of the Camberwell Primary Care Development Team described in chapter 4. In an unpublished 1989 study for the King's Fund Primary Health Care Development Fund, Dennis reviews a number of shared care schemes throughout the country. These have involved a variety of agencies working co-operatively: hospital departments; departments of general practice; FPCs; DHAs; LMCs; individual GPs and community workers, as well as nurse facilitators.

63. Marsh, G.N. Are follow-up consultations at medical outpatients departments futile? *British Medical Journal*, 1982, **284**, 1176.

HEALTH PROMOTION CAMPAIGNS

The nurse facilitator has played a leadership role in developing health promotion. Indeed the genesis of many facilitator appointments has been a local health campaign developed by a community medicine or health education department. This was the case in Derby and is a feature of the Welsh Health Programme,[64] the Somerset Look after your Heart Campaign[65] and the Barnet Healthy Living Project. In Leeds, three nurse facilitators were appointed following a local authority sponsored report: *Inequalities in Health in Leeds*.[66] This revealed a mortality rate from coronary heart disease 12 per cent higher than the national average. Facilitators were appointed to introduce coronary heart disease screening into general practice.

Health promotion facilitators have also begun to be appointed in FPCs. In Hillingdon, a DoH funded nurse facilitator started work in 1987. She has compiled a comprehensive list of objectives for general practices. These include screening for heart disease, breast and cervical cancer, asthma and diabetes; increasing the take up of vaccination and immunisation; the promotion of healthier lifestyles and the expansion of minor surgery. These ambitions are to be realised by 1992 by increasing the numbers of practice nurses, working both full and part-time. Such developments will require a high degree of collaboration between the FPC and a number of DHA departments.

On the basis of these examples, it is possible to envisage a permanent role for the nurse facilitator in primary care development as an individual who initiates and implements a policy for health promotion. This may involve entrepreneurial activities such as approaching local educational institutions to support courses, or raising funds from the private sector. The dairy and drug industries have both supported health promotion initiatives.

From all the examples of facilitators given so far, there appear to be two main areas of activity. One is providing support, information and expertise to GPs and their practice staff. The other is developing collaborative work, whether by helping to develop shared-care protocols, or through local health promotion campaigns. In all these roles, training is a critical issue.

64. Welsh Office. *Heartbeat Wales: Welsh heart survey preliminary report*, 1985.

65. Somerset Health Authority. *The Somerset Take it to Heart Campaign survey report*, 1988.

66. Leeds City Council Health Committee. *Inequalities in health in Leeds: a report*. The Health Unit, Leeds City Council, 1987.

TRAINING PRACTICE NURSES

Practice nurses are frequently the focal point for screening, health education and health promotion in a practice, yet they may not have received the training to equip them for a health promotion role. Moreover, they may have little contact with nursing colleagues and lack opportunities for professional development. GPs themselves are often ignorant of their obligations as employers and they do not always make the best use of their practice nurse.[33] In a number of FPCs – Avon, Leeds, Leicestershire – a nurse facilitator has been specifically employed to support and train practice nurses. They have drawn on DHA nurse trainers, and local polytechnic or university departments, to mount both general and specific courses. They have provided skills training and peer group networks for practice nurses. These can help to enhance technical skills and change attitudes and values. For example in Avon FPC, the facilitator provides training for nurses on the technique of carrying out cervical smears for practices without a female partner, so that patients can have a choice of male, or female, practitioner. In Leeds, the facilitator sees training as a critical factor in changing, ie the culture of the practice as a whole. She runs joint sessions geared to helping GPs and nurses develop a shared vision for their practice (interview).[67]

67. Leeds Family Practitioner Committee. *Report by the Primary Care Facilitator*, 1988.

MANAGEMENT STRUCTURES

Nurse facilitators themselves occupy a number of different positions within DHAs and FPCs. There are three basic models. In one, the nurse works entirely from the DHA. In another, the nurse is free-floating between the

DHA and FPC. In a third, the nurse works from the FPC and may be part of the management structure. Management arrangements tend to be related to funding. If the FPC funds the post, it is likely that the person will be based with them. DHA and jointly funded posts are more variable. The position from which the facilitator works is likely to affect what can be achieved. It has not been possible to explore this issue fully due to lack of data on DHA-based nurses. A comparative evaluation of the work of nurse facilitators in different organisational settings should be undertaken to investigate three aspects of their work. How the setting affects their screening and health promotional activities; their role in training and their impact on practice structure and organisation.

On the basis of questionnaire and limited interview data there were two relevant findings about DHA-based facilitators. First, some nurses who were developing DHA-led health promotion programmes said they preferred to maintain independence from the FPC. This is possibly because they had considerable autonomy, professional support networks and career prospects within the DHA. Second, this arrangement can be compatible with a strong partnership with the FPC as in Brent and Harrow and Barnet. The link with the FPC is important as FPCs have the resources and the powers to help GPs develop and sustain health promotion activities. Furthermore, the facilitator can draw on the knowledge which FPCs have of practices. It was clear however that in some areas FPCs had no contact with DHA-based nurse facilitators or knowledge of their work. This is a missed opportunity for collaboration.

Nurses who work between DHA and FPC may feel they belong to neither organisation and as a consequence, experience feelings of isolation. For example, one facilitator based in a health education department but with joint funding and a desk at the FPC described her position as: 'Like being on board the Marie Celeste' (interview). The health authority had no coherent programme and although most of her week was spent at the FPC, there was no designated person with whom to relate managerially and no training budget. Her job was to help practices to introduce systems for screening on the Oxford model but she had no prior briefing on the ethos and structure of practices. Some were hostile. She was asked: 'Are you the spy from the FPC?.' She believed her work to be hampered by mistrust.

Nurse facilitators working solely for FPCs could, and sometimes did, work within a clear framework of objectives and were often members of the management team. For example, in 1985, Lincolnshire FPC drew up a strategic plan jointly with the local medical committee (LMC). A nurse facilitator in the north of the county worked directly with GPs and the LMC to negotiate a programme of work. They agreed to make shared-care protocols a priority.

In Derbyshire, the FPC employs two facilitators who work within the context of a joint DHA/FPC health promotion programme. Both are funded from the FPC administrative budget. One works with general practices as a whole, the other with inner city GPs. In this FPC, the nurse facilitator role is recognised as being crucial to future practice development and the number of practice nurses has increased by over a third in 18 months. There are plans to appoint four more facilitators as locality-based managers, each with a budget for administrative and nursing staff. They will have a clearly defined task within a single organisation.

A general comment made by all nurse facilitators who were interviewed related to the workload generated by practices wanting assistance. They

complained about being 'overwhelmed' by new demands and of being unable to maintain support for practices where the Oxford system had been introduced. FPCs may have to consider increasing nurse facilitator posts in ratio to the number of practices, as in Derbyshire.

Before leaving the nurse facilitator, a final illustration of how the role can be used imaginatively to fit local circumstances is provided by the nurse manager appointed in Trafford FPC. Here the post holder has carried out a range of activities from practical support to GPs to assisting with service development between the DHA and FPC. In 1988, a senior nurse manager was seconded from the health authority to the FPC. He had a range of managerial and clinical skills as well as a detailed knowledge of the DHA structures and policies. He was able to combine support work with GPs with joint service planning between FPC and DHA. The brief he was given by the FPC was indeterminate: to go and meet the doctors and help them in any way he could to improve their services (personal communication). The instruction is of interest as it illustrates the role of the facilitator as policy developer where the FPC is uncertain about how to proceed. Subsequent chapters will show that many facilitators have been faced with this open ended responsibility.

The list of tasks undertaken by the facilitator is impressive. He has helped a number of GPs to develop their premises; assisted in the introduction of screening for heart disease in three practices; advised GPs on management and employment problems; run computer awareness days; written booklets on how to select practice staff, helped GPs to identify their needs for new staff and helped with computerisation and practice audit. He also assisted in drawing up a joint FPC/DHA plan for cervical and breast cancer screening.

The facilitator suggests that he has represented a GP view to the district and, in his capacity as liaison officer, has negotiated open access referrals for GPs to district services such as physiotherapy. He has also arranged practice-based consultant sessions in psychiatry and rheumatology; examined ways of reducing waiting lists in certain specialties and organised the secondment of DHA community nurses to general practice and training programmes for practice nurses. The facilitator considers himself to be part of FPC management, and attends FPC meetings.

The main interest of the Trafford post is that it involves a senior nurse with local knowledge of both FPC and DHA and with management experience. The post holder argues that this has enabled him to look at issues strategically across authorities and has helped to ensure policy implementation. It would be valuable if the outcomes of this work could be assessed.

In summary, during the second half of the 1980s, nurse facilitators have increased in number and developed their role. Nurses have the technical knowledge and skills to promote the prevention of ill health in general practice. Figure I illustrates the range of tasks. On the national level, professional education and training have not kept pace with the new demands on primary care prevention and nurse facilitators are filling a gap in training. They are also contributing to the management capacity of FPCs. There are clear benefits in nurses working closely with the FPC to support initiatives within individual practices. In the future these links are likely to become closer as the new contract for GPs creates greater incentives to expand their work.

FIGURE 1

NURSE FACILITATOR TASKS

in GP practices	health promotion schemes requirements: database trained staff shared care schemes requirements: database protocols trained staff
in the FPC	contributing to FPC strategy establishing requirements for health promotion communicating information about practices generating resources for health promotion setting up training courses for practice nurses/ receptionists/GPs promoting good professional practice in nursing
in the DHA	establishing links with health promotion units and community nurse management

DOCTORS AND COMMUNITY DEVELOPMENT WORKERS AS FACILITATORS

3

General practice is the foundation of the system of health care in Britain. It deals with nine-tenths of health care episodes yet, as was discussed in chapter one, there are weaknesses in the delivery of primary care. A group of GPs in Newcastle[68] summed up the issues when they commented: 'There is the lack of direction; the relative lack of accountability; poor measure of outcome; inconsistency in service provision and difficulty in marrying the salaried community health services with an entrepreneurial and independent practitioner service'. The authors might have added that these problems are compounded by the absence of a clear authority to plan for primary care. FPCs have lacked the statutory powers and the skills to instruct or evaluate practices. Some FPCs have had neither the vision nor the energy to support GPs in improving their services. Others have worked with facilitators to achieve these ends by assisting GPs in planning the future for their practice and developing inter-agency collaboration between the FPC and DHA.

68. Brown, A, Jachuk, S, Walters, F and van Zwanenburg, T. The future of general practice in Newcastle upon Tyne. *The Lancet*, 15 February 1986, 370.

Facilitation work with GPs is based on the concept of professional colleague support, a shared view of the world of general practice and assistance in winning resources and sorting out problems as they are seen by the practice. The facilitator needs to understand problems and win the trust of GPs. This is called here the *best friend* model. Joint service development work on the other hand, is based on the concept of strategic planning and demands different skills: the ability to gather data, formulate policies and persuade groups to cooperate. This is termed the *service development* model. Section one of this chapter describes facilitator projects which follow the best friend model, section two, the service development model. In practice these models overlap but it is convenient to separate them conceptually. Both models were successfully combined in the Camberwell Primary Care Development Project, described in chapter four, where GPs and a community development worker operated as a team.

This chapter draws on three sources of data. Reports written by facilitators, semi-structured interviews and the questionnaire returns. Where facilitators have written reports which are quoted, they are referred to by name. In early 1989, there were 13 facilitators in post who were GPs and two who were community development workers with social science or health and social service experience.

The amount of data available on particular projects varies considerably and for this reason they have not been compared. The aim here is to describe and draw out lessons that may be learnt in the light of the national and local context at the time. It is apparent that facilitators themselves learnt from doing the work and in many cases built on the work of their predecessors. It is a pity that more of them do not write accounts of their aims and working processes.

THE 'BEST FRIEND' MODEL

The facilitators who worked in the best friend model are described in chronological order. The first ones were based in inner London. They were

appointed in response to the London Health Planning Consortium (LHPC) Report which in 1981 indicated the shockingly poor quality of primary care in some parts of the capital. It is important to see their work in the context of both time and place. Some were appointed to work on service development, as well as practice support but failed to achieve the former because the infrastructure for joint working did not exist. Early facilitators had to be sensitive to the prevailing GP culture at the time, which was sometimes mistrustful of the FPC. Post holders were careful to put loyalty to the GP first. However they could act as bridge builders and mediators with the FPC. Later best friend facilitators have taken their brief more directly from the FPC and have been concerned to persuade practices of the advantages of practice profiles, health promotion or the use of computers, all issues of importance to FPC management.

Islington

In 1981, a GP facilitator was appointed by North East Thames Regional Health Authority to assist GPs in Islington to improve their premises. The LHPC welcomed his appointment as they believed surgery premises were a key factor in developing general practice. They argued that facilitators (these were called coordinators in the LHPC report) would: '. . . be able to call on the advice of architects and other relevant professionals . . . liaise with responsible bodies and build up a profile of land available in areas of need: help GPs in searching for suitable premises, and promote groupings of practices. They should assist in arranging improvements, repair and maintenance'. LHPC suggested that facilitators would need personal experience of general practice, extensive knowledge of NHS procedures and the ability to deal with other professionals. 'One important aspect of their work will be to liaise with the FPC and local authorities in obtaining knowledge of sites and premises available.'[25]

The first facilitator, Arnold Elliott, placed considerable importance on his independence from the FPC. He believed he was there to assist doctors in developing their business and not to reveal the nature of that business to a statutory body. Any information given would be confidential and 'could not be used to institute disciplinary proceedings'. This nicely illustrates a traditionalist view of the FPC which was seen as unduly concerned with 'policing' the GP's contract.[69]

Elliott worked part-time for 3 years. He visited all the practices in Islington and collected data on surgery premises, staffing, services provided, such as clinics and screening, and about the arrangements for patient access out-of-hours. The aggregated findings from this practice survey indicated that standards of premises were indeed very low. Furthermore, less than half the practices employed a nurse and in some surgeries, telephones were left unanswered out-of-hours. It is not possible to establish any clear outcomes from Elliott's work. His own subjective assessment was that by identifying deficiencies and providing support in a sympathetic way, he achieved improvements.[69]

Camden and Islington FPC derived little benefit from the exercise as none of the data collected was made available to them. In the early 1980s, FPCs did not yet have responsibilities for planning services and it is possible that formal links with the FPC would have jeopardized Elliott's credibility with his colleagues. However, it cannot have been in the interests of the users of services in Islington that the links with the FPC were so tenuous. Eight years on, it seems surprising that the FPC knew so little about the way in which their contractors practised.

69. Elliott, A. The general practice facilitator – a personal view. *Health Trends*, 1984, **16**, 74–76.

Tower Hamlets

In 1983, a facilitator was appointed in Tower Hamlets to work with GPs, the FPC and the DHA. This was a joint venture between Tower Hamlets DHA and City and East London FPC, with financial support from the King's Fund. It was a full time post which lasted for four years. The job description for the post holder covered a wide range of activities relating to both practice and inter-agency service development with an emphasis on community involvement. The facilitator was expected to: assess how primary care in the district could be improved and take steps to achieve practical results; work with grass-roots field staff not only GPs but also health visitors, district nurses, social workers, receptionists, community and voluntary organisation workers; consider policies for primary health care with managers and seek ways of involving health service users in issues of policy and provision.[70]

Tower Hamlets was chosen for development work in the belief that such an approach was necessary to galvanise change. The area has a high level of social deprivation with many low income households, living in poor housing or without homes. There are large ethnic minority groups unable to communicate readily in English. In the early 1980s, the pattern of general practice had been slow to change and premises were particularly poor. Many GPs practised from small council flats which had not been converted or modernised. They were very dissatisfied with their premises and their relationship with the health authority.[70, 71, 72] The facilitator, Nancy Dennis, found GPs struggling to cope with heavy demands in poor conditions. Many had been waiting many years for surgery improvements. Others who owned their premises found that the available cost rent schemes were either inappropriate or inadequate. The cramped and unsuitable conditions often made the employment of ancillary staff impossible.

70. Dennis, N and Malin, S. *Tower Hamlets Primary Care Development Project*. A report for the King's Fund London Project Executive Committee, 1988.

71. Heath, H and Sims, P. The general practitioner in the inner city: a survey of a London health district. *Journal of the Royal College of General Practitioners*, 1980, **34**, 261, 199–204.

72. Bowling, A and Betts, G. The scope for preventive medicine in general practice in the East End, *Health Education Journal*, 1984, **43**, 96–99.

Development work in Tower Hamlets

The regional health authority had funded a small academic unit, the Centre for the Study of Primary Care, at Steel's Lane Health Centre in east London. Dennis worked from here as it was believed that the neutral base would allow her to move more easily across professional and organisational boundaries. The centre could also provide a focal point for all groups concerned with primary care.

Part of Dennis's brief was to develop inter-agency collaboration between DHA and FPC, but the focus of the work soon became the development of GP practices, where it seemed most progress could be made. All practices were visited and a survey carried out of GP facilities and services; GPs' experience of working with the health authority; and their future plans for the practice in the next two, five and ten years. Data was collected on 43 out of 45 practices. By the end of the project, two-thirds of the practices had development plans.

Dennis argued that discussion with GPs was necessary to turn aspirations into firm plans.[70, 73] In the tradition of the best friend model, most of the helping was of an essentially practical kind related to difficulties with premises and the interface with the hospital and other primary care workers. Dennis was a link with the FPC, with the Medical Architecture Research Unit (MARU) which could help with premises, as well as other relevant bodies. During the period, new buildings were planned for 16 practices and 25 others proposed service changes of some kind. Increasingly, Dennis was used by GPs as a resource – giving advice on how to extend the range of services and on how to improve premises. She was able to increase the informal flow of information between the DHA, the FPC and GPs. Location at the centre

73. Dennis, N. *Primary Health Care Development Fund Projects: progress report for the King's Fund London Project Executive Committee*, 1989.

allowed meetings, seminars and workshops to be organised for a variety of primary and community health workers. Dennis' work is described in greater detail elsewhere.[72]

One of the major practical issues Dennis identified was the absence of information about services. This is not unique to Tower Hamlets and the 1987 White Paper *Promoting Better Health* addresses the issue specifically.[4] In Tower Hamlets, GPs said they lacked information about hospital consultants, clinic times, policies and practice in district nursing services, social services and services available from the voluntary sector. Clinicians and other professionals lacked knowledge about GPs, about where they were located and what they provided. Patients knew least of all.

It also became clear that it was no one's responsibility in the DHA to supply the information GPs said they needed. The medical list produced by the FPC was inaccessible, out of date and unimaginative: typical of many at that time. Dennis set out to gather the information which was wanted and to present it in a way which was easy to use and attractive. She produced a directory listing GPs and their services with accompanying maps which showed the location of surgeries. She produced directories of hospital departments and clinics; community health services; social services and voluntary organisations. In all, it was an enormous and successful task and the directories were in heavy demand.

Finally, the project played a role in assessing needs and developing plans for GP and community health services on the Isle of Dogs. This is an area undergoing rapid structural and demographic change as part of the development of London's dockland. Data on the locality was collated into a 'patch profile' for use in future planning and local people and organisations contributed their knowledge and skills in the discussion of future options.

How was the work carried out?

The impact of the Tower Hamlets project depended on drawing others in to think about primary care rather than the measurable output from specific tasks. Dennis herself comments on the importance of 'legging it around the district'. She attended meetings, talked to people, found out what they thought, what they wanted and how they could be helped. She wrote reports, collected and disseminated information. This enabled people from different backgrounds to get together to discuss topics jointly: 'So booking rooms, buying and preparing lunches or refreshments for use in different locations, ferrying round displays and equipment, and clearing up and washing up were frequent project activities'.[74] This type of activity tends to be mentioned by female rather than male post holders, suggesting that gender roles affect facilitation strategies.

Dennis saw the independence from health service hierarchies as important in gaining the trust of practitioners. She chose to concentrate her efforts on the majority of practices which were relatively under-developed and not on the exceptional few which hitherto 'had a lion's share of resources'. She provided advice and support and suggests that she may have been less threatening than a medical colleague (interview). There is no suggestion in her work that she met with any hostility, rather, she was welcomed as an ally. She acted as a channel of communication with the FPC, and as a resource, and in consequence built up a network of organisational support for general practice. This was done in a broader way than other GP facilitators because community organisations were also brought in.

The task of developing policies across organisations was less easy. Relationships with some health authority departments were unproductive.

74. Dennis, N and Malin, S. *Tower Hamlets Primary Care Development Project*. A report for the King's Fund London Project Executive Committee, 1988, 16, 14

This may have been due to staff changes and the vacuum created by prolonged vacancies in management posts but there were also territorial boundaries around separate health authority units which the facilitator, as an outsider, found difficult to penetrate. She suggests that the project was not seen as a 'district' initiative or policy, '... most professionals had not been consulted or informed and ... were too busy with their own concerns'.[74] Most important of all, there was no structure for planning primary care and no one with responsibility for managing the interface between primary and secondary care. For example, there were no joint care planning teams to develop or progress strategies for dependent groups such as elderly or mentally handicapped people. Liaison groups attempted to plan but had no executive power.

Relationships with the FPC, a simpler single purpose organisation, were more straight forward. Despite being outside the structure, Dennis was able to work in tandem with FPC staff. At a time when FPCs were relatively weak and isolated she was able to assist them in identifying priorities for planning services. The general manager suggests that the major lesson was the importance of going out to practices and finding ways of helping them.

The practical successes of the project were the support given to GPs, the work on premises and the provision of information on local services. These activities had the effect of raising the profile of primary care in the area.

There were also frustrations and failures in Tower Hamlets. Some of the reasons lay in the broad remit of the project and the lack of a strong enough management group to take forward specific initiatives within the DHA. This was a major disappointment as poor working relationships with the health district were one of the main concerns of GPs.

Kensington, Chelsea and Westminster

In 1985 a facilitator was appointed to Kensington, Chelsea and Westminster FPC (KCW) to work part-time for three years. The project was funded by North West Thames Regional Health Authority. The facilitator, Michael Rope, had recently retired from general practice in Hertfordshire and had been active in promoting general practice locally, regionally and nationally. His terms of reference were: to encourage a movement to group practice and the extension of the primary care team; to develop close working relationships with the health and local authorities; to examine the problems of the singlehanded GP and to look at the uptake of post graduate medical education among GPs.[75] He was expected to be both best friend and service developer, although he achieved more in the former role than the latter.

In retrospect, these terms of reference were unrealistically wide given the context of general practice in KCW. A number of studies had indicated the problems. As early as 1977, a community health council (CHC) study had drawn attention to the difficulties which patients experienced in registering with a GP; in getting an appointment with a GP and on the high use of deputising services out of surgery hours.[76] The LHPC report showed that KCW had the highest rate of single-handed and very elderly practitioners in inner London.

In 1987 a study by Bosanquet indicated that little had changed.[77] He found that in 1985/6, 35 per cent of practitioners were over 60 and almost half of the doctors were practising single-handed. In one area, an astonishing 78 per cent of NHS patients were registered with GPs in practices with an average age of over 60. Premises were often very inadequate and certainly inappropriate for developing team working. The use of ancillary staff in KCW is among the lowest in the country.[78]

75. Kensington, Chelsea and Westminster Family Practitioner Committee. *Committee Paper FPC(86) 123*, 1986.

76. Kensington, Chelsea and Westminster Community Health Council. *The family doctor in central London*, 1977.

77. Bosanquet, N. *The outlook for general practice in Kensington, Chelsea and Westminster*. Report to the FPC, KCW FPC, 1987.

78. DHSS and the Welsh Office. *District health authority use of family practitioner committee patient registration data*. DHSS, 1987.

High land values are part of the problem. The area includes the extremes of wealth and poverty and, paradoxically, high property prices coexist with poor quality housing, overcrowding and homelessness. Bosanquet's report drew attention to the disincentives to change facing individual practices. Practice income could be very low due to the small number of patients and few additional item of service payments. The costs of moving to new premises, or improving an existing surgery were high. Subsidies through cost rent schemes were insufficient to cover central London prices. Bosanquet argued that some GPs could not afford to retire. Their income was too low. The study found that between 1980 and 1985 the gap between the large, dynamic practice with younger GPs and the small, static practices of older GPs had increased. The general interest of the report is that it drew attention to the impact of financial factors on GP behaviour, a topic which its author has gone on to develop.[79, 80]

For the FPC, Bosanquet's work began to provide data on a small area basis. It was thus possible to plan for service changes. The number of very elderly GPs meant that if a retirement age were introduced by government, there would be opportunities to change the pattern of practice. However, this needed to be handled correctly in order to preserve good relationships between GPs and the FPC. The GP facilitator took on some of the detailed work of finding out the intentions of particular practices. He found that many GPs were isolated from each other, from the FPC and from the hospitals. GPs felt badly informed about service changes in the district and expressed 'fear' about the consequences of bed closures and the high level of morbidity among their patients. For many GPs, the FPC was not seen as a source of help. In this situation the facilitator acted as a friend, spokesman and mediator in establishing a better relationship.[81,82] Rope was also called upon to solve disputes within practices. The level of disputes between partners leading to practice dissolution is high in certain inner London districts and other FPCs have referred to the same phenomenon.[36]

Rope was also expected to play a service development role with the FPC and DHA. This proved virtually impossible due to the turmoil in the London health districts in the 1980s.[83] Resource reallocation to the shires and changes in management structures added to the problems of boundary changes and high staff turnover. The task of building collaborative relationships was bedevilled by the complexity of health authority organisation. KCW straddles part of three districts: Paddington and North Kensington (now Parkside), Bloomsbury and Riverside. Furthermore, in the second half of the 1980s all three districts became national centres for the treatment of AIDS patients, and in Parkside in particular, there was a rapid increase in the numbers of homeless families from all over London in hostel and hotel accommodation.

Rope developed links in two districts. He visited managers and clinicians, particularly those working in community medicine and nursing in order to identify areas of mutual concern. Health promotion, screening for disease and developing systems for vaccination and immunisation and child health were high on the DHAs' agenda. In one district, both nurse managers and the FPC wished to develop a policy for community nursing. The facilitator was asked to canvass GP views about nurse attachment and discover why the take up of the ancillary staff scheme was so low. From their side, the GPs wanted to have better information about hospital waiting times and clinic services.

Collaborative activity was time-consuming and demonstrable outcomes were small. Three projects were set up which had identifiable outcomes. In one district, Rope worked with the community unit managers to prepare an information booklet on hospital clinics and community health services for

79. Leese, B and Bosanquet, N. *Family doctors and economic incentives*. Dartmouth Publishing Aldershot, 1989.

80. Horder, J, Bosanquet, N and Stocking, B. Ways of influencing the behaviour of general practitioners. *Journal of the Royal College of General Practitioners*, 1986, **36**, 517–521.

81. Rope, M. *GP facilitator: a report of activities up to June 1986*, 1986.

82. Rope, M. *GP facilitator report*. KCW FPC, 1988.

83. King's Fund. *Planned health services in inner London; back to back planning*. King's Fund Publishing, 1987.

GPs. Second, he carried out a survey to establish how GPs used their practice nurses. The findings showed that nurses spent more time doing reception, telephone and organisational duties than on nursing. Third, he helped to set up a GP forum, the Sentinel Project, with the departments of community medicine and general practice. This is discussed further below as the work was developed by a subsequent facilitator.[84]

In summary, Rope adopted a way of working which was informal and unstructured. No steering group was set up until two thirds of the way through the funding period. As a result, he had to determine his own programme and priorities. The FPC at this time did not have an annual programme or plan, and their database on practices was poor. There were no practice profiles and computerised information systems were not introduced until 1986. As a consequence, Rope's main activities were in building relationships and, as he himself says, this activity is difficult to measure in terms of tangible results.

However, local managers argue that the work was important in building trust between GPs and the FPC and between the local medical committee and the FPC. One manager commented: 'The problems in some practices were much worse than we realised. We learnt how isolated GPs were and therefore how resistant to change. Perhaps we need to start even further back and have a support worker for particular practices over a longer period' (interview). In acting as the doctor's best friend and drawing in the FPC in a supportive capacity, local managers suggest that the facilitator laid the foundation for subsequent initiatives. Without this bridge-building, neither the the GP forum nor Bosanquet's work on GP lists would have been accepted as legitimate by the local medical committee or individual doctors. The facilitator himself believed he was expected to achieve too much with too little. His reports show his increasing impatience with the funding body's 'unrealistic' demands.[81, 82] The pace of change and staff turnover in the health districts, the lack of FPC strategy and the intractable problems facing some GPs made progress in developing collaborative links extremely difficult.

84. Beardow, R. *The sentinel practice scheme*. Report to the Steering Group of the KCW FPC, 1988.

Progress since 1987 ...

Since 1987, an increasing number of FPCs have appointed GPs as facilitators on a sessional basis although none of the projects has, as yet, been documented as fully as those just described. These appointments have been made by innovative and leading FPCs, as well as those with poor practices and premises within the inner city. In general, facilitators' work now tends to be targeted on issues of concern to FPCs and facilitators act in an outreach capacity for the FPC although their method of working is still the best friend approach.

Lambeth, Lewisham and Southwark FPC, in inner London, has employed two GP facilitators with DoH funding, one working in Lewisham, the other in Southwark. Lambeth already has the Camberwell primary care project described in Chapter 4. The facilitators aim to help GPs improve their premises by increasing the take-up of cost rent schemes, to introduce age/sex registers and encourage them to employ practice nurses as the uptake is exceedingly low. In addition, the FPC has a policy of supporting new GPs and GP trainees and the facilitators play a role in this. They are familiar with the working of the FPC and, the general manager suggested, act as its 'eyes and ears' identifying difficulties faced by particular practices. This can help the FPC to determine priorities and channel resources more appropriately.

In Greenwich and Bexley, a local GP was recently appointed to work in the more deprived part of Greenwich. The post is funded by the DHA and FPC and is a way of implementing a jointly produced primary care plan. This aims to develop primary health care teams within general practice and to

concentrate more resources on the poorer parts of the borough. The facilitator is well placed to influence decision-making. He is a member of the district management board and of the FPC. The project is in its early stages and has not yet been evaluated.

In 1987 Barnsley appointed a retired GP as a facilitator for five sessions a week. Financial support comes from the DoH. The facilitator works with individual practices to enable them to use the computerised information systems developed by the FPC. Barnsley's planning strategy is based on practice profiles which provide data for GPs and allow them to monitor their performance within the practice and against other comparable practices.

The facilitator has worked with a group of hospital consultants to agree a protocol for shared care in diabetes, and has set up paediatric training in preparation for extending the GP role in child health surveillance. He also intends to develop a policy for practice prescribing. According to the FPC Performance Indicators,[78] Barnsley has a high rate of GP prescribing compared to other similar areas. This is due to the number of items prescribed per prescription, rather than the high cost of single items. The aim is to reach agreements with GPs over the levels of prescribing which they consider appropriate to their practice.

Although he is extending his activities into new areas, the facilitator works within the best friend model. He has visited practices, talked to GPs and offered his services in response to the problems presented. His work with GPs remains confidential and is not reported back to the FPC. The quality of Barnsley's database provides a wealth of comparative data on practices and the facilitator is extremely well informed about each practice.

Some FPCs have employed GP facilitators for very specific purposes. For example, Derbyshire, Norfolk and Northumberland have appointed a GP on a sessional basis to advise other GPs on the use of computers for practice management. The Northumberland facilitator acts as a GP representative on regional and district bodies concerned with the use of computers. In this FPC, the local medical committee acts as an agent for GPs to fund the facilitator through the ancillary staff scheme.

In general, there has been a shift in the work of best friend facilitators to working more closely with the FPC, often on the basis of having particular

FIGURE 2

TASKS CARRIED OUT BY GP FACILITATORS: PRACTICE SUPPORT ('BEST FRIEND MODEL')

in the practice	developing record systems: age/sex registers
	practice profiles
	computing
	advising on premises
	partnership arrangements
	employing practice staff
	explaining policy
in the FPC	explaining GP problems
	contributing to FPC strategy
	advising on priorities
	standards of practice
in the DHA	obtaining information for GPs on hospital services

expertise to offer, for example in computers or audit. The colleague relationship based on shared values, knowledge and trust between professional practitioners underpins this model of facilitator, just as it did with the first facilitator in Islington. The emphasis is now on a partnership with the FPC and an acceptance of its managerial concerns for measuring performance and output, assuring quality and developing services. Figure 2 illustrates the range of tasks.

THE SERVICE DEVELOPMENT MODEL

In the service development model, the facilitator's task is to develop or implement joint service strategies between the DHA and FPC. Most projects of this type were begun in the late 1980s and, in the case of Kensington, Chelsea and Westminster, built on earlier work. Typically the facilitator has a degree of independence from the DHA and FPC. In the more successful projects they have had strong political links with both organisations.

Kensington, Chelsea and Westminster

In 1987, KCW FPC and the Department of Community Medicine at St Mary's, Paddington agreed to the secondment of a community physician, with dual qualifications and experience in community medicine and general practice, to the FPC for two sessions a week. This post appears to be unique, although the joint working group on the use of FPC data suggested that 'community physicians are well informed about environmental and demographic health issues'.[78]

An important influence on the development of the joint post was the emphasis given to public health by the DHA. In 1983, a directorate of public health was set up in Paddington and North Kensington, and the director was a member of the district management team. She gave support to a number of initiatives, including a research project which involved GPs in measuring morbidity in general practice, under the leadership of the Community Medicine Department. A prerequisite was strengthening contacts between the department and GPs. Although the research project was later abandoned it was agreed that a community physician, Rosemary Beardow, should be seconded to the FPC. She would provide advice on the information base necessary for service planning and also introduce a cervical cytology call and recall system.

A GP forum, known as the Sentinel Practice Project, developed from discussions between Michael Rope, Rosemary Beardow and the FPC. A survey of the 80 practices in Paddington was undertaken. Twenty GPs expressed an interest and 15 finally agreed to take part. The GPs met every six to eight weeks to discuss a topic of mutual concern and 'have a really nice lunch at the community hospital'.[81] In the facilitator's view, such events were crucial to building networks and commitment. The issues discussed have included the following: the use of the emergency bed service; vaccination and immunisation policies; the impact of AIDS; open access to physiotherapy and ultra sound; communications between hospital and general practice and health visiting for elderly people.

As a consequence of discussion, a number of actions were taken. A form was designed to monitor emergency admissions and a report written for DHA managers. A meeting for all GPs in the district was set up to explain the district vaccination programme. As a consequence, participation in the programme increased. A survey was carried out to establish GPs' need for support and education in dealing with AIDS patients. Open access to physiotherapy was negotiated for Sentinel Practice GPs and this may be extended to all GPs.

The Sentinel Project is a small-scale, low-cost method of building relationships between the health district and general practice. There are mechanisms for reporting back to the FPC and DHA on a formal and informal basis so that knowledge is shared. The facilitator is well acquainted with the strategic objectives of both authorities and has an assured route into the management structures of both. She has a sympathetic understanding of the difficulties of inner city general practice and can involve the academic departments and the DHA when blocks to progress are identified. This occurred, for example, when it was found that some GPs had no experience of taking samples for testing for cervical cancer. Training sessions were provided.

In her FPC service planning role, the facilitator has concentrated on making the best use of the data which the FPC already has. The introduction of computerised registrations and financial systems is fairly recent in KCW, and the planning potential has not yet been developed. In the first instance, practice profiles on localities linked to postal districts must be laboriously built up so that the information can be readily linked to census data.

KCW is a good example of the way in which the work of one facilitator may prepare the way for another. Beardow's service developments built on Rope's work with practices which had established good will. Beardow's skills have been used to improve the FPC database and provide practice profiles. These will be important to support a further development – the appointment of a nurse facilitator, to develop health promotion. The problems are likely to be formidable. Practice team working is not well developed and population mobility in the area is so high that over 50 per cent of names and addresses on the patient registers are incorrect.[52]

Speke

Speke is a large council housing estate nine miles from the centre of Liverpool. It was chosen by an FPC/DHA steering group as the site for a Department of Health/King's Fund project in 1985. Its primary care provision was poor. There had been a local campaign to improve services and a new health centre was being planned as the project began. The aim was to develop inter-agency collaboration to demonstrate what could be achieved. A facilitator with a community development background was appointed to identify specific tasks in consultation with a range of primary care managers and providers. She would act as their agent in gathering data to develop policy. It was agreed to investigate antenatal services, community services for elderly people, and information exchange between district nurses and GPs about 'at risk' groups.

The provision of antenatal services had been an issue of local concern for some time. None of the local GPs provided maternity services nor were there shared care arrangements. A DHA clinic had recently closed. The development worker attempted to establish patterns of service use but this proved impossible. There were different and incompatible data sources and women from Speke could not be identified. The project also ran into difficulties due to lack of support from local GPs. They had not been consulted about the appointment of a development worker. Fortunately, a newly constituted maternity liaison committee took up the issue of ante-natal services and plan to survey women's views and preferences for antenatal care.[14]

In relation to elderly people, the facilitator's aim was to make available information about local services. A comprehensive guide was produced.[85] Information exchange about frail elderly people as an 'at risk' group, was also examined. A description of the existing information systems was drawn up

85. Pepper, L. Speke services for the elderly group. In: Marks, L (ed). *Planning Primary Care*, King's Fund Centre, 89/4, 1989.

and it was decided that age/sex registers were essential if data were to be shared. Although the academic Department of General Practice offered to install computers and support GPs in developing registers, practices did not respond. 'None of the GPs felt they had time to install a system or learn how to use it'.[14] However, the nursing officer in Speke set up a simple card index system for developing a database of nursing records of elderly patients. This allowed her to identify people being treated and to assess changes in the severity of symptoms. In addition, the facilitator established a common core of information about services which professionals agreed to share.

In summary, the concrete achievements of the Speke project were limited. If it demonstrated anything it was the loopholes in the planning framework. The steering committee at authority level was remote from service providers and managers. It had neither a policy framework nor executive power or authority. Areas for development work were not chosen strategically and the support of key providers, the GPs, was not negotiated. The tasks chosen required a specific data set which had to be especially developed. This was time consuming and in the case of ante-natal services, impossible to develop. A negative lesson can however be drawn from the project – that without active involvement of those who provide services at street level, little may be achieved.

Progress since 1987 ...

Towards the end of the 1980s, GPs and social researchers were appointed not only as facilitators, but to assist in the development of a strategy for planning primary care. This has involved commissioning research either to establish how services were being provided or to prepare strategies for integrated primary care services.

In Kensington, Chelsea and Westminster the work of the GP facilitators was helped by Bosanquet's analysis of general practice structure and list size. However, few FPCs have had sufficient funding to fully investigate the patterns of service in their area. In the late 1980s, the DHSS funded two study teams one in Halton Cheshire, the other in the Loughborough area of Leicestershire.[86, 87] Both reports identify deficiencies in the database available to FPCs and in services. They make a number of recommendations outlining the areas where action should be taken. Some require extra resources such as additional funding for premises, others depend upon collaborative working with the DHA in targeted areas. For example, the Loughborough report stresses the need for the better use of existing FPC and DHA data in areas which could be useful in assessing the adequacy of primary care services, but are not currently analysed.

These studies contribute to building up a more detailed framework of the prerequisites for planning. The research methodologies adopted by the studies have lessons for other areas, although there is always a need to identify local circumstances and establish local priorities.

In 1988 Enfield and Haringey FPC and Haringey Health Authority commissioned a social researcher to undertake a review of general practice in Tottenham as part of the joint planning process. Although in outer London, Tottenham has a pattern of general practice characteristic of a deprived inner city area. The review focused on collecting data from GPs about their practice premises, attached and auxillary staff, their use of deputising services, information systems, access to and use of opportunities for post graduate education, their need for interpreter services and their experiences of using the hospital and community services.

The results provide a detailed profile of the locality and identify gaps

86. Cheshire Family Practitioner Committee Study Team. *Halton: A report by the Cheshire Study Team*, 1988.

87. Leicestershire Family Practitioner Committee. *Study into the delivery of primary health care services in Loughborough, Barrow-on-Soar, Quorndon and Shepshed*, 1988.

88. Grace, J.F. *The role of the GP-facilitator in the delivery of health services to the population of Medway Health District.* Unpublished report for the South East Thames Regional Health Authority, 1988.

in both data and services. The researcher also interviewed managers, clinicians and community nurses in the health authority about how best to improve support for GPs and develop policies collaboratively. She believes that the process of doing the research has itself raised consciousness about primary care services within the health authority. It has identified networks of people concerned with primary care, and raised awareness of the need for more collaborative planning. The research report provides a common denominator of shared knowledge about services, and about attitudes towards them in general practice and the DHA. It makes a series of recommendations pinpointing areas for action in the short and longer term.[38]

Another approach was taken by South East Thames Regional Health Authority. They agreed to fund a local GP, with knowledge of DHA services, to assess the need for a permanent GP-facilitator. In Medway, community services are well developed and hospital services are being planned to provide primary care hospitals reliant on GP care. Kent FPC covers a large geographical area and is considering devolving management to district-based localities. Both authorities were therefore keen to support developments which integrated GP and hospital care.

The GP's report[88] is critical of existing arrangements and declares that currently: '(DHA) involvement is patchy, peripheral and apparently too indeterminate, irrelevant and insensitive to GP planning needs.' It suggests a number of areas where GP facilitators could develop joint services between the DHA and FPC: protocols for an integrated diabetic service; for the management of myocardial infarction and the assessment of the pre-school child; the care of terminally ill patients; the organisation of the community nursing services; the development of primary health care teams and screening services for elderly people. The development of a shared information base between the district and general practices would be an important prerequisite for such developments.

The report illustrates the facilitator's potential role with three examples: protocols for the management of vaginal discharge (a commonly presented symptom in general practice); for prescribing non-steroidal anti-inflammatory agents; and a scheme to provide out of hours cover through a GP cooperative. It sets out a logical process for involving participants and concludes with proposals and costings for single, and multi-person facilitation projects. The report as a whole represents an overt and rational, step by step approach to changing the pattern of service delivery in areas of concern to the GP. Decision takers are presented with a set of options for action and because objectives are set out in a clear way, they provide a basis on which to evaluate progress.

The report's author, John Grace has himself 'facilitated' the implementation of one recommendation – the setting up of the deputising cooperative. A local manager commented that this had been 'an immense success'. The cooperative has replaced three commercial deputising services despite opposition from the local medical committee. The success was attributed to the enthusiasm of the facilitator and his political connections with the district medical committee and the DHA (interview).

In Newcastle, the local medical committee (LMC) has taken a lead in developing and implementing plans for general practice in the city. A local GP and LMC member, has DoH funding to support a project planning comprehensive primary care within GP practices for the city.

There are a number of factors which explain why this approach has been

taken in Newcastle. GPs in the city have a strong sense of professional identity. The academic department at the university's medical school is linked to local practitioners through educational and research activities. Membership of the Royal College of GPs is over three times the national average.[89] In 1984, the LMC formed a sub-committee to develop a planning strategy. This was based on the view that general practice should deal with chronic conditions such as asthma, diabetes and hypertension and provide anticipatory care, particularly for elderly people and for children. The strategy was predicated on a high level of support from ancillary staff in each practice, on attached or aligned community health staff, and on computerisation in the FPC with on-line links to GP surgeries.

In 1987, an LMC planning group undertook a review of eight practices in south east Newcastle. Virtually all were providing a full range of preventive services. The present facilitator has extended the review to the remaining Newcastle practices (approximately 50). Practices are being helped to introduce practice profiles and information systems. From this database, targets can be set for service delivery in each practice so that the needs of practice populations are met. The aim is to establish a basis on which the FPC can negotiate a contract with each practice to provide certain services in the light of what is available from DHA community services. The work of the Newcastle facilitator provides an example of the type of primary care planning which could develop as a consequence of the new GP contract.

Morrell supports this kind of development:[90] 'General practitioners could contract (with the FPC) to provide services for a defined community of patients to a standard defined by the committee in consultation with professional and consumer interests'. The Newcastle project is particularly interesting, because first it indicates the amount of detailed work necessary to develop an adequate planning base and second because it has developed under medical leadership. However neither the extent of support for the project among local practices nor the problems which may occur in implementation are known.

Inter-agency service development: a summary

Figure 3 summarises the contribution of facilitators in service development. Previous studies have indicated the intrinsic difficulties in inter-agency working.[14, 29, 30] The lack of progress made by some facilitators underlines their findings. The contrasting managerial and professional structures within DHA and FPC, often lead to conflicting lines of communication and accountability. The two agencies have a different knowledge base and systems of funding. These create opposing timetables, interests and priorities. Any facilitator has to identify issues of mutual concern; set up structures; establish a constituency; develop a policy and a strategy for implementation.

When faced with these difficulties, there have been three types of approach. First, some have abandoned the attempt at inter-agency collaboration and concentrated on working with GP practices. Second, others have aimed to develop a knowledge base through research and use this as a springboard for subsequent action. Third, yet others have used a combination of personal, technical and political skills to put forward their own particular vision for primary care.

The more successful service development facilitators have certain common characteristics. They have a medical training with a specialisation in general practice; an understanding of information systems, a good knowledge of their areas and they have belonged, as members or managers, to at least two of the

89. Kaim Caudle, P, Allsop, J. *Health services in Northern Region*. North Tyneside Borough Council, 1988.

90. Morrell, D. The new general practitioner contract; is there an alternative? *British Medical Journal*, 1989, **298**, 1005–1007.

three key agencies – FPC, DHA or LMC. They have also had a sufficiently high position in the hierarchy to influence decision making. Put another way, facilitators appear to achieve positive outcomes in interagency service planning when they share a frame of reference with other primary care stakeholders and when they are able to use the political system to promote their ideas.

The greatest strength of the medically trained service development facilitators is that they have been able to present the concerns of general practitioners to district officers and at the same time provide a way of working with individual practices to achieve changes. The chapter following describes how these factors are combined in a team project: the Camberwell Primary Care Development Project.

FIGURE 3

TASKS CARRIED OUT BY FACILITATORS IN SERVICE DEVELOPMENT

in the local medical committee	discussing problems and priorities
with GPs	establishing contacts/assessing priorities
in the FPC	establishing data sources advising on data collection carrying out research into service provision raising funding for primary care developments dealing with local authority planning and housing authorities
in the DHA	establishing contact with relevant clinicians and managers developing shared care schemes and clinical protocols
in community nursing	establishing contact assessing the database arranging joint training sessions

THE TEAM MODEL: CAMBERWELL PRIMARY CARE DEVELOPMENT PROJECT

4

This chapter describes the development work carried out in Camberwell by the Primary Care Development Project (CPCDP). The project was set up in 1984 and by 1989 included a full-time development worker, two GPs working on a sessional basis, secretarial assistance, a variety of health care professionals providing specialist input, both full time or on a occasional basis, and a network of contacts with health and welfare agencies. It was funded originally by the King's Fund, and is now funded by the DHA, the RHA and the FPC as a resource for planning, researching and stimulating changes in the delivery of primary health care. The uniqueness of the project lies in its base in the Department of General Practice; its initial independence from the statutory authorities; its team approach; its strong links with local general practice and its skill in bringing statutory agencies together. Its priorities have been determined by the concerns of 'street level' professionals, GPs and nurses – and by its philosophy of education as a way of bringing about change.

ORIGINS AND CONTEXT

The pattern of general practice in Camberwell is fairly typical of inner London with only half the GPs in group practice and a low level of take up of practice staff under the ancillary staff scheme. In 1987, the London Borough of Southwark Anti-Poverty Strategy Team concluded that the Camberwell district is the sixth most deprived in the country on the revised Jarman indicators.[91] The district contains King's College Hospital and during the 1980s has had to plan expenditure for the next decade on the basis of a 12 per cent reduction in revenue.[84]

Lambeth, Lewisham and Southwark FPC is large, covering a registered population of 870,000. There are 400 GPs and 170 practices. Until 1986, the FPC was run along traditional non-interventionist lines. The then administrator saw the primary function of the FPC as paying the practitioners and not seeking to influence or change their ways of working. His view was that: 'There was a market out there which was working perfectly adequately and there was no need to interfere unless there was a request to do so' (interview). In 1986, a new manager was appointed but relationships between the FPC and GPs were poorly developed and relationships with the DHA almost non existent. Furthermore, the knowledge base of the FPC was poor. No new medical list had been published for nine years.

The genesis of the CPCDP lies in the establishment of the Department of General Practice Studies at King's College Hospital Medical School. The head of department, a local GP, believed that the work of the department could be strengthened by drawing in a network of local GPs to teach from the realities of inner city practice. In return, the department would act as an educational resource for them. A network of about 20 tutors had been built up when a bid was made to the King's Fund to employ another part-time GP. This post holder would identify the service and educational needs of practices;

91. Morley, V, Evans, T and Higgs, R. *The Camberwell Primary Care Development Project*. King's Fund Publishing (forthcoming).

improve liaison with community nursing and other health authority departments; and provide a firm leadership in the development of higher quality primary care. The bid was successful, an appointment made and interviews were undertaken with all Camberwell GPs. Soon more commitments were generated than could be met and in 1985 the King's Fund made a further grant for three years which enabled the department to appoint a development worker with a social science background and experience in both health and community development. This allowed the depth and range of activities to expand and the primary care development project began to 'take off'.

DEVELOPMENT WORK

In-depth interviews with almost all the 134 GPs in Camberwell formed the core of the projects's understanding of priorities in the area. They were the means by which contact, knowledge and networks were established. These were maintained and strengthened by monthly open meetings run by the Department of General Practice Studies.

One of the early concerns was the removal of clinical waste from GP surgeries. Over the decade, the amount of such waste had increased as equipment became more disposable. GPs wanted a better service and, furthermore, from May 1986, they could claim reimbursement for specialised refuse collection. The project team took the initiative, set up an inter-authority steering group, established a policy for specialist refuse collection for all independent contractors, and it started in July 1987. The service is subject to regular review[92] and the project has now withdrawn from active involvement.

Problems with practice premises were another major issue raised in GP interviews. Many of the factors preventing practice improvement were related to tenure arrangements. GPs renting from the local authority or health authority complained of difficulties in ensuring that adaptation and repairs were carried out. Among those who owned property, some had unwittingly entered into expensive maintenance contracts which were a financial burden on the practice. Others had borrowed through cost rent schemes but found they lacked the expertise and energy to carry the improvements through. Yet others wished to find new premises but had been unable to find a site or raise capital.

CPCDP played two roles. It acted as a source of advice to individual GPs and set in motion a process to generate commitment from the statutory bodies. Only they could provide long term support in planning a strategy for practice premises. An initial meeting attracted a quarter of all the GPs and representatives of the local authorities, the FPC and the health authorities. A strategy liaison group was set up and subsequently, three local authority based planning groups chaired by the FPC have developed policies for the longer term. The CPCDP team argue that their intervention had a demonstrable effect on the uptake of cost rent schemes between 1985 and 1988.[93]

The project has also been instrumental in developing shared clinical protocols for diabetes and asthma with the hospital departments concerned. The impetus for this came from one of the monthly meetings, held at the Department of General Practice Studies, at which GPs are invited to 'meet the department' of their local hospital. The aim was to increase collaboration between consultant clinicians and GPs in the management of chronic and recurrent disease. Support came from both hospital consultants and managers as cost savings could accrue and all clinicians took the view that patients could be looked after within general practice if specialised nursing care and clinical back-up were available. The role of the project has been to act as a catalyst.

92. Morley, V, Evans, T and Higgs, R. Danger in the dustbin. *Health Service Journal*, 19 May 1988, 568.

93. Morley, V, Evans, T and Higgs, R. Work on the premises. *Health Service Journal*, 22 September 1988, 1094–1095.

It has generated extra resources to fund nurse facilitators to liaise between hospital and general practice, to produce cooperation cards and more generally to fund the administrative support which new schemes require.

Another concern of GPs was the lack of contact with the community nursing service, particularly health visitors. A series of interviews with nurse managers and health visitors in the district confirmed the comments made by GPs. Health visitors and GPs worked largely in isolation and information exchange was poor. The lack of liaison was all the more serious given the high level of social deprivation in Camberwell and the large number of families on the 'at risk' register. GPs had fewer complaints about the district nursing service but the amount of contact in the surgery was limited, often less than an hour a week.[94] As a result of these concerns the project organised a study day for health visitors and GPs. Twenty practitioners from each group attended. Subsequently, further study days have been held and regular joint lunch time meetings between community nurses and GPs arranged at four locations within Camberwell. In two areas at least there is now regular high attendance.

The take up of practice nurses funded through the ancillary staff scheme was low in Camberwell. The DHSS performance indicators for 1984/5 show that Lambeth, Lewisham and Southwark rank half way down the lowest quartile on the ranking of all FPCs.[11] A first step in tackling this was to identify why so few GPs employed nurses. Survey findings showed that GPs were inhibited by insufficient surgery accommodation and the costs of advertising, recruiting and training practice nurses. There were also cash flow disincentives: the GP has to wait for reimbursement of the nurse's salary from the FPC. Again acting as a development agency, the project fostered links between community nurse management and the FPC and set up a steering group of all agencies involved to promote a practice nurse scheme. The FPC will now undertake advertising and recruitment and second nurses to practices full time or part time. Nursing advice to the FPC is to be provided by a community nurse manager. A training programme has been developed with the local polytechnic. Evaluation will be undertaken by CPCDP.

Providing information for all those concerned with primary care has been a major role of the project. GPs indicated that they felt isolated and ill-informed about other health and social services. From May 1985, the project has provided a monthly information bulletin for GPs on a variety of topics such as the services provided by district physiotherapists and chiropodists, specialist clinics and the ambulance service. Special leaflets have dealt with problem issues such as child abuse and drug misuse where a variety of agencies across organisational boundaries provide help. A handbook for the public on all health and welfare services in Camberwell has been published.

94. Camberwell Primary Care Development Project. *Developing practice-based nursing in Camberwell*, 1987.

STRATEGY AND PROCESS

The work of the Camberwell Primary Care Development Project falls into three phases. The first consisted of a vision of how to improve primary care services, a small King's Fund grant and two doctors interviewing their colleagues. In the second, there was a larger grant for three years, a full-time development worker and an outside advisory group. The third phase was marked by a shift to DHA/FPC funding, a steering group of local stakeholders and a management structure which makes a clear distinction between the General Practice Studies Department and the Primary Care Development Project. The work has expanded and evolved through every stage of facilitation described in this study.

The CPCDP has had a number of demonstrable outcomes to its work and it

95. Stocking, B. *Initiative and inertia: case studies in the NHS*, 1985.

is clear that pace of change would not have been so rapid had they not been there to set the agenda and initiate action. Some of the factors which assisted the process are similar to those referred to by Stocking[95] in her study of successful innovation in the NHS. The project members are active supporters of primary care with a vision of what could be achieved. In Stocking's terms, they are product champions. There was a fit between their concerns and a climate of opinion in the health authority which had to cope with reduced revenue and therefore aimed to shift costs to the community. The project had access to power holders and could affect decision-making at authority level. It took a relatively small amount of resource from the DHA, and once the FPC became more active, the three could work together in the same direction.

There were additional factors which related particularly to Camberwell. The project was initially at least grounded in medical networks and medical values.These encompassed the medical school, the hospital and general practice. They rested on an educational and clinical ethos and were based on a notion of reciprocal exchange and mutual support among colleagues. Throughout, the project has had strong local support. It was able to build coalitions from a powerful base which had some bargaining capacity. The coalitions were of different types depending on the activity, but they were held together by a number of shared interests and values.

First, there were the medical collegiate links. The project was seen to represent medical professional values such as respect for confidentiality and the requirements of clinical practice. While the department could draw doctors and others together to discuss priorities, the project could attempt to find solutions to problems without the threat of managerial control which was anathema to many GPs. In the eyes of most service providers in the district, the distinction between the project and the department was blurred and this tended to enhance the bargaining power of the project. Furthermore, the project could legitimately claim to reflect the views of local general practice. The average attendance at the regular department meetings was between 60 and 70 people.

Second, the project was independent of managerial hierarchies and could therefore negotiate and play the honest broker in conflicts which arose. Independence was increased as a consequence of external funding which in turn enhanced the project's standing in raising further funds for primary care in the district.

A third factor which enhanced the project's influence was its representation on decision-making bodies within DHA management, the local medical committee and the FPC. The GP project member saw his role on these bodies as a spokesperson for primary care, explaining the pressures and concerns within one organisation to another. This enabled the mobilisation of support around particular issues, such as proposed reductions in hospital services to GPs that involved a transfer of costs to the then non-cash limited FPC budget.

A fourth factor which enhanced the project's position was that members worked as a team and between them had a range of skills to carry out the many tasks which fell to them. They also had access, acceptability, inspiration and the organisational position to develop the work. As members of a team they supported each other through the many ups and downs of trying to bring about change.

Finally, two other aspects of CPCDP were crucial to its success. The team members had a long term commitment to the district and the two GPs in particular had worked in Camberwell for many years. Secure funding for this first few years meant that numerous initiatives could be started and followed

through, gradually building up the momentum of change. These factors are in marked contrast to other facilitation projects.

In many ways the project filled a vacuum left by the lack of activity by the statutory agencies. The particular strategies they adopted were to work across organisational boundaries, to work from a problem upwards, to encourage and support others in making change, to withdraw when initiatives were underway and structures had been set up. They found that the latter was not always easy to achieve.

It is possible, of course, to point to weaknesses in the CPCDP as well as strengths. One manager commented: 'They could only initiate and then support. They did not have executive power nor the responsibility to plan strategy for service development across the board. They had no ability to coerce or even persuade agencies and GPs into changes' (interview). This view perhaps represents a misunderstanding of the facilitator role. But it does point up the importance of facilitators working closely with agencies which do have executive power. There is perhaps an inevitable tension between doing so and continuing to speak for, and being perceived to represent, street level health providers.

Another manager commented that CPCDP had tended to be reactive, responding to the needs which were most clearly articulated, suggesting they did not have to weigh priorities carefully; had not had access to appropriate information and had tended to back solutions which later proved to present problems. The clinical waste service for example, got caught up in the territorial concerns of the local boroughs. It could, in his view, have been run more effectively at a lower cost over a larger area. However, comments have to be interpreted in the light of ambivalence towards the project felt by other interested parties. It is unlikely that initiatives would have been taken at all had it not been for the project.

The high profile of the project in Camberwell has had some costs for project members. They commented on the difficulty of drawing boundaries round their work; in assessing priorities and feeling overwhelmed by demands. This sometimes brought a sense of being used to do the 'dirty work' which the statutory organisations were avoiding. The constant search for funding to develop beyond the core activities was time consuming and members lacked the support typically available in a large organisation. For the development worker, there has been no obvious career structure. For the GPs, their long term commitment to the area also meant living with their mistakes and failures (interview).

In conclusion, the teamwork model of the CPCDP has many advantages over the lone worker facilitator. Their range of activities, the way in which they were able to mobilise support from the majority of GPs in the area, their established base, their strategic vision, their mutual support and their ability to work with, and influence, the statutory agencies contrasts, not surprisingly, with the more limited activities of most single facilitators. Although relationships between the various interested parties have had elements of conflict as well as consensus, both structures and relationships have been sufficiently robust and long-lasting to provide a good basis for change and adjustment.

5 THE PRESENT AND FUTURE ROLE OF FACILITATORS

'The great facilitator': a transitional figure, indispensable to the transformation of the Soviet Union, but not surviving perhaps to see the process completed.[96]

96. *Guardian* Leader 28th January 1990 (of Mikhail Gorbachev).

This study began by posing a number of questions about facilitators. Subsequent chapters have outlined the policy context which has influenced the growth in numbers and the range of work carried out. The literature indicated that, a priori, facilitators could be used as change agents in a number of ways. The concluding chapter summarises the contribution of facilitators as a group. Facilitators who were nurses, doctors, community workers or social researchers made a specific contribution related to their professional expertise, but there were also common factors to their tasks. All facilitators were engaged in developing links between GPs, the FPC and the DHA. The purpose was to move general practice from a fragmented, unmanaged and unaccountable service, to one in which there was greater accountability for the use of resources, the pursuit of policies and the maintenance of standards and quality of care for patients. In the 1980s facilitators were appointed to ease the transition. They provided a flexible, low cost solution. They were first appointed in the inner city where problems were most obvious. By the end of the decade the term was being used to cover almost every person appointed to develop services. With the implementation of *Working for Patients* and the new GP contract will facilitators have a role in the future or will they, as predicted for Gorbachev, be transitional figures?

CONTRIBUTING TO CHANGE

The supporting role of facilitators within general practice has taken a number of forms. At the most general level, facilitators have been someone for GPs, practice nurses and practice managers to talk to about their problems and plans. They have been able to offer suggestions, formulate solutions and act as agents in relation to other bodies. Facilitators have therefore reduced isolation among practitioners and helped to bring about shifts in attitude and a clearer view of what could and should, be provided for patients.

The demands on GPs have changed. Few GPs have been trained in business practice, employment law, property development, computing, statistics, personnel management or indeed in health promotion and screening. Yet many have to make decisions in these areas. In theory there is a network of institutions supporting general practice. But, with some notable exceptions,[97] particularly at the local level these organisations have often been less than effective. FPCs have been under-developed managerially and lacked resources. Faculties of the Royal College of General Practitioners have insufficient membership and lack the powers to undertake peer review although many faculties do provide a stimulus to good practice and education for their members in areas such as computing and clinical care. Local medical committee secretaries have tended to be protective rather than promotional.

97. Royal College of General Practitioners. *Towards quality in general practice*, 1986.

Regional medical officers, based in the Department of Health, have had a remit to oversee clinical practice, premises and prescribing behaviour but have been shadowy figures and are now to be abolished.

For GPs this has been a stressful decade. A recent study of practices in the Merseyside region, found that one third to a half of all practices considered they had difficulties with various aspects of practice management such as premises, finances, staffing, innovation, performance review, delegating work, managing personal time, planning for the future, team leadership and preventive care.[98] The finding confirms the work of Cooper and Hingley,[99] on occupational stress among GPs and is probably typical of the country as a whole. Facilitators have given practical help in all these areas but surprisingly, none has been appointed specifically for their management skills.

Nurse facilitators have made a considerable contribution in health promotion and in the care of patients with chronic illness. GP facilitators have filled other gaps. In their 'best friend' mode they have helped practices in real difficulties. In the inner city in particular, some practitioners work in conditions as deprived as the populations they serve. Facilitators have also strengthened practitioners' links with academic institutions, professional bodies and hospital services. This contribution has been most clearly and fully developed by the Camberwell Primary Care Development Project. However, other facilitators have built new links with training bodies and centres of good practice. These are critically important in both widening, and sharpening up, clinical standards in preventive and curative care.

The second area in which facilitators have contributed is in building relationships between general practice and the FPC. Facilitators have improved communications. They have assisted FPCs by collecting data and acquiring a detailed knowledge and understanding of GPs' problems and priorities. This has enabled the FPC to break down its policies into more actionable pieces. Pettigrew[100] has argued that any approach to managing change must be based on the principle of understanding the context, of knowing what you are dealing with, and choosing as a starting point some area of movement that can be built on. All projects reviewed here show an indication of a shift of some kind. Communication is not one way. Facilitators must be able, not only to translate one world to another but to mobilise the forces in their environment in the interest of primary care.

In addition, for the FPC, the facilitator has filled a gap in supplying specialist technical or clinical advice not available within the organisation. FPCs are relatively small and traditionally administrative bodies which are only now beginning to appoint people with managerial, research, medical or nursing skills to help them undertake their service development tasks. Few staff within FPCs have been able to assist practices in the way in which facilitators have done in Tower Hamlets, Kensington Chelsea and Westminster or Barnsley. The outreach role is time-consuming but essential if primary care is to change.

The third area in which facilitators have made a contribution is in building networks between agencies. In this way, they have helped to set an agenda. The content of that agenda has depended on local circumstances. In this respect, facilitators have met with mixed success. Some have worked in settings which provided poor opportunities. Others have been particularly well placed politically to exercise leadership and to influence decisions. There is a crucial link between leadership and management in generating change. There must be both vision and political skills to interpret the context and decide what is possible.

98. Atkinson, C. Donning a manager's cap. *Health Services Journal*, 5 October 1989, 1218–1219.

99. Cooper, L and Hingley, P. Occupational stress among general practitioners. *Journal of Management in Medicine*, 1988/89, **3**, part 2, 96–106.

100. Pettigrew, A. Contextualist research: a natural way to link theory and practice. In: Lawler, E (ed). *Doing research that is useful in theory and practice*. J Bass San Francisco, 1985.

Four factors appear to be important in supporting inter-agency collaboration. First, an inter-authority strategy for health and commitment to primary care. In Leeds and Derbyshire, joint plans provided an overall framework. Sometimes facilitators have been instrumental in creating these shared strategies, as in Camberwell.

Second, negotiation with people who are in a position to take decisions is essential. Such power holders can then either block, or support, change. Primary care initiatives which were blocked in Tower Hamlets and Speke, were encouraged in Haringey and Camberwell.

Third, it is helpful for the facilitator to occupy a powerful position in more than one organisation. In KCW, the community physician has a designated position within the community medicine department and the FPC. In Camberwell, members of the Primary Care Development Project have held variously, positions within the medical school, the DHA management board and the local medical committee. In Trafford, the facilitator was a seconded DHA manager and in Greenwich, a member of the FPC and DHA. The Newcastle facilitator was a local medical committee member and attached to the Department of General Practice.

Fourth, facilitators need skill, energy and a vision of primary care.

VALUE FOR MONEY AND WORKING CONDITIONS

The costs of employing a facilitator have been low. The majority of posts are short term. Usually, salary costs are shared between organisations or externally funded. The low level of investment has limited what could be achieved through this way of working. In terms of the funds handled by FPCs and DHAs annually, the salary costs of facilitators are extremely small. As one FPC chair put it, no commercial company would have to justify such small sums for organisational development in terms of value for money (interview).

In interview, facilitators have voiced a number of criticisms. A common theme was that employers had unrealistic expectations. They expected post holders to overcome structural and attitudinal barriers single-handed. Administrative and collegial support was sometimes lacking. Facilitators felt isolated and were blamed for lack of progress when they met organisational stone walls. Post holders have had to move between different cultures and structures and forge a role for themselves. For some, this has been demanding and stressful. In addition, some nurses and community workers in particular, mentioned the lack of career structure and insecurity. The job definition of facilitators is gender related. Nurses and community worker facilitators tend to be women with full-time, but short term contracts. Doctor facilitators, generally men, are semi-retired or the post is additional to their main means of livelihood.

The trend over the period has been towards the appointment of facilitators more closely aligned with the FPC or to some steering group composed of representatives of primary care organisations. This reflects the stages of primary care development through the 1980s. The free-floating role played by Elliott and Dennis in the early 1980s has no parallel in recent appointments. Policies are clearer, management is better, facilitators have more specific tasks and better support. The job may still be difficult and challenging but those linked to FPC management, or working in a team, appear to have greater job satisfaction. This position has clear advantages.

Where one facilitator appointment succeeds another, the benefits in terms of forging additional links between primary care providers are cumulative. Of all the examples in this study, Camberwell is the only one which has had the

time, funding and continuity to develop and sustain a comprehensive network.

A FUTURE ROLE FOR FACILITATORS

Klein has argued that in society as a whole there is a trend towards more flexible organisational models; an erosion of the hierarchy of knowledge; and the contracting out of knowledge and risks to small enterprises. 'The large health organisation will exist in a symbiotic relationship with a growing number of small organisations, some of which will be private and some producer cooperatives'.[101] It is this model which has been promoted by the proposals in *Working for Patients* and the new GP contract. In future, FPCs and DHAs will be policy-making, planning and regulatory authorities contracting for services. There are profound implications for general practice.

Under the new contract, GPs have an obligation to provide health checks for their practice population and to be available for longer hours to provide access for the sick. More information on practice activity will be required by the FPC,[102, 103] and the monitoring and regulating role of the FPC will increase. So will their discretion in reimbursing practices for ancillary staff and practice improvements. For the time being at least, FPCs will be the lead authorities in primary care and under the new regulations the committees are smaller and contain only one doctor. Not only will they set standards for premises but they will also accredit programmes for health surveillance carried out in general practice. All practices will need systems for auditing their practice records. Prescribing practice and referrals have been items picked out for monitoring in the early stages. Protocols and setting standards for other areas will also be important. As well as a medical audit advisory group, it is envisaged that the FPC will appoint an independent medical adviser. This may be part time or full time and some FPCs have already made these appointments.

What are the implications of these changes for the primary care facilitator? It was suggested earlier that the main tasks of the facilitator were to develop links between GPs, the FPC and DHA. The need for this role will continue as the process of implementing the new legislation will be complex and difficult. Some tasks previously carried out by facilitators will be incorporated into permanent positions within the FPC itself – the medical advisers becoming a permanent form of GP facilitator. Each FPC will determine its own job description for the adviser and it is likely that such a person would take a lead in working with the FPC and GPs to agree and set standards and determine policy. This might also mean working with the DHA where joint approaches need to be developed.

The nurse facilitator as a health promotion manager and as a professional leader of practice nurses is already a permanent member of staff in some FPCs. Some FPC planning officers already play a research and development role. However, it is likely that there will still be room for short term facilitators for special tasks. For example, practices with good management and information systems will be better able to cope with new demands than the poorly equipped. Several commentators have suggested that polarity between the large well-run practice and the poor small practice is likely to increase.[79, 90, 104, 105] The former will have incentives to increase their staff and patients while the latter may struggle with diminished resources and increased commitments. Those who opt for practice budgets will become more independent and have a financial incentive to run their practice cost-effectively, with a range of staff and services. Conversely, small practices may become unviable. They will be expected to meet higher

101. Klein, R. Towards a new pluralism. *Health Policy*, 1987, **8**, 5–12.

102. NHS Review. *Indicative prescribing budgets for GMPs*. Working Paper 4, Department of Health, 1989.

103. NHS Review. *Medical Audit*. Working Paper 6, Department of Health, 1989.

104. King's Fund Institute. *Managed competition: a new approach to health care in Britain*. Briefing Paper 9, King's Fund Institute, 1989.

105. Pringle, M. The quality divide in primary care. *British Medical Journal*, 1989, **299**, 470.

standards but lack the means to do so. A 'best friend' GP facilitator may be needed to support the practice with problems – a task not appropriate for the medical adviser.

In addition, specialist support may be necessary to implement policies for health promotion and to think strategically across the FPC/DHA boundary. If new configurations of service are to develop between secondary and primary care, facilitators with planning skills will be needed to ensure that adequate information and complementary databases are available. Above all, it will be necessary to have mechanisms to sustain good relationships between doctors and managers to complete the transformation of primary care. As individuals, facilitators may be transitional figures but their role remains vital.

APPENDIX I

METHODS

A number of methods were adopted for collecting information. A short questionnaire to FPCs was used to establish how many facilitators were currently employed; their professional background; the method of funding the post and the job description. Questionnaires were sent out in November 1989 with a follow up letter in December. The response rate was 90 per cent; i.e 90 out of 98 FPCs replied. The data was analysed on a matrix with the characteristics of each facilitator categorised under qualifications, terms of service, tasks and management arrangements.

It became clear from the data and the existing literature that one of the key characteristics which distinguished one type of facilitator from another was professional background and training. Nurses, GPs, community development and research workers were able to offer particular kinds of expertise in supporting practice, and/or service, development.

The professional background of the facilitator became the basis for collecting further data. Semi-structured interviews were carried out with selected facilitators: past and present. Interviews were also carried out with FPC general managers to provide a different perspective on facilitation. The interviews aimed to collect information on work content and the processes of the work facilitators did, and the structures within which they worked. Telephone interviews were carried out where time and cost precluded face to face discussion. Reports written by facilitators provided a further source of information on what facilitators had done and their process of working.

King's Fund Centre for Health Services Development
126 Albert Street
London NW1 7NF
Telephone: 01-267 6111
Director: Barbara Stocking, BA MSc.

15 November 1988

Dear Administrator

GP/Family Practitioner Committee Facilitators

We have been commissioned by the King's Fund Primary Health Care Group to conduct a study of the predominant types of primary health care GP/FPC facilitator schemes. These have developed in recent years in a variety of ways and it is important at this stage to assess their strengths and weaknesses.

As a background to indepth studies we wish to collect basic data on the numbers of FPCs in which facilitators have been employed or where they have been involved in schemes funded by another organisation.

We would like to have a brief description of the reasons for employing a facilitator, the duration of the project and the source of funding.

We are very grateful for any information which you can provide for us. The King's Fund plan to publish the study and to organise a conference next Spring.

Yours sincerely

Judith Allsop.

JUDITH ALLSOP

PRINCIPAL LECTURER IN SOCIAL POLICY
South Bank Polytechnic

Please reply within two weeks of receipt - a sae is enclosed for your use.

A STUDY OF GP/FAMILY PRACTITIONER COMMITTEE FACILITATORS

Name of FPC: _____

In recent years, has a facilitator/s been working within the FPC area to promote change/development in the general medical service? Yes ☐ No ☐

If yes, which organisations are involved in the project/s? _____

_____

Please give the START DATE of the project and the END DATE: _____ / _____

What are the source/s of funding? _____

How many posts does this cover? _____

Please state whether posts are full-time ☐ part-time ☐

For part-time posts, specify the number of sessions per week: _____

What are the aims and objectives of the facilitator post/project? _____

_____

Please attach a job description if one is available.

In what area are the professional qualifications of the facilitator/s?

Medicine _____

Nursing _____

Other [please specify] _____

What are the reporting back arrangements? _____

_____

Do you know of any other primary care facilitators working within your area, who are responsible to another organisation? Yes ☐ No ☐

If yes, please describe briefly: _____

_____

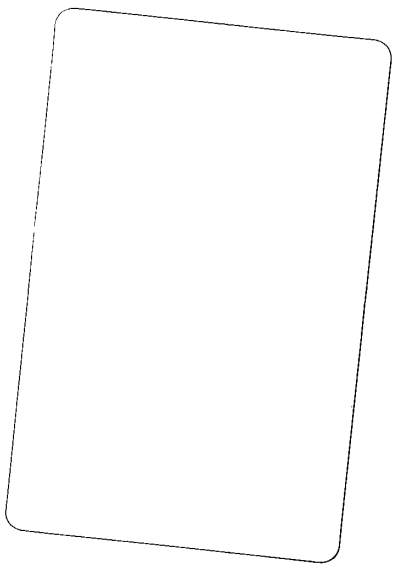
_____

_____

_____

Nov 1988


8572 020000 0485



PRIMARY HEALTH CARE GROUP PUBLICATIONS continued

Pimlico Patch Committee. An experiment in locality planning.
Dunford H and Hughes J. *Aug 88*
ISBN 0 903060 06 X £5.00
An experiment involving consumers and both statutory and voluntary service providers, planning for their locality. Includes lessons and recommendations.

Primary Health Care on the Agenda? discussion document.
Marks L.
July 87 £2.50
Outlines the management challenges facing primary health care, including raising standards and assessing quality of services.

The Emperor's New Clothes. Family Practitioner Committees in the 1980s.
Allsop J and May A.
1986 £8.00
Analyses the political climate in which FPCs operate, their influence on primary care and potential for development. Essential reference text.

An Experiment in Advocacy. The Hackney multi-ethnic women's health project.
Cornwell J and Gordon P. *Dec 84*
KFC 84/237 £1.50
Describes how this influential project was planned and established and how the workers operate. Discusses the differences between advocacy and interpreting.

Improving Health Care for Travellers.
Cornwell J. *June 84*
KFC 84/124 £1.50
Describes three initiatives to improve health care for travelling families.

Series of Working Papers for Managers

Coordinating Change in Child Health Services. Working paper for managers: 1
Winn K.E *Jan 88*
KFC 88/5 £2.00
How Newham Community Unit set about decentralising the administration of its clinics and health centres and the benefits that resulted.

Preparing for Cumberlege. Working paper for managers: 2
Brown P. *Feb 88*
KFC 88/4 £2.00
Lessons from workshops for district nurse and health visitor managers working together. Focusses on caring for elderly people at home. Includes checklist for running similar workshops.

Introducing Neighbourhood Nursing: The Management of Change. Working paper for managers: 3
Dalley G and Brown P. *March 88*
KFC 88/17 £2.00
Examines the difficulties of transition to a decentralised nursing service.

Can 'Cumberlege' Work in the Inner City The Wandsworth View. Working paper managers: 4
Dalley G. *July 88*
KFC 88/34 £2.00
Report of a workshop on Wandsworth's experience of introducing neighbourhood nursing teams in the inner city.

Locality Management. From proposals to practice in Lewisham and North Southwark. Working paper for managers: 5
Morgan D. *Aug 89*
ISBN 0 903060 35 3 £3.50
Describes the process of decentralising health services in a Priority Care Unit. Includes consultation exercise, objectives for patch managers and financial considerations.

Decentralising community health services in Islington. Working paper for managers No: 6.
Dalley G. *Jan 90*
ISBN 0 903060 68 X £3.50
This is the latest in a series of working papers for managers from the Primary Health Care Group and describes the steps by which one health authority decentralised its community health services. It discusses the management process, consultation exercises and the scope and aims of evaluation. It also discusses some of the issues and options surrounding "patch management" as a means of improving the quality of primary health care.

DETAILS OF ORDERING

Postal sales only from:

Bailey Distribution Ltd
Department D/KFP
Warner House
Bowles Well Gardens
West Bay Road
Folkestone
KENT CT19 6JP

Cheques to Bailey Ltd., plus 10% p+p

Counter sales only from:

King's Fund Centre
126 Albert Street
London
NW1 7NF

Tel: 071 267 6111

Cheques to King Edward's Hospital Fund for London.

If you have any difficulty please contact the Primary Health Care Group direct at the King's Fund Centre.

The last decade has seen an explosion in the appointment of 'facilitators' in primary care. Their task has been 'to get GPs on board' – to build bridges between GPs, family practitioner committees and health authorities. This report examines the kind of work they do, their achievements and the factors that help or hinder progress in a rapidly changing primary care world.

Facilitators were first appointed in the early 1980s in inner cities where the problems facing general practice were most acute. Within a few years the term was being used to describe almost every person appointed to develop services. This study looks at the work of nurses, of GPs, community workers and researchers. It records the expectations of those who appoint facilitators as well as some of the difficulties they face. It describes 'lone worker' projects as well as the cumulative benefits of a sustained team approach.

Facilitators have been part of the vanguard of change, a low-cost, flexible solution in a period of transition. Judith Allsop analyses their contribution to primary care and their likely future.

Judith Allsop is Principal Lecturer and Reader in Health Policy in the Social Sciences Department at South Bank Polytechnic. She has written a number of books and articles including *Health Policy and the NHS* and, with Annabelle May, *The Emperor's New Clothes – a study of Family Practitioner Committees*. She is a member of a special health authority in London and is currently working on a study of complaints against GPs and medical regulation.

ISBN 0 903060 73 6

Price: £6.50

The King's Fund Centre for Health Services Development, which dates from 1964, is in purpose-built premises in Camden Town. Its aim is to support innovations in the NHS and related organisations, to learn from them, and to encourage the use of good ideas and practices. The centre also provides conference facilities and a library service for those interested in health care.