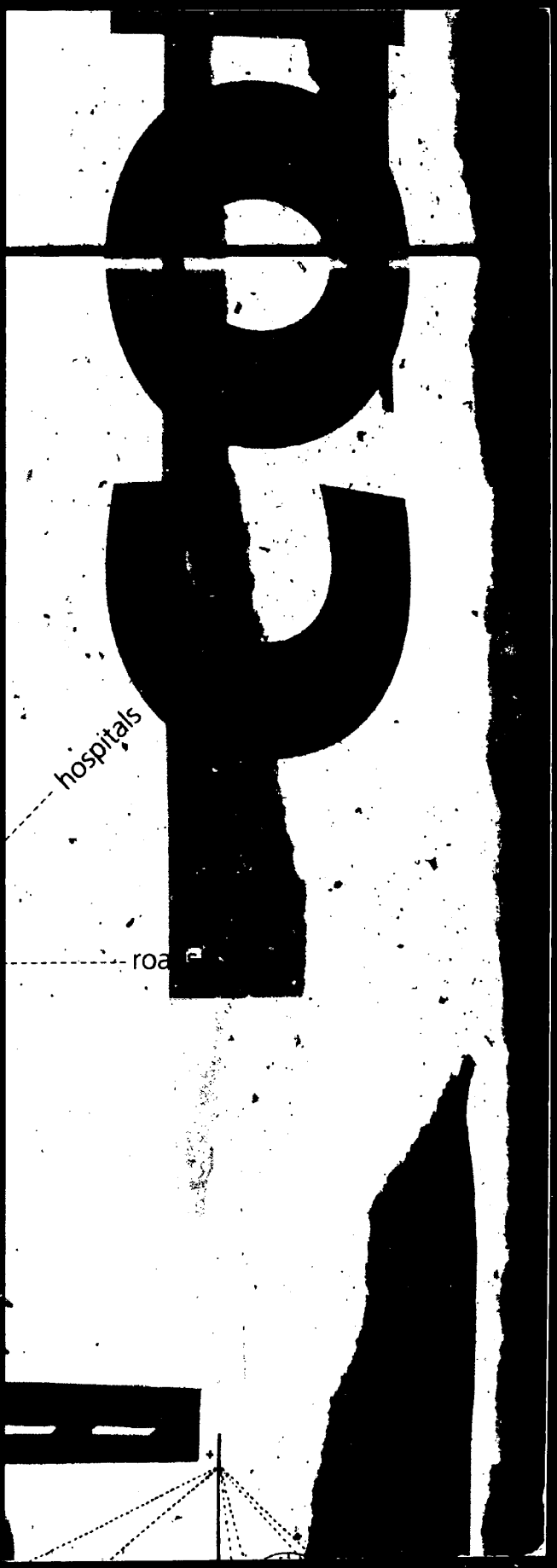
King's Fund

COPC – A Public Health Experiment in Primary Care

Stephen Gillam
with Rachel Miller



100 YEARS SUPPORTING PEOPLE'S HEALTH 1897–1997

King's Fund
Publishing
11–13 Cavendish Square
on W1M 0AN

COPC – A Public Health Experiment in Primary Care

Stephen J. Gillam with Rachel Miller

King's Fund

Published by
King's Fund Publishing
11–13 Cavendish Square
London W1M 0AN

First published 1997

ISBN 1 85717 154 3

A CIP catalogue record for this book is available from the British Library

Distributed by Grantham Book Services Limited
Isaac Newton Way
Alma Park Industrial Estate
GRANTHAM
Lincolnshire
NG31 9SD

Tel: 01476 541 080
Fax: 01476 541 061

Printed and bound in Great Britain

Cover illustration by Clare Youngs

Dedicated to Phil Strong

Contents

Figures

Tables

Preface

Community-oriented primary care (COPC) is an approach to health care which combines the principles and skills of public health and family practice. It offers participants an action-oriented framework for working together on health needs at practice level. Though established in many parts of the world, COPC has attracted little attention hitherto in the UK. In 1992, with the support of the NHSME, the King's Fund in partnership with the Department of Social Medicine, Haddassah Medical Organisation and Hebrew University – School of Public Health and Community Medicine, Jerusalem, initiated a pilot programme on four sites in the UK. An interim report was prepared to coincide with publication of a resource for trainers and contained reflections on early experience (Gillam *et al.* 1994). COPC appeared to offer an effective way of linking strategic intent with service and organisational development.

This book describes an evaluation of the programme. Insofar as many of the COPC projects initiated in pilot practices are ongoing, this too is necessarily incomplete.

Chapter 1 looks at the relationship between general practice and public health and outlines the history of COPC. Chapter 2 considers the policy contexts into which COPC has been introduced in the UK: successful implementation of the NHS reforms is predicated on the continuing development of general medical practice. These chapters make clear the rationale for the pilot project. The King's Fund programme is described in Chapter 3. The next three chapters present results. In Chapter 4, the impact of the workshops is described. The sites, practices and their projects are detailed in Chapter 5. An attempt to assess the costs and cost-effectiveness of projects comprises Chapter 6. The final two chapters look at lessons learned, successes, failures and the future development of COPC.

Stephen Gillam

Acknowledgements

Dr Jo Ivey Boufford initiated the community-oriented primary care project in the UK while she was director of the King's Fund College. She introduced the Israeli team to the King's Fund. From Professor Leon Epstein, Dr Jaime Gofin and Professor Hava Palti, I learned much of their previous experience. The King's Fund Primary Care Committee and the NHSME provided financial support for the development of COPC resource materials and the evaluation.

Dr Michael Joffe and Dr Angela Coulter advised on the evaluation methodology. Dr Rachel Miller undertook interviews. Dr Alastair Gray provided health economics expertise.

I would like to thank Susan Gooding, Charlotte Humphrey, Scott Murray, Julian Tudor Hart, John Robson and Pat Gordon for helping clarify my ideas about COPC in the wider context of primary health care development.

Particular thanks go to the King's Fund fellow responsible for directing this project, Diane Plamping. I received invaluable secretarial support from Vivine Hamilton. Finally, I am grateful to all those participants from the practices, FHSAs and DHAs described in the following pages.

Summary

1. Community-oriented primary care is the continual process by which primary health care teams provide care to a defined community on the basis of its assessed health needs by the planned integration of public health with primary care practice. It is based on a set of principles that have been operationalised in different ways in different places. It stands in a long tradition of attempts to fuse the practice of community medicine and primary medical care.

2. A succession of government-led changes over the last eight years have radically altered British general practice. The balance of power within the medical profession has swung markedly in favour of general practitioners but with new powers have come new responsibilities. The particular requirements of purchasing – for locally sensitive information, for gauging consumer priorities, for new skills in the assessment of need – lend new salience to the principles of COPC.

3. Health authorities require new kinds of intelligence if they are to be successfully transformed into organisations capable of purchasing health care appropriate to the needs of their population. Members of primary health care teams are best placed to judge the quality of health services provided locally and the needs of the practice population or neighbourhood. However, the skills required to systematise such detailed local knowledge are often lacking. For many purposes, the successful delivery of primary care nowadays requires knowledge and skills traditionally associated with public health medicine. With the evolution of the general practitioner's purchasing role, a recognition of the need for new educational models has grown. The King's Fund regarded COPC as one such model.

4. The King's Fund COPC Programme began in 1991 with the following aims:

– to pilot the COPC approach in four sites.
– to develop a training package appropriate to the circumstances of the NHS.
– to evaluate the COPC model as adapted in the UK.

The evaluation aimed to investigate the hypothesis that COPC helps PHCTs, DHAs and FHSAs undertake the shared responsibilities of assessing practice populations' health care needs, before devising and implementing strategies to address them. The principle of triangulation informed the evaluation for which a range of qualitative and quantitative methods were employed. The evaluation was undertaken between June 1992 and May 1995 and focused on four areas: the effectiveness of the workshop programme, progress of practices' COPC projects, a comparison of COPC with alternative initiatives sharing similar objectives, and the generalisability of the programme including its cost-effectiveness.

5. The success of the COPC pilot programme was considered against normative criteria defined at the outset. While the pilot projects did not realise all the aspirations of the original participants, significant advances were achieved.

6. Evaluation of the pilot workshops helped formulate the definitive training package. This has been successfully field-tested.

7. For all participating teams, the workshops provided an illuminating learning experience and helped to develop links with other agencies. Participants were already aware of the need for time, resources and other forms of ongoing support if they were to further their projects. PHCTs gained the necessary support (technical, information, resources) from their local DHA/FHSA though experience on the four sites varied.

8. PHCTs were able to make a community diagnosis and identify problems on which to take action. PHCTs expended much energy on detailed problem assessment and few completed comprehensive evaluation.

9. COPC helped to develop teamworking and inter-professional collaboration. The time and energy required to underpin COPC was underestimated. Some teams learned enough about basic epidemiological principles to apply these to other problems. Many individuals learned new skills. COPC provided new learning for health authorities increasing managers' understanding of primary care.

10. Quantitative evidence of benefit was obtained in all eleven practices. COPC projects yielded limited health gains in terms of behavioural risk factor reduction (e.g. smoking cessation); other benefits were more difficult to measure. COPC helped develop skills in the collection and analysis of health data. The small size of practice populations determined that statistically significant changes in most outcome measures were unlikely to be detected for any but common conditions.

11. Cost-effectiveness – Many of the outcomes of community-oriented primary care are intermediate, encompassing the enhancement of staff skills and changes in patient behaviour. The application of the methodology of economic evaluation in considering the relationship between costs and benefits was therefore problematic. However, a costings analysis was undertaken and a framework for considering the cost-effectiveness of COPC proposed.

12. On average, approximately £25,700 was spent in support of each practice (including King's Fund and DHA/FHSA expenditure). Putting this estimate alongside information on the cost-effectiveness of a range of other interventions, the health gain that each project would have to yield to be considered cost-effective is low. The projects on smoking cessation and heart disease prevention appeared to be cost-effective.

13. Few teams came to regard the principles of COPC as central to their way of working. The utilitarian values underpinning COPC are at odds with the traditionally

individualistic doctor-patient relationship. Few teams made contact with patients or their representatives at any stage in their projects.

14. Audit – COPC helped develop skills relevant to the continuing development of general practice audit. The audit movement is seeking to encompass much that COPC sets out to do. A systematic approach to needs assessment in determining the choice of projects distinguishes COPC from conventional audit.

15. Team-building – The COPC workshop model with follow-up is closely akin to the Health Education Authority's Team-building Workshop Programme. Similar problems have been encountered: on re-entry, in sustaining support and securing financial backing. Dysfunctional teams will struggle to achieve COPC objectives and may benefit from prior team-building activities.

16. Fundholding – Fundholding practices in this pilot programme demonstrated that COPC can provide the framework through which outreach work and direct approaches to the community can broaden their understanding of patients' needs and hasten the development of more appropriate services.

17. Locality planning – COPC may be of relevance to newly formed commissioning groups. The model can be adapted to help them achieve important early tasks, for example, the development of a locality profile and a list of planning priorities.

18. Health promotion – COPC provides a baseline assessment against which to identify local priorities. In contrast to the banding scheme, COPC inculcated care in the collection of data. An assessment of the impact of interventions is not required under the banding scheme.

19. Community participation – The lack of commitment to community involvement diluted the power of COPC for some managers. Change at both the individual and community level is likeliest where patients share responsibility for planning and management decisions. A supplementary COPC module on community participation has been developed.

20. The following factors facilitated expansion of COPC programmes at a local level:

- decisive leadership from a health authority manager
- a multi-disciplinary support group
- the active participation of staff with a public health perspective
- visible early successes in one or other practice on the project site
- the involvement of local champions from pilot PHCTs
- flexibility in application of the programme
- a strategic framework for primary care development
- support from other parts of the DHA/FHSA
- direct managerial control over defined budgets.

21. The following factors may inhibit expansion of the COPC programme nationally:

- financial constraints
- organisational turbulence
- poor professional morale
- lack of evidence for the effectiveness of many interventions
- unrealistic expectations among both managers and health professionals
- an emphasis on short-term projects as the main source of innovation.

22. COPC is best seen as an inclusive set of general principles providing the basis for the development of new forms of joint learning. The training package should be of value to those with an interest in the professional development of many groups of health professionals. COPC does not provide a radically new way of delivering health services in the UK setting. It should be used to complement other initiatives that aim to increase understanding of the factors influencing the health of practice populations and how to address them.

Chapter 1

Primary care versus public health

Traditionally, general practitioners and public health doctors have sought health goals by different means. General practice has concentrated on continuing health care via the consultation, while public health physicians have focused on the population through changes in the environment, society and health service provision (Bhopal 1995). Such differences have produced considerable ignorance and prejudice on both sides:

> *My only dealings with public health in the past were at medical school when they did things like closing down cooking establishments.* (GP)

> *Well, the thing with public health is you can't tell whether they are doctors or managers. They are basically managers but with certain medical skills.* (GP)

> *Public health doctors are not really willing to give away the skills. They want to fudge the boundaries. They're old-fashioned centralisers at heart.* (Manager)

> *On the whole GPs don't know why they are doing anything, and they do still take an individual approach to every patient that presents, rather than seeing things in a broader public health context. I think it's going to take years for that shift to happen.* (PHP)

Is it possible to bridge the gap?

Various changes are now realigning these two branches of medical practice: the growth of primary health care teams, the broadening of the health promotion role in general practice and the increasing involvement of a wider range of professionals in health service planning and policy making. All these require much closer integration of public health and primary care than has been possible in the past.

Before considering the origins of COPC, this chapter therefore looks at the often uneasy relationship between public health general practice. The key players and their perspectives require introduction.

The roots of general practice

Today's UK general practice is descended mainly from the apothecaries, at the heart of whose practice lay the dispensing of drugs (Loudon 1981). By the early years of the 19th century, apothecaries had extended their services to include medical care, midwifery and surgery. Increasing numbers had become members of the Royal College of Surgeons as well as Licentiates of the Society of Apothecaries. The surgical qualification raised their professional status and distinguished them from such irregular practitioners as dispensing druggists (Peterson 1978). To ensure the public recognised the difference, apothecaries called their places of practice 'surgeries', a name that has survived to this day.

For centuries, members of the medical elite of physicians had lorded it over the lowly apothecary, a superiority stemming more from social class origins than the effectiveness of their practice. As new forms of alternative medicine developed in the 19th century, the growing core of general practitioners tried to outlaw all irregulars. The Medical Act of 1856 by creating a register of qualified practitioners gave them official recognition (Newman 1957). The supply of doctors rose at a faster rate than the numbers of patients that could afford to pay decent fees and GPs, physicians and surgeons were brought into competition with one another (Peterson 1978). A rudimentary referral system arose under which dispensing was left to apothecaries while physicians and surgeons assumed the role of consultants. Advances in medical science during the 19th century ensured the survival of this system. For the first time in medical history, a meaningful distinction was created between those who practised generally and those who specialised (Honigsbaum 1995).

With the development of anaesthesia and antisepsis, many specialist medical and most surgical procedures could only be performed in hospitals. Through their influence over appointments committees in larger hospitals, consultants ensured that GPs were not admitted. Outside the larger cities, a shortage of sufficient paid work for specialists and the shortage of qualified specialists, meant that as recently as the 1930s doctors who combined general practice with specialist care made up over half the staff of voluntary hospitals (Honigsbaum 1995).

In the face of this competition, GPs found protection in club practice. The clubs run by friendly societies offered the most opportunities for registered doctors. Club doctors were paid mainly by capitation fees but employment conditions were poor. Had they been more generous, it is possible that the National Health Service (NHS) might never have evolved. Low pay, poor management and the lack of a voice in management led doctors to resort to trade union action to improve staff conditions. They were thus ready to accept state intervention in the form of Lloyd George's National Insurance Act in 1911. The panel system that emerged subsequently strengthened the profession's position. By raising GP pay, it also reduced interprofessional tension and reinforced the referral system, permitting many doctors to confine their work to general practice and leave specialist care to consultants. It also separated dispensing from doctoring, enabling many GPs to discard the apothecaries' heritage. But the panel system did little else to the way GPs practised. There was little incentive to extend treatment beyond the narrow range of GP care with capitation the predominant method of payment. Various attempts at reform such as the Dawson report failed. General practice thus entered the NHS in a demoralised state, neglected at the expense of developing hospital and specialist services.

The creation of the College of General Practitioners in 1952 helped set a new course for general practice by stressing the unique function it performed in the community. GPs were seen as the main defence against excessive specialisation (Fox 1960). The move to integrate general medical practice closely with Social Services was supported by medical officers of health (MOsH) who had lost their hospital empires in 1948 when Aneurin Bevan decided to take municipal as well as voluntary hospitals under national

control. Returning to their preventive traditions, MOsH needed GP aid to develop services in the community, particularly for the aged and mentally ill. To facilitate this process, they offered the attachment of health visitors and district nurses to general practices. The Family Practice Charter of 1966 offered GPs financial incentives to employ staff and improve premises paving the way for the development of primary health care teams (Honigsbaum 1995). The Charter inaugurated what is now regarded as a golden age of general practice as it expanded in importance and popularity through the seventies and eighties.

This historical detour serves to highlight factors that both facilitate and inhibit development of population-oriented approaches to general practice. On the one hand, a tradition of round-the-clock responsibility for the health care of defined populations is deep-rooted. On the other hand, general practitioners remain intensely defensive of their independent contractor status. Their powerful trade union has generally resisted attempts to widen practitioners' public health responsibilities.

Redefining 'public health'

If the history of general practice has broadly been one of success against many odds, the speciality of public health over the last 150 years has followed a different trajectory. The Acheson Report on the development of public health in England defined public health as 'the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society' (Acheson 1988). As such it is a function, rather than an area or discipline. The existence of a group of professional workers designated as public health doctors, nurses and others, including environmental health officers, is an important part of a strategic approach to protecting the health of populations but their work is indivisible from that of many others professionals whose activities impact on public health. Primary care professionals are of particular importance.

In Europe and North America, three distinct phases of public health can be identified over the past 150 years (Berridge 1991, Kickbusch 1986). In the 19th century the main causes of premature death were infectious diseases, against a backcloth of urbanisation, poverty and squalor. The Victorian public health movement built on the work of medical officers of health backed up by public health legislation concerning standards for housing and the quality of air, water and food. As the most pressing environmental problems were brought under control, action to improve the health of populations moved on first to personal preventive medical services, such as immunisation and family planning, and then to a later therapeutic phase.

Until the discovery of insulin and the sulphonamides in the 1930s, there were few medical treatments of any proven value (McKeown 1976). The beginning of the therapeutic era coincided with the apparent demise of infectious disease and the development of organised treatment services in developed countries. Historically, it marked a weakening of departments of public health and of the position of general practitioners and a shift of power and resources to hospital-based medical services. For the next 40 years, future improvements in health were thought likely to depend on further technological

advances. Traditional public health went into decline. Indeed, the very term was commonly abandoned.

This medical scientific domination was increasingly challenged by the early 1970s. Most countries were experiencing a crisis in health care funding, irrespective of the structure of their health services or the methods of financing them. This escalation in costs was in part a consequence of technological innovation in treatment methods and in part a consequence of major demographic changes with the growth of elderly populations. Critiques of the domination of secondary and tertiary care began to converge with wider political and economic imperatives (Illich 1975).

The Lalonde Report in 1974 on the health of Canadians inaugurated a new era of public health by focusing attention on the fact that much premature death and disability in Canada were preventable (Lalonde 1974). Written by the Canadian minister of health, it inaugurated what is often called 'the New Public Health': a synthesis of environmental and lifestyle change together with appropriate prevention and treatment interventions. Many contemporary health problems – mental illness, cardiovascular disease, cancers – are seen as having social antecedents. Issues of local and national public policy underlie them. It is argued that what is needed to address these problems are healthy public policies in many fields which support and protect health. The right balance between socially oriented and technically warranted services is seen as central.

The Alma Ata declaration stressed community participation, intersectoral action and the reorientation of medical care towards health promotion, prevention and primary medical care as prerequisites for implementation of WHO strategy. This reorientation involved a further shift from primary medical care (a professional concept based on the availability of services from a team of health workers based in the community) to primary health care (a social concept concerned with populations as well as individuals that seeks to involve a range of people other than trained health workers) (see Table 1). Champions of the new public health see primary health care as the means through which the public health function can best be implemented (Ashton and Seymour 1988).

Table 1 From primary medical to primary *health* care

	Conventional	*New*
Focus	Illness Cure	Health Prevention and care
Content	Treatment Episodic care Specific problems	Health promotion Continuous care Comprehensive care
Organisation	Specialists Physicians Single-handed practice	General practitioners Other personnel groups Team
Responsibility	Health sector alone Professional dominance Passive reception	Intersectoral collaboration Community participation Self-responsibility

Other considerations have drawn public health practitioners back from the periphery of medical practice. The power of medical officers declined with the creation of the NHS and was further reduced following the NHS reorganisation of 1974. The speciality of what was now 'community medicine' fell into abeyance. However, the NHS reforms placed new responsibilities on health authorities for the assessment of their populations' health needs. Managers looked to the speciality of public health for particular skills. While some expressed concerns that their traditional roles would be compromised (Whitty and Jones 1992), the majority of public health practitioners have eagerly espoused the purchasing agenda.

Bridging the divide

The shifting relationship between public health and general practice over the course of the century is sometimes portrayed as a territorial battle for areas of health service decision-making. It is perhaps more usefully seen as a waning and waxing of two groups' influence against a background of common interests – and common hospital-centred adversaries. The complementarity of their skills in improving the health of practice populations has never been more evident.

At the heart of the relationship between general practice and public health is an ethical conflict between individual and collective freedom. The roles of advocate, mediator and enabler may overlap and conflict with one another (Pratt 1995). Traditional primary care based on the perspective of the clinician exposed exclusively to patients appearing for care has evident limitations. There are several reasons why a population focus in clinical practice is desirable.

First, knowledge about the distribution of health problems in the community cannot be derived from experience in the practice alone. Most people who experience an illness (about three quarters of the populations in a given year) do not consult a doctor (White *et al.* 1961). Second, doctors overestimate their role in the provision of care. Primary health care is not, of course, synonymous with general practice and is provided through a range of other outlets in the community. As patients survive longer and the burdens of morbidity increase, other health personnel become increasingly central to the maintenance of well-being. Third, feedback is important for the continuing education of health professionals. A community focus underpins the development of information systems for monitoring routine care of chronic illness and minimising loss to follow-up. Finally, a population-based focus adds new knowledge about diseases, their natural course in the absence of treatment and how that course can be modified by various interventions.

Several authors over the last 20 years have thus called for the integration of public and primary health care. Most have sought the transfer of some public health functions to general practice (Russell 1988). Less radical commentators have argued since the reforms that public health doctors should provide a support function for general practitioners (Hannay 1993).

John Ashton sought to order the major tasks of the potential public health function in primary medical care (Ashton J 1990). His model acknowledged the central place of the consultation in the work of general practice and primary care. It identified the other components which must be developed in order to move to primary health care. The need for accountability both to the individual patient and to the public at large via general management was acknowledged in his model (Figure 1).

David Mant and Peter Anderson have proposed that general practitioners accept responsibility for auditing the state of health of their patients, publicising the results, monitoring and controlling environmentally determined disease, auditing the effectiveness of preventive programmes and evaluating the effect of medical interventions (Mant & Anderson 1985). Responsibility for these functions has traditionally been vested with public health specialists. They suggested that these functions now be assumed by general practitioners along with an appropriate transfer of resources.

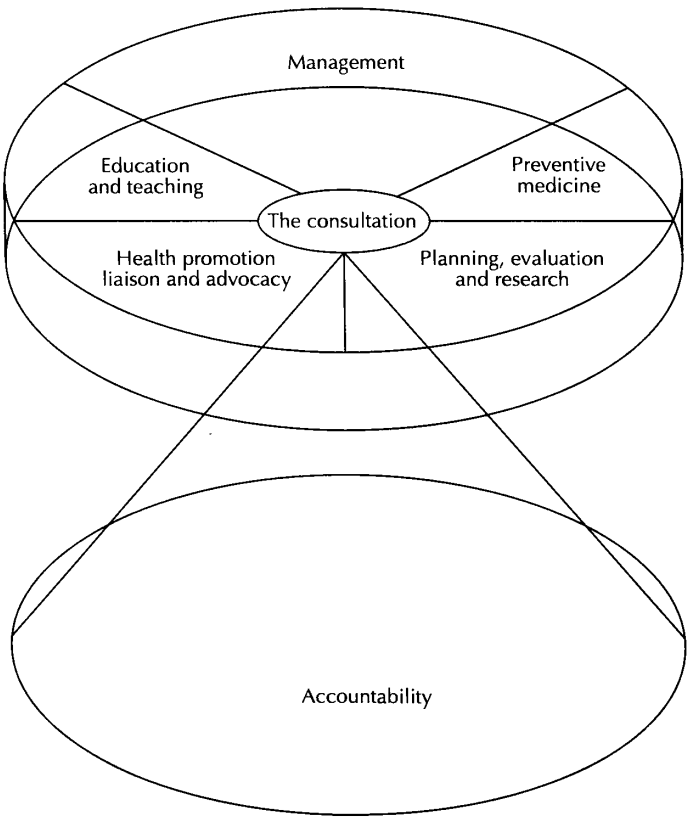


Figure 1 Ashton's model

The most radical of these visions, however, is the 'community general practitioner' – a new type of physician who is engaged in local participatory democracy in the pursuit of the maximisation of health (Tudor Hart 1988). It remains a minority aspiration for good reasons. General practitioners remain ill-equipped to take on this role. They are often untrained as health educators, with a narrow view of health promotion and limited experience of community development activities (MacDonald 1993). However, recent changes in the NHS have compelled all general practitioners to re-examine their public health role. Some rapprochement with public health is inevitable (Bhopal 1995; Hannay 1993). The time is therefore ripe for testing new ways of doing this.

Community-oriented primary care

Community-oriented primary care (COPC) has been defined in many ways. Common to all formulations is the complementarity of epidemiological and clinical skills. The King's Fund has defined COPC as 'the continual process by which PHCTs provide care to a defined community on the basis of its assessed health needs by the planned integration of public health with PC practice' (Gillam *et al.* 1994).

The basic approach has many ancestors. Something resembling the conceptual basis of COPC can, for example, be identified in the writings of Will Pickles describing the use of epidemiology in rural general practice in this country (Pickles 1994). Likewise, the Peckham Pioneer Health Centre, established in the 1930s by G Scott Williamson and Innes Pearse, has exerted a strong posthumous influence on succeeding generations of practitioners (Scott-Samuel 1991). The philosophy of the Centre was that of protecting good health through a combination of individual and family assessment and the provision of a supportive environment (Pearse & Crocker 1943). The Centre was endowed with a range of social, legal and medical advisory services but was not supported at the inception of the NHS in 1948.

The principles of what became known as COPC were first formally delineated by Sydney Kark (Kark 1974; Kark 1974). His ideas grew out of the experience of attempting to provide appropriate services in deprived areas of rural South Africa and were refined following his subsequent emigration to Israel (Kark & Kark 1983; Kark 1981). His colleagues at the School of Social Medicine, Haddassah Medical Organisation, Jerusalem, remain among the principal exponents of COPC (Abramson 1983; Palti *et al.* 1977; Abramson *et al.* 1981; Palti *et al.* 1977). With the imprimatur of the World Health Organization, programmes have now been initiated in many parts of Africa, Asia and South America (Brabeman & Mora 1987).

The other main focus for COPC activities has been the USA. Here COPC has served as the conceptual basis for many publicly funded programmes over the last three decades (Geiger 1983; Butting *et al.* 1985). The growing national concern with rising health care costs has renewed interest in primary care as a means of rationalising the use of high cost secondary care (Wright 1993).

In the UK, Julian Tudor Hart's studies of hypertension from Glyncorryg provide notable examples of community-oriented general practice (Tudor Hart 1993). His practice located in a Welsh mining village took responsibility for both community and clinical functions. He stresses the need for accountability to the population served through such means as patient committees, annual reports and meetings. He has argued the need to look in a new way at the relationship between doctors and patients as 'co-producers of health' and develop alliances between health workers and the public in defence of health. Tudor Hart's vision is of general practitioners as quasi-local medical officers of health, but whether a general practitioner would be more effective than other public health structures is unknown.

Other British proponents of an 'anticipatory care' model include the Oxford group whose writing had a major bearing on the 1990 contract (Fullard *et al.* 1987). A more community-oriented example is 'Healthy Eastenders' a project involving a number of practices in Tower Hamlets (Robson *et al.* 1995).

The egalitarian emphasis of COPC is easier to reconcile with socialist political philosophies. Indeed, the utilitarian values underpinning COPC are at odds with the libertarian emphasis on the rights of individuals that characterise the traditional doctor–patient relationship. There is a second contradiction inherent in COPC. This is between the paternalistic tendency to define preventive needs in medical terms (well illustrated in the writings of Tudor Hart) while exhorting the involvement of 'communities' at all stages of the process.

So from Zululand to the Indian Health Service to Inner City Baltimore, COPC has been alleged to improve certain health outcomes (Cassel 1955; Rhoades *et al.* 1987; Gordis 1973). Among enthusiasts, this is an article of faith despite, little direct evidence for the cost-effectiveness of COPC (Institute of Medicine 1984; O'Connor 1989). (Appendix 1).

Summary

The boundaries between public health and general practice are constantly shifting. In the UK, a public health tradition has competed with other philosophical strands in defining what constitutes primary medical care of high quality (Toon 1994).

Community-oriented primary care is best regarded as a set of principles. These have been operationalised in different ways in different places. It stands in a long tradition of attempts to fuse the practice of community medicine and primary medical care. These principles have received repeated endorsement from the World Health Organization over the last two decades as it sought to place primary care at the centre of health care systems.

Chapter 2

Reforms in practice

A succession of White Papers over the last eight years have brought about enormous changes in British general practice. Though much policy has been clearly articulated, realities have not necessarily matched the rhetoric. In particular, responsibility for the requisite organisational development of general practice remains ill-defined.

Increasing accountability

Several issues placed reform in general practice high on the political agenda by the late 1980s. Spending on general practice was growing at a faster rate than expenditure on the hospital and community services. Expenditure on prescribing, in particular, was demand-led and could not be kept under control. There were long-standing concerns about the state of general practice in the inner cities, as reflected in the Acheson Report (Health Planning Consortium 1981). There was growing interest in prevention and the role that general practitioners might play in this. Finally, the Government was committed to encouraging consumer choice.

The first bids to reform general practice culminated in the White Paper *Promoting Better Health*, published in 1987 (Ashton 1977). The proposals it contained were intended to achieve three main policy aims. They were designed first to improve the quality of general practice. A proposal for a good practice allowance was dropped in the face of opposition from the BMA to be replaced by a system of incentive payments designed to reward those general practitioners who achieved certain targets for immunisation and cervical cytology. Other preventive tasks including the regular screening of patients over 75 and new patient checks were introduced as contractual obligations. They were also designed to make professional providers more sensitive to consumer preferences by making it easier to change doctors and to make complaints. Thus the proportion of general practitioners' income derived from capitation payments was increased from 45 to 50 per cent. Finally, they introduced greater managerial control over the activities of general practitioners, in particular their prescribing. For the first time, general practices were required to submit an annual report to their family practitioner committee.

A more fundamental review was initiated in early 1988, largely in response to mounting political pressures over the underfunding of hospital services (Day & Klein 1989). Having examined alternative methods of funding and organising health services, the Government opted in *Working for Patients* (1989) to preserve the existing taxation-based funding system and to concentrate instead on various methods of increasing efficiency and value for money: by devolving responsibility, promoting competition and encouraging consumerism (HMSO 1987). The main mechanism was the introduction of an internal market through which health care purchasing was separated from service provision.

The internal market was established by encouraging hospitals and community units to become self-governing provider trusts. They were separated from direct management by the district health authority (DHA), allowing them to control their own finances, staffing resources and capital investment. Two different types of purchaser were introduced. Whereas DHA purchasers were exhorted to carry out formal needs assessments as the basis for their purchasing plans and to balance priorities for the complete range of health care needs in a large population, GP fundholders were expected to respond to their patients' demands by purchasing a selected range of services for relatively small practice populations. In addition to competition between providers, the new system introduced a competitive market between purchasers, since patients could, in theory, choose whether or not to register with a fundholding practice.

The old machinery of local practice administration, first devised in 1911, was to be dismantled. Family practitioner committees were replaced by smaller managerial bodies of which only one member is a general practitioner. The responsibilities of the new family health services authority (FHSA) were greatly enlarged with more power to control the pattern of health care provision and call individual general practitioners to account for their use of public funds. The introduction of audit and of indicative prescribing budgets was evidence of this control.

The third major tranche of government reforms was laid down in the White Paper *Caring for People* (1990) (Stott & Davis 1979). This heralded the introduction of a comparable purchaser/provider split in the social services departments of local authorities. Its impact on the working lives of general practitioners, who play a major part in the assessment of individuals' health and social care needs, may indirectly be as large as the other changes described. In many parts of the country, primary health care teams are establishing closer links with local social workers. The care managers purchasing social care are aligned to do so on behalf of groups of practices. In some places, this brings closer the prospect of genuine joint commissioning.

The key policy objectives informing both *Working for Patients* and the contractual changes were consistent. The contract came into effect in April 1990 but only in the face of continuing professional resistance. A sense of diminishing autonomy greatly affected morale. GPs remained preoccupied with various bureaucratic manifestations of their increased accountability – 'the paperwork'. The early 1990s were thus an unpromising time to launch new initiatives such as COPC.

The wild card

Despite early opposition, the fundholding scheme has gained favour with many GPs and now covers more than 50 per cent of the population. Practices are given a budget to cover their prescribing, staffing and management costs and to purchase hospital outpatient services, admissions for elective surgery, diagnostic tests and investigations, community health services and paramedical services. Although fundholding represents a substantial transfer of resources, 'standard' fundholders have purchasing power over only about a quarter of the total hospital and community health care costs of their patients.

The remaining services are purchased by the DHA: accident and emergency services, general medical admissions, tertiary and some community services. The DHA also has to bear the cost of 'expensive patients', i.e. those whose health care costs amount to more than £6000 per annum.

The first-wave fundholders were drawn from the ranks of well-organised larger practices with good facilities, mostly in prosperous areas. Extra benefits that these practices have managed to extract may therefore be going to those areas least in need. The charges of widening inequity or 'two-tierism' are politically sensitive but, without more data on inequities that existed before 1990, difficult to substantiate.

Because budgets for fundholders and non-fundholding practices are calculated differently, it is difficult to establish whether or not funds are distributed equally. Budgets are still largely based on past patterns of service use (Dixon 1994). Rates of referral and admission vary widely among practices, and these variations remain unexplained. Budgets allocated to fundholders have therefore varied widely too (Day & Klein 1991) . One attempt to make a comparison of budgets for fundholders and non-fundholders concluded that fundholding practices in the North West Thames Region were funded more generously (Dixon *et al.* 1994). The Department of Health has been anxious to move towards capitation-based funding but the construction of a robust weighted formula for such small populations is probably impossible (Sheldon *et al.* 1994).

Fundholding has been nonetheless widely hailed by politicians and participants as a success. Fundholders have undoubtedly proved agile as purchasers, extracting new services and quality standards from service providers. Many of these achievements have indirectly benefited non-fundholders. However, the evidence that fundholding has improved the quality of care or of communication between GPs and hospital consultants remains limited (Glennerster *et al.* 1994; Newton *et al.* 1993; Bain 1994; Corney 1994).

Fundholders do seem to have been more successful than non-fundholders in curbing the steep increase in prescribing costs (Bradlow & Coulter 1993; Burr *et al.* 1992; Maxwell *et al.* 1993). Howie's uncontrolled study of fundholders in Scotland found a decrease in investigations and referrals among patients consulting for joint pain following the implementation of the scheme (Howie *et al.* 1994; Howie *et al.* 1995). Coulter and Bradlow studied referral rates in fundholding and non-fundholding practices before and after the reforms (Coulter & Bradlow 1993). They found little difference between the two groups of practices. There was no evidence that fundholding was encouraging a shift from specialist to general practice care or that budgetary pressures were affecting referral behaviour.

Fundholders are able to reinvest any savings they make. Many use this money to develop new practice-based services, such as physiotherapy, counselling or specialist outreach clinics. These services may be popular with patients but they are not necessarily cost-effective (Bailey *et al.* 1994). Coulter and Bradlow found that practices which introduced their own physiotherapy services increased their use of physiotherapy threefold, but their rates of referral to hospital consultants in orthopaedics and rheumatology remained at the same or higher levels (Coulter & Bradlow 1993).

There is, moreover, little evidence that fundholders' purchasing plans have been based on systematic assessments of their populations' needs. The transaction costs incurred in dealing with numerous small-scale purchasers are greater than when purchasing is carried out by one DHA (Le Grand 1994). Whether the greater cost of this form of purchasing is justified in terms of greater health benefits remains unknown (Coulter 1992).

Primary care-led purchasing

Despite the lack of evidence of benefit and despite obvious risks, in September 1994 the Secretary of State for Health announced her intention to extend fundholding to smaller practices (NHSE 1994). This marked a significant shift towards demand-led purchasing and away from a system based on equitable allocation according to need. In addition to standard fundholding, two new models have been offered to entice the undecided. Practices entering community fundholding can now purchase their own staff, computers and a limited range of community services. Most interest is focused on 'total purchasing', where practices are purchasing an expanded range of services.

The health authority's role henceforth is to be distanced increasingly from the mechanics of purchasing. Their skills and resources are to support increasing numbers of general practitioners in the business of contracting. Newly fused DHA/FHSAs are to develop strategy and monitor providers' performance in the light of those strategies. The fundholders' accountability framework issued in January 1995 is an attempt to ensure consistency in local purchasing priorities (NHSE 1994).

Simultaneously, numerous alternative commissioning models – many based on localities – are beginning to evolve (Ham 1993; Shapiro 1994). However, health authorities will struggle to support increasing numbers of small-scale purchasers. The skills that underpin effective and equitable commissioning need rapidly to be developed in primary health care teams (PHCTs). These skills include an understanding of data sources and their limitations, competencies in needs analysis and service evaluation.

Evidence-based practice

The internal market has thus focused attention on the effectiveness of health care. It is estimated that less than a quarter of health care interventions have been fully evaluated (Eddy 1991). It is argued that, if ineffective practices are abandoned, then sufficient resources will be released for those procedures of demonstrable value (Smith 1991). The task of producing that evidence is the main aim of the NHS Research and Development initiative (DoH 1993).

As big a challenge is to change behaviour among those whose decisions determine treatment. Little is known about how doctors respond to research evidence. A focus on cost control is unlikely to motivate health professionals to implement clinical guidelines. Controlling the diffusion of medical technologies, for example, requires much more than the rapid dissemination of effectiveness evidence (Hunter 1994).

Table 2 Sources of effectiveness information

Institutions:

- NHS Centre for Reviews and Dissemination
- Wessex Institute for Health, Research and Development
- National Co-ordinating Centre for Health Technology Assessments

Documents which will be useful in carrying out macro-level reviews of services:

- Health Needs Assessment Documents
- Health of the Nation Key Area Handbooks

Documents which will be useful for reviewing the detailed provision of services:

- Effective Health Care Bulletins
- Bandolier
- Cochrane Library
- Confidential Enquiry Reports (Stillbirths and Deaths in Infancy, Maternal Deaths, Perioperative and Operative Deaths, and Counselling for Genetic Disorders)
- Consultation Documents on Health Outcome Indicators
- Health of the Nation Target Effectiveness Documents

Securing changes in clinical practice is a complex process involving co-ordinated effort by both managers and clinicians in a number of different settings using a variety of 'levers'. Partnership across various interfaces within the NHS (e.g. primary/secondary care, purchasing/providers, clinicians/managers/users) is of critical importance. Local flexibility is needed in determining priorities (NHSME 1993).

There has been rapid growth in the number of sources of effectiveness information (NHSE 1996) (Table 2). However, they remain unfamiliar to most health professionals in primary care. There has been a rapid expansion of evidence-based clinical guidelines. Their more naive proponents see these as the solution to controlling bad doctors, inappropriate health care, spiralling NHS costs and the rationing dilemma (Hunter 1994). Criteria for the effectiveness of guidelines are well described. The key to their success is to strike the right balance between scientific rigour and local ownership. Much painstaking research is required for the production of a national evidence-based guideline (NHSME 1993). These need to be tailored to local needs and actively 'marketed'. Particular skills must be developed among professionals to further the process at this level.

Audit

The Royal College of General Practitioners has long been promoting the role of audit in education and training. Its 'Quality Initiative' contributed to the development of practice visiting methods and practice activity analysis (Irvine 1990).

There are a number of theoretical frameworks for audit in primary care (Baker 1988; Hughes & Humphrey 1990). Audit can be viewed as a spectrum of activities ranging from 'internal' case analysis, or disease audit, through peer review to 'external' analysis of service indicators, according to who owns the data under consideration. The need for audit in primary care to be professionally owned is generally acknowledged (Shaw 1980).

Working for Patients installed medical audit as formal NHS policy (HMSO 1987). Every doctor was to participate in regular, systematic, medical audit. New organisational arrangements and new money were introduced to facilitate this. However, there were important differences between the arrangements made in general practice and secondary medical care. Audit does not feature in the general practice contract, and does not automatically attract resources to individual practices. Audit funding levels have also varied widely between different parts of the NHS. Over the five years to 1994, £160.8m was allocated for medical audit in the hospital and community health services, up to £42.2m for medical audit infrastructure and development in primary health care and £17.7m for nursing and therapy audit. FHSAs received audit monies as part of their general administrative allocation to support primary health care development. This money has not been ring-fenced (DoH 1994).

The role of the Medical Audit Advisory Group (MAAG) was to 'direct, co-ordinate and monitor medical audit activities' in all practices (DoH 1990). They remained predominantly medical in their membership (Humphreys 1993), though increasingly, MAAGs have included members of the wider PHCT and the general public. Most audit groups have some formal input from FHSA managers or medical advisers. They use a combination of different processes: individual practice visits, geographical patch work, topic groups, inter-practice or district-wide audits, practical help, education and training. Audit groups also collect, collate and distribute information about audit for the use of local practices (Griew & Mortlock 1993).

Audit's traditional focus on clinical practice is incomplete. To achieve consistently good care, effective management systems are required. Two well known organisational audit models are the King's Fund's Organisational Audit (Blakeway-Phillips 1993) and the ISO 9000 (formerly British Standard 5750) (Irvine 1994). Both offer a systematic multi-disciplinary review of practice procedures. Clinical and organisational audit are complementary tools in ensuring overall quality.

Despite progress on the implementation of audit, obvious shortcomings placed the future of MAAGs in question (Spencer 1993): the failure to integrate audit with the broader quality assurance agenda, the lack of a consumer focus and limited evidence of value for money. However, the DoH continues to support audit in primary care. In many parts of the country, MAAGs have been refashioned to include stronger educational and research representation.

Promoting health

Over 90 per cent of the population consult their general practitioner at least once over a three-year period. PHCTs have always been pivotally placed to reconcile high risk and population approaches to disease prevention (Rose 1992).

The 1990 contract introduced new incentives for general practitioners to undertake a range of health promotion activities. These included target payments for achieving specific coverage levels for cervical cytology and immunisation and fees for child health

surveillance. Among the more controversial elements was the payment of £45 for running health promotion clinics (Morrell 1991). Though predominantly concerned with cardiovascular disease prevention, eligibility criteria were wide. They encompassed the management of various chronic diseases, stress reduction and travel clinics. This financial incentive led to a steady growth in clinic activity of questionable effectiveness (DoH 1993). This growth was greatest among larger, well-organised practices serving healthier populations (Gillam 1993).

In the wake of much criticism (Bain 1990), the contract was amended in 1993 (Barnes 1992). The *Health of the Nation* White Paper published in the same year placed the reduction of cardiovascular disease and stroke mortality as its first priority (DoH 1992). Health promotion activity was thenceforth focused in this area. Sessional payments for clinics were abolished and replaced by a set fee per registered patient for providing a defined level of screening and recording risks factors on a given percentage of the practice population (NHSME 1993). The fee bands corresponded to three levels of activity, according to how much information is collected. More than 90 per cent of practitioners opted for Band 3 (Langham *et al.* 1995). In addition, general practitioners are paid a fee for providing special programmes for the management of asthma and diabetes. The introduction of the banding scheme was to affect both the choice and the progress of several COPC projects.

The modifications to the health promotion element of their contract were coherent in terms of national health priorities but linking the banding scheme to *Health of the Nation* did not enhance its credibility with PHCTs. General practitioners perceived a disproportionate share of the responsibility for the *Health of the Nation* falling upon their shoulders (McBride & Metcalfe 1995).

Barriers to service development

Secondary care domination

Hospital services dominate the planning agendas of most health authorities. Money is not yet 'following the patient' as more care is shifted into the community (Hughes & Gordon 1993). The NHSME's planning guidance in recent years has emphasised the need to 'invest in primary and community care, and ensure a better balance between hospital and community services' (NHSME 1993/4). But short-term support for new projects can endanger the longer-term strategic investment upon which the future development of primary care depends: in premises, training and information technology. There remain numerous strategic and operational constraints to development in primary care:

The GP contract

The terms and conditions of this contract are negotiated centrally. FHSAs cannot easily withdraw contracts from those family doctors providing poor services. Practice-specific contracts that reward high-quality performance and reflect local needs have previously been rejected by the GMSC (GMSC 1994). However, protracted debate between the

GMSC and the Government over 'core' versus 'non-core' services has yet to threaten the national contract. The recent 'Choice and Opportunity' White Paper may encourage experimentation with forms of locally negotiated contract (Secretary of State for Health 1996).

Poor communication

There is room for improving collaboration between the various professions involved in providing health and social care (Gregson *et al.* 1991). Health visitors' skills are often overlooked. A practice-based approach to needs assessment/audit can overlook the enormous volume of information collected by and for community units.

Skills shortages

A needs led-health service requires an understanding of public health frameworks in primary care. The requisite levels of management and technical skill (e.g. epidemiological, information technology) among professionals working in primary care cannot be assumed.

Tension between practice and district priorities

Rigid imposition of nationally determined health promotion priorities will stifle local innovation. The traditionally individualistic approach of general practitioners can be difficult to reconcile with the utilitarian approach of planners at DHA/FHSA level (Petchey 1994).

Professional support

General practitioners seek benefits for their patients but not at the expense of growing waiting lists and quality severely compromised elsewhere in the service. They are understandably reluctant to take on more responsibility as they wrestle with the implications of recent contractual and other changes (Handyside 1994). Hospital clinicians may be unwilling to shift responsibilities to colleagues in primary care.

Low staff morale

This has been attributed to many factors, including burgeoning consumer demand (particularly out of hours), bureaucratic overload and the nature of GP career trajectories (Howell *et al.* 1992). Applications for practice vacancies and places on vocational training schemes have fallen in recent years (McBride & Metcalfe 1995).

Summary

Working for Patients inaugurated the most radical changes in the NHS since its inception, reinforcing policies that underpinned the new GP contract. The balance of power within the medical profession has swung markedly in favour of general practitioners, but with new powers have come new responsibilities. With the evolution of general practitioners' purchasing role, there is growing recognition of the need for new skills. Health authorities require new kinds of intelligence if they are to be successfully transformed into

organisations capable of purchasing health care appropriate to the needs of their populations.

GPs are being asked to contribute to the assessment of health care needs in several ways: supplying information or an expert opinion, specialised committee work and audit. Members of the PHCT are best placed to judge the quality of health services provided locally and the needs of the practice population or neighbourhood. However, the skills required to systematise such detailed local knowledge are often lacking (Shanks *et al.* 1995; Pollock & Majeed 1995). A population-based approach to the delivery of health care underpins both contractual target payments and the choice of health promotion priorities.

For many purposes, the successful delivery of primary care nowadays requires knowledge and skills traditionally associated with public health. New educational models are required to develop primary care. The King's Fund regarded community-oriented primary care as one possible model.

Chapter 3

The public health experiment

In 1992, the Director of the King's Fund Management College was Dr Jo Ivey Boufford. She had had extensive experience of using the COPC model in her previous job as the Director the Residency Programme in Social Medicine/Department of Family Medicine, Montefiore Medical Centre, in New York (Boufford & Shonubi 1986). COPC had come to be seen as offering salvation from the market oriented extremes of the US health system. With the introduction in the UK of the internal market and a retreat from the equity-oriented traditions of NHS, COPC exercised some of the same appeal. Dr Boufford's reasons for championing the approach were clear:

> *'We need to look at new ways of developing general practice to cope with the strategic and organisational burdens of a primary care-driven service. The danger otherwise is of an increasingly demand-led system.'*

The King's Fund COPC project

The aims of the King's Fund COPC project were threefold:

1. to pilot the COPC approach in four sites
2. to develop a training package appropriate to the circumstances of the NHS
3. to evaluate the COPC model as adapted in the UK.

The programme began in 1991 with a series of meetings between the Israeli originators of COPC and invited audiences from general practice, DHAs, FHSAs and the Department of Health. Multi-agency teams from several districts explored their interest in being pilot COPC sites at a series of workshops. A list of interested authorities was compiled.

The first pilot programme began in Northumberland in November 1991; eight practices from three further sites (Sheffield, Winchester and Haringey) joined the programme between June and October 1992. Pilot practices received local support from their FHSA and DHA. The King's Fund funded the initial workshops and additional support as part of a national network. This support took the form of process consultancy from King's Fund fellows.

The training programme

An assessment of the practice population's health needs was carried out in three stages. For the first stage, **Community Diagnosis,** the PHCT defined the health problems of their community on the basis of available quantitative and qualitative data (Table 3). This included team members' local knowledge derived from working in the community over years. Each PHCT produced a comprehensive list of the major health-related problems in their practice population.

Table 3 Data used for community diagnosis

1. **Practice environment –**	e.g. physical location, topographical features, transport, physical description of surgery premises, local employment, housing, local environmental risk factors.
2. **Community characteristics –**	e.g. practice list age/sex breakdown, socio-economic status, ethnic minorities (numbers and special needs), deprivation indices, unemployment rates.
3. **State of health – Morbidity**	e.g. data on patients with chronic diseases (e.g. hypertension, heart failure, stroke, asthma, diabetes), antenatal and births data, teenage conception rates, termination rates, infectious disease notifications, specialist referral rates, in-patient admission rates.
– Mortality	e.g. local ward-level standardised mortality ratios specific (e.g. CHD, lung cancer).
4. **Risk factors –**	e.g. behavioural data on smoking, alcohol consumption, dietary, exercise patterns, substance misuse, sexual behaviour.
5. **Health service system –**	Within the practice, e.g. number of GPs, nurses, other practice attached staff, special interests, complementary therapy, patient turnover rate.
	Outside the practice, e.g. health services (e.g. hospital and community), voluntary services (e.g. meals on wheels) – gap analysis.

Much data on this list will tend to be available at ward, not practice, level. Care is required in their interpretation.

The second stage is **Prioritisation**. A simple grid is used to score each health problem in relation to specific criteria, i.e. size of problem, availability of an effective intervention, acceptability to the team and the consumer, feasibility, community involvement and resource requirements (Table 4). PHCTs could override the scoring system in certain instances, e.g. when the top priority problem was already being addressed.

Table 4 Example of prioritising grid

	PROJECT					
CRITERION	*Coughs and colds*	*Postnatal depression*	*Carers*	*Asthma*	*Smoking*	*Cancer*
Prevalence/incidence	3	3	3	3	3	3
Severity of problems	1	3	3	3	3	3
Effective intervention	1	3	3	3	2	1
Acceptability/feasibility	1	3	2	2	3	2
Community involvement	1	2	3	2	2	2
Costs and resources	3	2	2	2	2	2
TOTAL SCORE	10	16	16	15	15	13

A rural practice initially ranked cardiovascular disease as their highest priority. However, the team felt that they were already investing a great deal of effort in this area. In discussing other priorities a practice nurse drew attention to a major cause of distress to affected patients: urinary incontinence. The doctors initially did not appreciate the extent of the problem. In the words of the nurse: 'You don't see it. We're always replacing the leaflets on incontinence. They come to us'. The team elected to accept this as their priority. A prevalence study has been performed on women aged 40–49 years with a 75 per cent response rate. The results show that only 31 per cent have never had an episode of incontinence and that 23 per cent could be defined as having marked incontinence. The planned intervention will include both preventive exercises, community education and the setting-up of a local continence clinic by a specially trained practice nurse.

Two inner city practices with very high rates of unemployment concluded that highest priority should be given to adolescent health. The high prevalence of cigarette smoking,drug and alcohol abuse in this age group was well established. In addition, adolescents were often caught up in the violence and social unrest afflicting the community. The extent of teenage pregnancies was only realised during the workshop.

Having selected one health problem, the teams next explored the extent of the priority problem in the total practice population – the **Detailed Assessment**. This constituted a baseline for later evaluation. The inclusion of non-users is a cardinal feature of COPC. The teams used their own and local expert knowledge as well as specialist literature.

Intervention plans should have defined relevant activities, who was responsible for their **Implementation**, records required, training needs, milestones and deadlines. Realistic objectives needed to be clearly defined. DHAs/FHSAs provided limited extra resources and advice for survey design, questionnaire development, data processing and analysis.

The teams then considered the methods they will use to assess the degree to which programme objectives have been met. Early definition of the data required for the **Evaluation** is a critical part of the COPC process.

In the final **Reassessment** phase a decision was made as to whether or not to continue the particular intervention in the light of the evaluation. The community diagnosis should be revisited prior to re-entering the COPC cycle (see Figure 2).

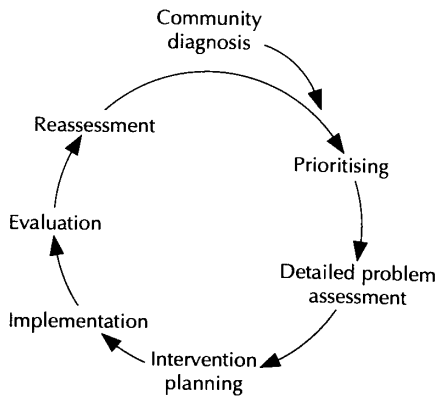


Figure 2 The COPC cycle

A fundholding urban practice has used the COPC process imaginatively. Beginning with a single project on hypertension. The team has moved on to identify a range of subjects for investigation and intervention. This now includes asthmatics, elderly people with special needs, mothers with young babies and bereaved people. The presentation of an individual clinical case problem at a practice meeting elicits the question: what is the extent of the problem in the community as a whole? All staff are involved in the decision-making process.

Alongside the PHCTs, representation from the DHAs, FHSAs and community units complete the same cycle. While teams completed the cycle in three and a half days, only the first two stages were undertaken to a stage of possible completion. All teams left the workshop with information to collect on their chosen problems.

Evaluation

Evaluation of the project focused on (a) its impact on the organisational development of both providers (PHCTs) and purchasers (FHSAs/DHAs), and (b) its potential for providing suitable data to inform purchasers' assessment of needs.

The evaluation was oriented towards both process and outcome. It embodied the principles of methodological triangulation in drawing on a range of data sources (Cantley & Smith 1985). A combination of quantitative and qualitative methods was employed. Qualitative research explores the nature, strengths and interaction of variables (Black 1994). Qualitative approaches – interviews, observational activities, interpretation of written material – are most valuable when the subject studied cannot be controlled and is poorly defined (Brody 1992). The focus here ranged from single individuals (health professionals) through small groups (primary health care teams) to the functions of large organisations (health authorities).

A schematic outline is shown in Table 5. This divides the evaluation into four parts, considered from the point of view of purchaser (DHA/FHSA) and provider (PHCT):

Table 5 Outline of evaluation

	PHCT	*DHA/FHSA*
1. Training		
– Process		
– Outcome		
2. Projects		
– Process		
– Outcome		
3. Alternatives		
4. Generalisability		
– Costs		
– Roll out		

1. Training

1.1 Process – e.g. problems encountered by PHCTs at each stage of the COPC cycle (e.g. data gathering/interpretation, priority setting, project planning).

1.2 Outcome – impact on participants in enhancing the following: skills in project management, needs assessment, decision-making, planning, team-building and a shared understanding of service goals.

Methods: semi-structured interviews / questionnaires / participant observation / changes in other practice activities (e.g. annual reports, health promotion, audit, other process measures). Various tools have been used to assess interprofessional collaboration in PHC organisations (Gregson *et al.*; Poulton & West 1992).

2. Projects

2.1 Process – For PHCTs, the appropriateness of projects and the quality of data collected, the extent to which their projects' original aims were met, the nature of problems identified and details of interventions. For DHAs/FHSAs, the problems encountered managing these projects from a distance.

2.2 Outcome – Changes in practice activity or to the way services were delivered that result from the projects. For DHAs/FHSAs, how data generated by COPC projects were used in purchasing.

Methods: questionnaires/scrutiny of project documentation/interviews/participant observation at health authority steering group meetings. Criteria were devised for rating projects' progress at successive stages of the COPC cycle (Table 6 on pp. 24-6).

3. Alternatives

Comparison of COPC with other approaches to practice development. These approaches included audit locality purchasing projects, GP fundholding, the Health Education Authority's Primary Care Development Workshops (Spratley 1989) and community development models.

The following six programme aims served for the purposes of comparison:

- to further understanding in HAs/PHCTs of purchasing, primary care and its role in promoting strategic objectives.
- to increase PHCTs' skills relevant to commissioning (assessment of needs, planning, evaluation).
- to increase integration through the involvement of GPs in commissioning.
- to use data from primary care to inform purchasing.
- to involve consumers in priority setting.
- to improve the range and quality of services offered.

Methods: interviews/site visits/literature review/survey of PHCTs involved/secondary data analysis where possible.

4. *Generalisability*

The extent to which the model of COPC, and its strengths can be extended to other sites.

4.1 KFC/PHCT/DHA/FHSA costs – establishment and support: workshops, staff time, information technology, other project expenditure.

4.2 Replicability – feasibility of 'rolling out' the COPC model: what were the organisational, professional or other barriers to extending the programme.

Methods: analysis of costings data/questionnaire/interviews/observation.

The overall success of COPC were judged against the following criteria corresponding to the four stages of the evaluation:

1.1.1 – that an appropriate, coherent training package was constructed.
– that PHCTs were helped to obtain the necessary support (technical, information, team-building) from their local DHA/FHSA.

1.2 – that PHCTs were able to make a community diagnosis and identify problems on which to take action.
– that they worked as teams.

2.2.1 – that PHCTs, having identified problem(s) that they wanted to work on, were able to undertake and complete projects to a satisfactory standard of rigour and practical applicability.
– that COPC succeeded as an educational process, i.e. that the teams learn enough about basic epidemiological principles to apply these to other issues and problems.

2.2 – that projects yielded measurable benefits for patient care.
– that work undertaken informed DHA/FHSA purchasing and contracting.

3.3.1 – that COPC compared favourably with other approaches in terms of its contribution to the purchasing process (see above).

4.4.1 – that local resources could be employed to disseminate the COPC approach across a DHA/FHSA.

Summary

The pilot project aimed to investigate the hypothesis that COPC helps PHCTs, DHAs and FHSAs undertake the shared responsibilities of assessing practice populations' health care needs, before devising and implementing strategies to address them. The principle of triangulation informed the evaluation for which a range of qualitative and quantitative methods were employed.

Table 6 Staging criteria for COPC functions

1. Defining the practice population	
Stage 0	No effort has been made to define or characterise beyond a statement of practice list size.
Stage I	The practice population is characterised with reference to an age-sex register.
Stage II	Demographic characteristics of the practice are compared with secondary data that correspond closely to the community of which the practice population forms a part.
Stage III	The practice population is characterised through the use of a database that contains information to describe its demography and employment status.
Stage IV	Systematic efforts ensure a current and complete enumeration of more than 90 per cent individuals in the practice population, including pertinent demographic and socioeconomic data. For each individual, information exists that facilitates targeted outreach, e.g. address, telephone number.
2. Identifying community health problems	
Stage 0	No systematic efforts were made to understand the health status or health needs of the community.
Stage I	Community health problems were identified through general consensus of members of the primary health care team ('brainstorming').
Stage II	In addition, community health problems were identified by extrapolation from secondary data, such as vital statistics, census data, other epidemiological data, etc.
Stage III	In addition, community health problems were examined through the use of datasets specific to the practice population e.g. audits, PACT, morbidity registers. The results from studies of practice attenders were assumed to reflect the health problems in the community as a whole.
Stage IV	In addition, patients' views were sought, e.g. through patient participation groups, rapid appraisal or other profiling techniques.
3. Choosing a project	
Stage 0	No systematic attempt was made to prioritise possible community health needs.
Stage I	Prioritisation criteria were considered but the choice of project was determined by one individual's preference.
Stage II	Prioritisation criteria were used by participants representing at least three different professional groups within the PHCT.

cont.

Table 6 *cont.*

3. Choosing a project

Stage III The same process of prioritisation was shared by the extended PHCT on return to the practice.

Stage IV In addition, the practice population (or representative) were consulted prior to implementation concerning the choice of project and its implications for the local community.

4. Detailed problem assessment

Stage 0 Following the workshop, no further data were collected concerning the prioritised target population/health problem.

Stage I Further information was collected through informal discussion with other providers of services addressing the target population/health problem.

Stage II Secondary data and/or the results of studies performed elsewhere were used to characterise the target population.

Stage III In addition, formal mechanisms (e.g. surveys) were used to identify the correlates, determinants and existing patterns of the health care relating to the health problem(s) under consideration.

Stage IV The mechanisms incorporated the results of direct contact/consultation with members of the target population.

5. Implementing the COPC Project

Stage 0 No modifications were made to services provided by the practice in specific response to identified health needs of the target population.

Stage I Modifications addressed health problem(s) identified but were made in response to a national or organisation-wide initiative, e.g. banding.

Stage II Modifications addressed important community health problems, but were chosen largely for the availability of special resources to address the particular problem, and closely follow guidelines that may not be tailored to the target population needs.

Stage III Modifications in the program were targeted to specific groups, with active efforts (e.g. outreach) made to reach them.

Stage IV Modifications in the health services were tailored to the particular needs of the community and involved (where appropriate) both primary care and community/public health components.

6. Evaluating the COPC project

Stage 0 No examination of project effectiveness has been undertaken.

Stage I Project effectiveness was assessed via the subjective impressions of members of the PHCT.

Stage II Project effectiveness was estimated by extrapolation from studies elsewhere.

cont.

Table 6 *cont.*

6. Evaluating the COPC project	
Stage III	Project effectiveness was determined by systematic quantitative examination of a dataset that was specific to the target population.
Stage IV	Project effectiveness was determined by techniques that are specific to the project's objectives, account for differential impact among risk groups, and provide both quantity and quality information on the positive and negative impact of the project.

Chapter 4

The workshops

Expectations

Reasons for attending the COPC workshops varied. Some described it as a way of bringing the principles of public health into primary care.

> *For me COPC is reaching out into the community to look at what people's needs are and looking at what their health is now. Trying to look at a way, if their risk factors are high, to change them either medically or through dietary or exercise advice or other methods of health promotion. And try to reach people who don't normally present.* (Practice Manager)

But for others it was not so much a way of learning about public health as an endorsement of the democratic ideology to which they were already committed.

> *From what he said it sounded as though it fitted in very much with the way we work. Like aiming not to impose a very rigid set of expectations on patients. Wanting to hear what they wanted, rather than waiting for them to come in and giving them what we thought they wanted.* (Counsellor)

To convince their team to accept COPC, others had to stress the expectation of some material advantage from their involvement.

> *I saw it very clearly as a way of getting extra resources for the practice.* (GP)

Public health physicians hoped that COPC would introduce a new perspective on the health problems of practice populations.

> *It's the concept of actually introducing a population-based idea into primary care. I think general practice [could be] taking note of the broader health patterns that are going on around it ... providing individual medical care but also taking an interest in the broader public health picture that lies within its boundaries.* (PHP)

Managers saw COPC as addressing several different agendas.

> *Along came the COPC idea and that seemed to kill several policy birds with one stone. It was a way for practices to organise themselves for data collection, to do needs assessment, start taking a community view of their practice populations. We also hoped, I think perhaps a little unrealistically, that we would start to get our hands on some more meaningful morbidity data.* (DHA Manager)

COPC was seen as reassuring participants that they were, after all, all striving towards the same goal. COPC's potential to create new links had particular appeal where there was a history of problematic relationships between DHAs, FHSAs and practice teams.

> *Our relationships with the FHSA had been a little variable previously. The levels of communication about activities, needs assessment and so on have varied, so COPC could be very useful.* (Practice Manager)

Finally, there were those who had no clear idea of what they were letting themselves into.

> *He gave us a leaflet all about it ... very confusing at first, really. I mean we went with an open mind and it all came together.* (Receptionist)

Community diagnosis

What this profiling exercise demonstrated was that such information as existed was not easily accessible. The 'hard' data available were very limited.

> *One of the first things that struck us was how little quantitative, clinical information we had.* (Practice Manager)

> *We had some crude data, we'd been keeping a mortality register on all patients dying for a number of years ... we also had morbidity registers for asthma, diabetes, hypertension ... but we had never actually used them in a meaningful way.* (GP)

> *I think the assessment of the health needs of the population ... that element of it has been less rigorous in some ways than I might have hoped for. Very often I think what the projects have been about has been assessing the quality of information collected on people who are coming to the practice. Now that is not a bad thing in itself but often it is a little less than a population-based assessment of health. I suppose I would have seen it as moving to a population-based framework for needs assessment, trying to use ... the framework provided by general practice as a denominator.* (PHP)

Prioritisation

Prioritisation proved difficult.

> *At one point I remember being totally exhausted and thinking I don't want to go back there. Other people felt the same because it was quite hard to find an agreement on what we should do.* (Practice Nurse)

Although in most teams there was a desire to tackle mental health problems (stress, misery, loneliness, the effects of unemployment), such topics were usually rejected. Reasons included a lack of control over the causes and the absence of effective interventions.

In fact, at the workshop the thing that came out top may have been the mental health needs of the elderly but we ditched it quite deliberately because we knew the practice couldn't handle it. (GP)

The emphasis at the workshop was on being realistic about what was manageable. The decision not to tackle mental ill health was pragmatic: what mattered initially was to learn the techniques of COPC. They wanted to apply these to a straightforward problem before trying to 'sell' a larger project to the rest of the team.

In the one practice which did choose to tackle mental health, the problem was seen to be of overriding importance by all team members.

I remember the very first meeting we had, it became obvious we very much wanted to tackle mental health. This was with GPs, health visitors, everyone there including me. Because it seems that a great deal of the problems people come in presenting have a basis in stress of some sort. Stress, anxiety, depression. And if we took something like CHD or smoking it would be just tinkering about with the symptoms ... It would be much more satisfying, getting to grips with it properly, if we tackled it as it really was. (Counsellor)

The outcome of the prioritisation process was that a large number of the teams chose topics related to coronary heart disease (CHD).

I have to say we were slightly disappointed that everybody went for the obvious ones, but then it is the major health problem in the area ... though again I think there was an edge of cynicism because that was where the money was going to come from in terms of health promotion. (DHA Manager)

Many of the practices felt that, in view of the DoH's encouragement to address the problem of CHD and the way the prioritisation process worked, such a choice was almost inevitable.

We basically looked at ischaemic heart disease simply because the pressures of government for that to be the main focus in general practice were overwhelming. (GP)

With the prevailing interest in CHD, they were aware that their data were inadequate and they felt that COPC presented an opportunity to rectify this.

It was just blatantly obvious that there wasn't enough information on anybody. Nothing had been done regularly. Hardly anything had been recorded. (Practice Nurse)

In some practices, the possibility that such information was going to have to be collected for banding slanted their choice in favour of CHD.

It coincides with the banding. It's great. It fits in well. (Practice Manager)

There was some criticism of the process of project selection. While most practice teams were happy with their choices, they were not necessarily convinced that the prioritisation process had been appropriate. Some regarded the process as spuriously scientific in producing a quantifiable result. They did not acknowledge that a qualitative endeavour might increase understanding.

> *I think you have to have a process like that but to think that it's based on statistical data and that you choose your project because this is the most sort of morbid or mortality-related topic or whatever, I think is partly a mistake.* (GP)

What the COPC approach offered was a sense of ownership – both of the decision and of the way the topic was approached.

> *It had got to be something that the majority of us were interested in and, although a lot of these other areas came up, people did keep coming back saying: 'I wouldn't mind doing something around heart disease'. Particularly, the receptionists and attached staff were keen on heart disease. So they were the main criteria that in the end focused us down on doing something around coronary heart disease.* (GP)

Putting the 'C' in COPC

The teams involved offered a wide range of meanings for the word 'community' interpreting it in the light of their chosen project. The differences in these interpretations depended as much on their practice's pre-existing ideology as on any message from the workshops.

One practice aimed to increase awareness of cardiovascular disease risk factors in a wide target group within the community.

> *Well, we're hoping eventually that the whole community will be aware of the drinking, smoking, the weight, and we'll eventually get through to them.* (Receptionist)

Another felt that they should be increasing their awareness of resources in the community so that the services they offered could be complementary to these.

> *What's different for me is to think of 'the community', the group of people we're talking about, how we might identify their need, what other agencies would help us in seeing their needs and providing a service that we can't provide and who would work with us.* (GP)

Several teams felt they should be listening to the views of community representatives to guide future developments in health care. But this was not always accepted as an appropriate use of time.

> *We might say there is a difference of opinion among different partners. Some of us are more community-oriented than others. I'm fairly interested in involving other people in our decisions, but some others are very against it.* (GP)

Others recognised that health was affected by adverse features in the community and that they should be making more strenuous efforts to address social causes of ill health.

> *Medical disease as a result of how society's changed. That's what we wanted to do. And then we looked at it and took a deep breath and said, 'No this is far too big'. There's nothing we can do about this.* (GP)

One practice developed the concept of mutual support within a community. Previous users of the service were trained to become listeners for people with similar problems.

> *I see this very much as an acorn growing into a big tree and I am sure that the commitment, not only of the people who are setting it up, but those people who are taking on the responsibility of providing support. They have been given a role and a responsibility and it's given them something tangible and they are developing as people and blossoming and hopefully that will have a knock-on effect.* (Practice Nurse)

Not all GPs were enthusiastic about consulting the community.

> *I know this is very anti-democratic but we could imagine a situation where certain people would get their hands on a patient participation group and it would be terribly destructive for the practice. So we're very wary about how you set it up.* (GP)

Failure to involve the community was particularly evident where teams did not have attached health visitors and district nurses. The practices where community nursing staff were fully integrated were most comfortable, pursuing needs assessment in the community. When face-to-face contact was confined to a short weekly meeting, there were difficulties sharing this aspect of the workload with community staff.

> *We have our hands more than full with other stuff so to get all these other people involved was just too much ...* (GP)

Where one outcome of the COPC experience was a focus on community diagnosis, this was welcomed enthusiastically by their FHSA.

> *[They] are doing a lot and will just say they feel as though it's an integral part of the way they work now ... I think what she's [the Practice Manager] picked up is community involvement which is absolutely fine because that's the hardest bit to crack.* (FHSA Manager)

The lack of consensus in the interpretation of the meaning of 'community' in COPC may derive from a lack of clarity at the original workshops. The examples they were given of existing COPC enterprises provided little indication that community involvement was even considered.

I tended to think that community ought to mean actual involvement of the community, i.e. on a personal level, whereas I think that some of the projects that were demonstrated as examples of the COPC process didn't actually involve members of the community at all. (GP)

Educational impact

Most participants have found the workshops highly informative, expanding their understanding both of primary health care and public health. Team members' ratings of the extent to which the workshop helped in various ways were strikingly uniform and the great majority were very positive.

For our practice, COPC was three things: a learning exercise, the trigger for practice development and a way of changing behaviour within the team. (Practice Nurse)

I see it as identifying the needs, and then deciding how the team can formulate a strategy to meet those needs. (Health Visitor)

Workshops are important as a way of focusing the team and sharing experience. COPC may need to be streamlined but not at the expense of the workshops. (GP)

I began by being a bit sceptical but at the end of the four days I had learned or perhaps relearned an enormous amount. All members of the team did. (GP)

Summary

For all participating practice teams, the workshops provided an illuminating learning experience and helped develop links with other agencies. However, participants were already aware of the need for time, resources and other forms of ongoing support if they were to further their projects. The community diagnosis, prioritisation and project planning were challenging for participants. Evaluation of the pilot workshops helped formulate the definitive training package. Their impact on inter-professional collaboration is discussed again in the following chapter.

Chapter 5

The projects

The four pilot sites

The health authorities were undergoing rapid changes over the period of the pilot study. Particular consideration is given to four factors in the descriptions below (Table 7):

- DHA/FHSA relations;
- strategic commitment;
- operational support;
- plans for the future.

Table 7 Characterising the purchasing authorities

1. DHA/FHSA relations	– boundaries – history of joint working
2. Strategic commitment	– strong leadership, local champions – clear aims/aspirations regarding COPC
3. Operational support	– dedicated finances – identified support – regular meetings – link with public health, academic departments, health promotion
4. Plans for the future	– COPC within strategic context – rolling-out

Northumberland

Health authorities

DHA/FHSA relations

The Northumberland FHSA was coterminous with the DHA but there had traditionally been limited contact between the two. Standards of local general practice were among the highest in the country, with several high-profile local opinion leaders. This sense of being at the leading edge perhaps heightened the organisation's insularity. Since 1992, the FHSA and DHA have merged to form a single health commission, Northumberland Health.

Strategic commitment

The FHSA general manager had played the largest part in ensuring that Northumberland hosted the first COPC workshop. He saw COPC as providing a bridge between the authorities. Also present was a newly appointed medical adviser with a traditional general practice focus. The DHA was interested to participate but unable to provide support.

The director of public health was singled-handed. A junior consultant attended the training but she was also too extended to provide long-term support.

The gulf between the organisations was apparent throughout the workshop. No strong leaders of the initiative emerged from the workshop, and responsibility for COPC was delegated to a planning manager. The FHSA was caught unaware by the scale of the request from the Prudhoe practice and only reluctantly agreed to meet the costs of the project. A simple extrapolation to assess the start-up costs of involving larger number of practices stifled enthusiasm for any large-scale expansion of the programme. With the general manager's departure in 1992, the main local champion was lost.

Operational support

At the end of the workshop, the FHSA agreed to consider bids for extra support. The planning manager administered funding but no other operational support was identified. A public health physician attended the original workshop but links with other agencies were not sustained subsequently.

Two meetings were held in the wake of the workshop. The medical adviser was instrumental in ensuring that the workshop was reported in *Pulse* magazine. He made a determined but unsuccessful bid for R&D funding to support the initiative. Thereafter, COPC was absorbed alongside a number of other developmental initiatives in primary care.

Plans for the future

Representatives from one practice spoke enthusiastically at a local postgraduate meeting about COPC in the hope of generating further local interest. Two years on, the COPC projects were not perceived to have yielded major benefits and there were no plans for extending the project. Northumberland has been at the forefront in developing MIQUEST software that allows the interrogation of practice databases (CIC 1994). Thirty-five linked practices are paid a capitation fee to provide information that allows sophisticated audit of practice activity (the MEDICS scheme). The maturation of local fundholders of which there are now 23 (covering 70 per cent of the population) is also felt to have superseded the COPC initiative.

Practices

Castle Surgery, Prudhoe

This four-partner fundholding practice was regarded as forward-thinking, and already well developed.

COPC project aims: To reduce the incidence of ischaemic heart disease in men and women aged between 35 and 44 years by reducing the prevalence of cardiovascular risks factors and changing lifestyle activities.

Two hundred and forty-seven people (28 per cent) out of 873 in the target group responded to a lifestyle questionnaire and an invitation for a health check. Attenders received

Table 8 Prudhoe results

247 patients screened – newly identified:		
Smokers	58	42 seeking to stop
Hypertensives	38	12 under review
Cholesterol elevated	28	88 borderline
Alcohol >recommended	15	51 moderate or heavy drinkers
Overweight/obese	84	

advice and information. One hundred and fifty-one (61 per cent) people had identifiable risk factors (Table 8). Thirty-eight were found to have raised blood pressure, of whom seven required long-term treatment.

COPC helped to refine this practice's data collection and smooth their path to health promotion Band 3 (introduced two years following the workshop). Skills in data analysis were extended beyond the partner who normally took this lead.

Disproportionate effort was expended at the detailed problem assessment stage, at the cost of energy and enthusiasm. In retrospect, they felt the data collection originally proposed was too ambitious. Little use had been made of the data collected. Their choice of a low-risk cohort, poorly motivated to attend, meant that they were unlikely to demonstrate significant changes on rescreening.

Though the core team felt they had learned much from the experience, they doubted that COPC as originally envisaged had a future. *'The central ideas are universally valid but the world has moved on. They are more familiar now.'* (GP) *'COPC is too resource intensive. We have too much else to do.'* (Practice Manager)

Haltwhistle Health Centre

This four-partner practice was well known to the FHSA through the figure of its senior partner, a local member of the LMC and GMSC. It serves the town of Haltwhistle and surrounding villages.

COPC project aims: To reduce prevalence of hypertension and smoking in patients aged between 15 and 74 years.

Limited information was available on patients in the target age range but the practice nurse collected data on 460 patients over the first year of the study. Risk factor management protocols were agreed. Interventions included individual counselling, the setting-up of a smoking-cessation group and various community-based initiatives. The practice nearly halved the proportion of patients for whom they had no record of smoking habit or blood pressure (Table 9). Two hundred and twenty-three smokers and 81 hypertensives were newly identified.

This team did not underestimate the likely volume of work required. With more realistic expectations, they were satisfied with what they had achieved. They were considering

Table 9 **Haltwhistle Results**

	1992	*1995*
15–74 yrs.		
Nos. (%) with no record of smoking habit	2993 (57%)	1692 (32%)
Known smokers	661	884
25–74 yrs.		
Nos. (%) with no record of BP	2053 (45%)	1103 (24%)
Known hypertensives	212	293

a project to address heavy alcohol consumption among their practice population following an initial assessment which identified 55 heavy drinkers.

Sheffield

DHA/FHSA relations

Sheffield FHSA was coterminous with the DHA. There had been some joint working with a jointly funded post in health promotion. The FHSA had pursued a premises improvement policy that had raised the quality of general practice in many parts of the city. The HA has a high profile as a leading proponent of the WHO Europe Healthy Cities campaign, with a strong emphasis on healthy alliances.

Strategic Commitment

The FHSA was represented at the workshop by the deputy general manager and a lively senior planning officer. The general manager had long experience in dealing directly with general practitioners. He hoped COPC would provide data on local needs of clear strategic value for his organisation. The lead was initially taken by the planning officer but he left for another post shortly afterwards.

Operational support

A support group has met at regular intervals since the training. Originally it comprised managers from community services, the DHA, the FHSA and representatives from the practices. A sum of £10,000 was made available each year to support the initiative.

As the prospect of an immediate return on the investment receded, the deputy general manager lost interest, and chairmanship of this group passed to a consultant in public health medicine. A regional adviser in general practice was co-opted. The group was active in linking project leads to registrars and senior registrars in the local public health directorate.

Plans for the future

Early on the authorities took the view that a decision on extending the programme should await results of the evaluation. Over time, as in Northumberland, COPC has come to be seen as one of a number of initiatives developing practices' need assessment and business planning capacities. A conference was organised to advertise these but there are currently no plans to extend the COPC programme.

Practices

Heeley Green

This four-doctor practice has a long-standing commitment to community development. This practice was well resourced with an extended team serving a mixed urban population.

COPC project aims: To improve the understanding of mental health problems in the community and lower the prevalence of depression in women aged 35–54 years.

A mental health and lifestyle survey was undertaken of women in the target age group. Two groups of female volunteers were trained in counselling skills and went on to offer support to anxious or depressed peers/neighbours. Focus groups involving members of the steering group, trainee counsellors and those receiving counselling provided strong and positive feedback.

The COPC project proved a useful vehicle for developing ideas that were already germinating in the team. This highly original project reflected the priorities of team members, their interest in mental health issues and a tradition of community participation. The key workers had successfully trained 14 volunteers after two years and remained enthusiastic about what had been achieved. The local community trust were also keen to support what they viewed as an imaginative project. However, the constraining disciplines of quantified evaluation were alien to the team. Large quantities of survey data were collected but not productively analysed. Long term follow-up appeared unlikely.

Birley

This five-doctor fundholding practice serves a deprived urban population. They too were regarded by the FHSA as providing services of high quality from new purpose-built-premises. They too had a history of community participation.

COPC project aims: To increase awareness of the risks of smoking across their community and to reduce the prevalence of smoking among women aged 15 to 25 years and men aged 45 to 55 years.

A questionnaire about smoking habits was sent to 1,035 people in the target group. This identified 127 new smokers. Stop-smoking clinics and a counselling service were established. Complete cessation has so far been documented in 17 smokers.

This busy practice came to COPC with a tradition of patient involvement. However, their more modest project made disappointing progress. The demands of fundholding and a variety of other ongoing initiatives consumed their energies. The team were nonetheless surprisingly positive about their COPC project possibly because the last two years had seen the practice developing in other ways. The lead nurse manager claimed that COPC had helped develop data gathering and analytical skills in several staff as well as those required to motivate smokers. The COPC principle of basing innovations on an assessment of health needs was now established at the practice.

Stocksbridge

This five-partner fundholding practice was less well known to the FHSA. They served a community under strain following closure of the local steel works.

COPC project aims: To reduce the prevalence of risk factors for stroke and ischaemic heart disease among patients aged 35 to 54 years.

A questionnaire was sent to all 2,883 patients in the target group. It was also administered by trained volunteers recruited from the practice population, 482 (36 per cent) of 1331 on whom data were collected were found to be at risk (Table 10). They were given detailed advice and supportive literature. Slimming and stop-smoking clinics were established, while other risk factors were managed according to agreed protocols.

Table 10 Stocksbridge results

	Male number	*%*	*Female number*	*%*	*Total number*	*%*
Eligible population	1448		1435		2883	
Patient who attended surgery	1228	77	1341	94	2469	86
Patients 'COPCed'	537	37	794	55	1331	46
Refusals	11	2	8	1	19	1.4
Employment Details						
Full time paid work	438	81.5	281	35.4	719	54
Part time paid work	11	2	291	36.6	302	22.7
Looking for work	43	8	28	3.5	71	5.3
Retired	7	1.3	12	1.5	19	1.4
Permanently sick/disabled	36	6.7	39	4.9	75	5.6
At home/family	0	0	139	17.5	139	10.4
Risk Factor Details						
Alcohol intake above recommended limit	107	19.9	59	7.4	166	12.5
CAGE score >2	29	5.4	31	3.9	60	4.5
BMI 30 or above	102	18.9	131	16.5	233	17.5
Cigarette smokers 1–5	15	2.8	38	4.8	53	4
Cigarette smokers 6–15	42	7.8	99	12.4	141	10.6
Cigarette smokers 16 or more	65	12.1	89	11.2	154	11.6
Cigarette smokers total	122	22.7	226	28.5	348	26.1
Cigars	25	4.6	1	0.1	26	1.9
Pipe tobacco	13	2.4	1	0.1	14	1.1
Blood pressure recorded	472	87.9	748	94.2	1220	91.6
Raised BP	16	2.9	15	1.8	31	2.3
Raised BP and smoker	2	0.4	4	0.5	6	0.5
Very high risk (Dundee Disk)	1	0.2	2	0.3	3	0.2
Negligible exercise	146	27.2	264	33.2	410	30.8
Good level of exercise	125	23.3	95	11.9	220	16.5

This practice faced much instability over the period of the project. Their project was ambitious but dovetailed subsequently with banding requirements. Much was learned from designing the intervention and from attempts to involve their patients. The disappointments were balanced by the creation of new links through their community volunteers. With the departure of the project's mainstay to train in public health, much momentum was lost. The project is likely to be subsumed within banding requirements but the database established allows for more detailed evaluation in future.

Winchester

Health authorities

DHA/FSHA relations

The Hampshire FHSA related to four DHAs of which two were approaching merger at the time of the workshop. Several managers faced uncertain futures.

Strategic commitment

The chief executive of North Hampshire Health Authority had strongly supported the initiative. He briefly attended the workshop but was to leave shortly afterwards. COPC was seen to synthesise a number of strategic priorities. Leadership passed to a DHA manager.

Operational support

A sum of £10,000 was secured in the month following the workshop to resource the projects on a recurrent basis over the first two years of the programme. An operational support group included DHA, FHSA and public health representatives but underwent constant change. None of the original members are still in post. Lead responsibility has changed three times. It now rests with a less senior primary care development manager, who has successfully secured the active involvement of a health promotion officer and public health specialist. Senior management support for the project is less visible.

This group has met quarterly and brought the practices together on a regular basis. They have nourished a general practitioner and health visitor as local champions and cultivated links with public health doctors, the local Institute of Public Health and the health promotion department.

Plans for the future

They feel that the practice projects have been sufficiently innovative and productive to justify expanding the programme. The COPC framework is seen as providing fundholders and locality commissioning groups with a valuable framework. Three local practices have participated in a second workshop.

Practices

Twyford

This five-doctor fundholding practice with a good reputation serves a predominantly middle-class commuter population.

COPC project aims: To reduce the incidence and prevalence of coronary heart disease through:

– full screening of males and females aged between 35 and 54 years;
– reducing the prevalence of smoking, raised blood pressure and serum cholesterol.

Limited information was available on the 3,139 people in the target group, for whom a new computer database was established. Patients were invited by telephone to evening clinics in Twyford and Colden Common surgeries held by the health visitor and practice nurse. Patients were managed according to protocols drawn up by the lead general practitioner.

After two years records had been entered on all but 355 patients (Table 11). Three hundred and forty-nine (11 per cent) patients had been newly worked up. The Dundee 'risk disk' identified 84 patients at high risk (score greater than 10 in patients with no family history; greater than 12 in those with a family history of heart disease).

Table 11 Twyford results

35–65 year olds	*Male*	*Female*	*Total*
All Groups	1583	1556	3139
Smokers			
1–10	113	95	209
11–20	116	90	206
21–30	23	20	43
31–40	10	3	13
41+	2	0	2
Total	264	209	473
Non-smokers	975	1151	2126
No record			355
smokers	224	122	346
blood pressure	140	58	198
Hypertensive	143	139	282
Hyperlipidaemia	11	1	12
Hypercholester	50	29	79
	61	30	91
Angina	39	15	54
Myocardial inf	43	5	48
C.A.B.G.	8	0	8
Angioplasty	5	0	5
	95	20	115
Peripheral Vasc	5	1	6
Diabetes Mellit	31	20	51

Having taken on a large project with little support from the rest of the team, all core group members felt over-burdened. But if COPC felt like an experience they did not wish to repeat, all agreed that the project had been worthwhile. Various indirect benefits had resulted. The health visitor felt she was now allowed much better access to patients. Both nurses had gained new skills, e.g. training in motivational interviewing. Data entry was greatly improved, and COPC had enhanced the data-handling skills of the general practitioners. The practice felt that they were doing much more than had been required under Band 3. *'The project is going to leave a lasting imprint on the practice.'* (GP) The health visitor, ever the most sceptical member of the team, admitted to having used COPC principles while investigating attendance rates for a group with which she was particularly concerned: women who had recently terminated a pregnancy.

Alresford

This five-partner non-fundholding practice serves a semi-rural population in and around the country town of Alresford. There is a strong correspondence between the practice population and the local community.

COPC project aims: To improve services for women in the practice with incontinence.

A baseline survey explored the prevalence of incontinence in the target group aged 40 to 49 years. 620 women (74.8 per cent) out of 1129 responded, of whom 12 per cent were incontinent. The team decided to address this newly identified need in two main ways. An educational initiative was launched from the practice to raise awareness of incontinence. A continence clinic was established at the practice following training for the lead health visitor. 86 women attended the continence clinic over the first six month of its operation of whom the majority benefited (Table 12).

This project highlighted the key role of a dynamic health visitor whose training well suited her to the COPC philosophy. She was equally comfortable working with antenatal women, talking about pelvic floors in secondary schools, or managing incontinence problems with the relevant advice and support.

Table 12 Alresford results

Diagnosis:	18 urge incontinence
	52 stress incontinence
	16 mixed
Intervention:	2 referred to gynaecologist
	8 referred to physio
	76 given advice/pelvic floor exercises/medication (11)
Results:	All benefited from advice
	41 discharged ('cured')
	32 significant improvements in symptoms
	13 little change

While COPC required a detailed problem assessment, the team felt that their survey was unnecessary. National data already existed on the prevalence of incontinence. Much time and energy were expended in designing, distributing and analysing the questionnaire for little new information. However, this exercise did build new skills in data analysis within the practice. *'All practices should have access to Epi info.'* (GP) The team were intermittently overwhelmed by the scale of possible unmet need. The evaluation of this service is ongoing, and they are not yet contemplating a new project. However, the core team remain enthusiastic advocates for COPC.

Stockbridge

This four-partner non-fundholding practice serves a relatively healthy rural population over a wide geographical area centring on the small town of Stockbridge.

COPC project aims: To reduce smoking prevalence in men and women aged 40 to 50 years.

A questionnaire on smoking was administered to 1085 patients (96 per cent coverage rate) in the target group over the following year. Individual and group counselling was offered to identified smokers. The practice nurse involved the community in various imaginative ways: publicised events on consecutive National No-Smoking Days, Valentine's Day pledges, a float at the town carnival, painting competitions in local schools and visits to pubs to gain agreement for the designation of no-smoking areas. A follow-up survey suggested that 31 patients had stopped smoking with a further 37 reducing their consumption (Table 13).

The project managers attributed their success to the whole-hearted commitment of the team, an emphasis on working in the community (*'You can't stay in your surgery and do* COPC. *You have to get out there.'* (GP)), disciplined project management, a range of marketing techniques and setting realistic aims. (*'We bit off something we felt we could chew'*. (Practice Nurse))

Table 13 Stocksbridge results

	Females	*Males*
Nos in target group surveyed at year one	373 (70% of total in target group)	406 (73%)
Non-smokers	267 (72% of nos surveyed)	262 (65%)
Smokers	87 (23%)	111 (27%)
Ex-smokers	19 (5%)	33 (8%)
Smokers surveyed at year two	73 (84% of smokers identified at year one)	70 (63%)
Stopped smoking	15 (17%)	16 (14%)
Smoked less	17 (20%)	20 (18%)

Having considered alcohol consumption, they finally chose the problems of menopausal women for their next COPC intervention. The team appeared genuinely enthusiastic about their success and were proud of their achievement in reducing smoking prevalence.

Enfield & Haringey

Health authorities

DHA/FHSA relations

At the time of the workshop, the FHSA was coterminous with two DHAs. Recent relationships were described by one manager as '*stormy*'. This wariness was evident at the workshop. The general manager of the FHSA had been appointed as shadow chief executive of a combined DHA in anticipation of the formation of a single health commission. She was widely admired but shortly to move. Health authority representation at the workshop was limited. The district fell into two distinct halves. All practices involved came from the more affluent west side of the borough.

Strategic commitment

The most vocal champions at the outset were from the public health department. Lead responsibility for the programme was to pass to a more junior planning officer in the FHSA. Alongside the strategic objectives, COPC was early on seen as providing a valuable tool in developing LIG funding initiatives.

Operational support

As on the other sites, little thought had been given as to how to meet requests for resources from the practices following the workshop. The organisational response was overly bureaucratic with two large committees (one strategic, one organisational) set up to oversee COPC. This was at least a tribute to the interest generated among several agencies, including the community trusts and local authority. A sum of £10,000 was made available to support the project.

After six months, the strategic support group had stopped meeting. A smaller operational group has continued to meet at regular intervals. Its membership has remained largely intact. With dynamic leadership from the original chairperson (now promoted to Director of Commissioning), this group has been productive. Public health and health promotion specialists are represented.

Plans for the future

A year after the first training, a follow-up workshop was held involving two practices from deprived parts of Haringey. COPC is set clearly within a strategic context. A further workshop involving three practices was held in mid-1995. The group has actively canvassed support from single-handed, less developed practices. COPC is providing a useful framework for various initiatives funded in the wake of the Tomlinson Report. A local GP champion has given visible support to the initiative.

Practices

Highgate

This eight-partner non-fundholding training practice serves 17,700 in this fashionable area of North London. The majority of the practice population are middle-class with a high proportion of elderly people.

COPC project aims: To increase cardiovascular risk factor recording in men aged 40 to 64 years.

A baseline assessment of 5,189 patients in the target group established that blood pressure measurement had been entered on the computer for only 2 per cent of this population. A concerted opportunistic screening campaign was undertaken that resulted in substantial increases in total coverage rates over the following two years (Table 14). Well-man and well-woman clinics were established.

Table 14 Highgate Results

	Numbers of 40–64 years old patients with BPs recorded and entered on computer	
	Male	*Female*
Nos aged 40–64	2985	2204
Recorded/Entered BP		
June 1992	56 (1.9%)	71 (3.2%)
Dec 1992	150 (5.0%)	218 (9.9%)
June 1993	465 (15.6%)	638 (28.9%)
Dec 1993	907 (30.4%)	1004 (45.6%)

Of all the pilot practices, the ethos in this practice was in many ways most alien to the public health principles underlying COPC. The project chosen was more closely akin to pure audit and stretched the definition of COPC to its limits. However, it underlined the importance of adequate computerisation as a prerequisite for COPC. Allowing the practice discretion over the choice of projects helped to ensure its success. Data entry and coverage rates were greatly increased. The results of internal audit, though threatening to some partners, were accepted and seen to be acted on. However, the project remained isolated. After two years, the assessment/planning principles upon which it was based had not entered deeply into the practice team's collective consciousness.

Dukes Avenue

This six-partner practice serves a similarly affluent and culturally diverse population in Muswell Hill. As a team they appeared demoralised in the face of the reforms.

COPC project aims: To reduce the incidence of ischaemic heart disease in the practice population by reducing levels of cardiovascular risk factors. They too were disconcerted by the lack of data they recorded. The target group of patients aged 40 and 50 years were recruited via cards sent on their 'milestone' birthday. They included an invitation to attend for screening. Eighty-four patients (31 per cent of those invited) have been

screened following their fortieth birthday and 74 (40 per cent) following their fiftieth birthday so far. Protocols for risk factor management were agreed. Evaluative semi-structured interviews conducted with a sample of 12 patients showed strong support for the scheme.

The project progressed slowly, hindered by the departure of the practice manager on maternity leave. This practice was among those that clearly indicated a desire that *'managers should keep their distance'* (GP). They resented attempts to monitor their progress. However, the team were surprised by their achievements. Despite initial reservations, the birthday cards were well received. This scheme was judged successful both as a means of attracting patients to health checks and in creating mutual goodwill. *'The birthday cards seemed a bit gimmicky to begin with but several people said how surprised they were and how much they appreciated them. As though we had taken the trouble.'* (Practice Nurse)

Following the evaluation, the practice was planning to continue the scheme but had no plans for further COPC initiatives. As a practice with a traditional, individualistic focus, the reforms have been viewed as threatening and destabilising. After two years, some of the gloom seemed to be lifting. One of the partners was actively involved in both local and national commissioning groups for non-fundholders.

Bounds Green

This young fundholding practice offers an exceptional range of services. They serve a culturally heterogeneous, predominantly middle-class list of 9,500.

COPC project aims: To reduce mean systolic blood pressure in men and women aged 45–49 years by 5mm of mercury over ten years. To increase the detection of asthma in children aged under five years in the practice.

Computer searches identified the proportion of patients in the respective target groups, on whom no details were available. A campaign to increase cardiovascular risk factor identification was initiated. A telephone survey and programme of targeted home visits was undertaken by the health visitor to identify children with wheezing histories. Re-audit at one year demonstrated an increase in risk factor coverage (Table 15). Fifty-one asthmatic children were newly identified.

After a painful, if cathartic, experience at the initial workshop, this practice was perhaps the most enthusiastic convert to the COPC cause. *'As a practice we were a philosophy in search of a name.'* (GP) As fundholders, they had greater scope to back their ideas with their own resources. As a strong team, they benefited from exceptional practice management and an imaginative, idealistic lead doctor. They were able to break through the confines of the COPC model and apply the principles to a multitude of other projects. The team moved on to establish new services to meet other identified needs: among mothers and toddlers, the newly bereaved, elderly people and adolescents.

Table 15 Bounds Green results

1. BP Programme

Baseline

June 1993	Age 40–75	No BP recorded in last 3yrs	No consultation recorded in last 3 yrs
Women	1443	452 (31%)	203 (14%)
Men	1621	825 (51%)	591 (36%)
	Total coverage	1787 (58%)	

Intervention

(1) BP clinic for known hypertensive patients

Dietician
Exercise
Yoga
Smoking
Drugs

(2) Contact Tracting: Non Attenders (794)

Letters
Phone call from PN
Home visit

(3) Increased vigilance with opportunistic screening by whole team.
483 patients contacted and BP recorded

June 1994

Total coverage 2270 (74%)

2. Asthma programme

	Practice prevalence	National prevalence
1. Asthma register	children 4% adults 3.3%	15% 7.8%
2.Searched: prescribed bronchodilators in last 2 years	children 9% adults 5%	
3. 10% survey random sample practice	(920)	556 – Postal questionnaire 364 – Telephoned
Postal Q Telephone	– 139 (25%) } – 296 (81%) }	children – 22 (16%) adults – 29(10%) 51 new asthmatics identified

Intervention

Asthma Clinic – GP + Nurse (x4)

Outreach / Contact
Tracing of all children

Table 16 Staging criteria for COPC projects

Practices	*1 Defining and characterising the practice population*	*2 Identifying community health problems*	*3 Choosing a project*	*4 Detailed problem assessment*	*5 Implementation*	*6 Evaluation*	*Total*
1 Haltwhistle	2	2	1	0	1	3	9
2 Prudhoe	4	3	3	4	4	2	20
3 Heeley Green	3	2	4	4	4	1	18
4 Birley Moor	3	3	2	3	3	1	15
5 Stocksbridge	3	3	2	3	3	2	16
6 Twyford	3	3	2	3	3	3	17
7 Alresford	3	2	2	4	3	3	17
8 Stockbridge	3	2	3	4	4	3	19
9 Highgate-	2	2	3	3	1	1	12
10 Dukes Ave	3	3	2	3	2	2	15
11 Bounds Green	3	4	3	4	4	2	20
Mean Score	32	29	27	35	32	23	16

Outcomes

In terms of the staging criteria described in Chapter 4, the progress of most practices' COPC projects conformed to a similar pattern (Table 16). After a partial attempt to define and characterise the practice population (often for the first time), practice teams identified health problems in ways that stopped short of direct consultation with the community.

There was a heavy reliance on consensus among the team members ('brainstorming'), assisted by extrapolation from sources of secondary data.

Choice of project usually involved formal prioritisation within a team representing at least three professional disciplines. Most successful teams shared this with other members on return to the practice but again there was little consultation with patient representatives.

Detailed problem assessment was the stage for which team scored most highly. Teams expended much energy on data collection usually in ways that directly involved their target population.

The remaining phases tend to be less successfully executed. Modified programmes to address specific problems were established in most cases, though the imperatives of the banding scheme were part of the reason for this in six cases.

The main problem from both teams' and authorities' point of view was the delay in establishing these services, itself the result of the unexpectedly long time taken to complete earlier stages. Consequently, the evaluation stage was the least comprehensively completed, with many teams' assessment based on objective impressions and extrapolation from other similar studies.

Table 17 Summary of patient-related outcomes

Practices	*Outcomes*
1. Haltwhistle	Increased coverage of cardiovascular risks factors in age group 25–74 yrs by 950 (21%). 223 newly identified smokers, 81 hypertensives. Stop-smoking clinic established.
2. Prudhoe	Increased coverage of cardiovascular risks factors (247 screened). Newly identified smokers (58), hypertensives (38), patients with raised serum cholesterol (88 borderline, 28 high), and heavy drinkers (15).
3. Heeley Green	Trained 14 community counsellors. Counselling/advice given to more than 100 patients.
4. Birley Moor	127 newly identified smokers, cessation documented in 17. Stop-smoking clinic and individual counselling for smokers established.
5. Stocksbridge	1331 patients newly screened. Newly identified smokers (348), hypertensives (31), moderate/heavy drinkers (166).
6. Alresford	Practice-based continence service established. 86 women treated.
7. Twyford	264 people screened. 127 patients with risks factors newly identified.
8. Stockbridge	779 (70.6%) patients aged between 40 and 50 years surveyed regarding smoking habits with follow-up at 1 year. Cessation documented in 31.
9. Highgate	Recorded screening coverage increased by 851 (28.5%) for males and 933 (42.3%) for females aged 40–64 years.
10. Dukes Avenue	80 (31% of those invited) patients screened on their 40th birthday and 74 (40%) on their 50th birthday.
11. Bounds Green	51 new patients with asthma identified via postal questionnaire and telephone survey. 483 patients blood pressure newly measured. New services for the bereaved, mother and toddlers, elderly, adolescents.

Patient-related outcomes of the eleven COPC projects are summarised in Table 17. In the practices focusing on coronary heart disease, these commonly amounted to increases in risk factor coverage and the identification of new smokers, people with hypertension and raised serum cholesterol. The question remains as to whether or not such benefits would have accrued anyway with the advent of Band 3. Participants were adamant that the quality of their data collection and monitoring of the impact of interventions was higher than the minimum required to meet banding criteria.

In five practices, new services were established. These have been sustained thus far. The long-term impact of a practice-based continence service and community counselling is, of course, difficult to assess. All practices reported benefits in terms of the following:

Closer integration within the team

One of the big payoffs from COPC, which seems to be a recurrent feature, brought up by the people who have participated in it, is the improvement in the interdisciplinary working within the practice, which obviously is a very positive thing, and to be encouraged. People started talking to one another and having shared perceptions. (PHP)

The thing is, there's such a wealth of skills in this building. It's working as a team and deciding which skills are most appropriate for the needs that have been identified. (Health Visitor)

I think the good things are that it makes you much more aware of people in the team and their difficulties ... you know it's very easy for doctors to say 'This is what we are going to do' and to actually forget how much it involves other people. (GP)

We were very enthusiastic: the fact of getting together with other members of the team and spending some time problem-solving about the practice and realising that we do think in the same way and we've got a variety of skills. (Practice Manager)

I think perhaps the biggest thing it's done is given us an insight into what other people actually do. (District Nurse)

There was a widespread view that integrated teams are necessary for primary care to have an increasing role in the prevention of illness.

As more preventive care in particular comes in, one is gradually moving away from a very strongly medical model to more interdisciplinary forms of care. Obviously the kind of thinking and the kind of co-operation that has developed in COPC and the fact that it's not only the medical view that is valued I think points in the right direction. (PHP)

Health visitors were especially likely to value the combination of COPC and an integrated team in meeting the needs of communities.

To encourage team co-operation. That's the whole core of it. Working as a team and recognising the skills that are in the team. What I find COPC has done is we have not only been able to incorporate the health visitors. It's all primary health care team members that are involved in part of it. It's one thing us being able to identify needs from a health visiting aspect, but unless you collaborate and co-operate as a team and you have a common aim then you may have to stop. (Health Visitor)

Improved communication within the team

The multi-disciplinary meetings for work on their COPC project offered an opportunity to cross professional boundaries.

> *I've got to know people in the team a lot more than perhaps I would have done. The meetings about* COPC, *because they were only small, you got to know people quite well.* (District Nurse)

The practices came to COPC at different stages of development as teams. After two years the teams which had progressed furthest were those that were most developed as teams to begin with. But, even for practices that already worked well together, the workshops were revealing:

> *I'm sure the initial meeting ... did actually gel quite a lot of relationships and make us work better together ... I think it has certainly cemented relationships between health visitors and the rest of the team ... they may have been a bit more out on a limb previously.* (GP)

Those practices with a history of good team relations questioned what they felt had been the *'prescribed conduct'* of COPC with its insistence that group involvement be maintained throughout.

> *It seems to involve so many meetings. We discuss it a lot. How you get the right mix of people on these, or how people meet informally.* (Practice Nurse)

Over the two years following the workshop, one of the teams which prided itself on its democratic ethos underwent a traumatic reappraisal of its ideology.

> *There has definitely been a shift ... a change in the way that decisions are made. Something that we have been demanding for a long time was an admission that actually the power was with the doctors.* (Practice Nurse)

One outcome of this upheaval was a shift towards smaller meetings.

> *The weekly meeting was kind of sacrosanct. But now it's really being thought that maybe it's a waste of valuable time for everybody to meet on a Tuesday, which would not have been accepted before ... We are a lot more realistic about what we can achieve as a team, in the sense of co-operative working. I think we had ideals of a co-operative which we don't have any more. It's too difficult in the current climate.* (Counsellor)

Teams have had to learn how to apply this in their own teams. Some have learned to distinguish between the value of large meetings where contributions are made by people with a wide range of opinions and smaller meetings where it may be easier to make decisions. As a result there was a natural evolution in the meetings as the project progressed and needs changed.

We had some of those meetings, we must have had 12, 13, 14 people there. It was good. Everyone was doing the work and talking together and mixed groups and disciplines. But I think it's very difficult to actually make decisions as to how you're going to do things. (GP)

My reservations are really because I think that the way COPC is sold is that by definition it is everybody. And that side of it hasn't really taken off here. That was what made me very enthusiastic when I was first involved with it. I think also, to be honest, there's a lot of apathy because there's so much on anyway ... When things are hard, you don't want any extra work on your plate. (GP)

Increased understanding of public health

That's our perspective all the time, to worry about equity and how we improve access to services, take a population view. Before we tended to take an individual perspective all the time. (Practice Manager)

Managers as well as team members felt that what the practices had learned about needs assessment had been useful:

In the first instance, it's shown us the work involved in getting GPs involved in needs assessment. So that is useful. It's useful to know how much they don't know about public health issues or about what other community staff do, and what data they collect. More importantly, it's been useful being able to offer something to practices who are interested in terms of a framework for linking their work to needs assessment. It's been useful when thinking about what needs assessment should look like in primary care. (FHSA/PH)

However, not all COPC participants came to terms with the role of public health, some retained a prejudice against what seemed too theoretical an approach.

One can't assume that clinicians want to take a population-based view all the time. I think it's reasonable to assume that they don't. (PHP)

They view it with suspicion ... COPC in the practice now means sort of rather ... not out of touch with reality, but it's something separate from our day to day work. Not at all pragmatic. I think they're happy for the nurses to do it. I think that they feel that it's a high-falutin idea that comes from people who have their head in the clouds, who have no real idea what it's like on the ground. (GP)

Increased respect for health visitors

COPC allowed health visitors to give expression to their particular skills and find an outlet that was appropriate for their public health orientation, their training in needs assessment and health promotion.

Because that's our role to identify health needs and to stimulate an awareness in the community. Those are the principles of health visiting, so we're trained to do that ... we've got to think about what is happening throughout the city all the time and wherever the work is. (Health Visitor)

Increased skill in the use of information technology

It has happened through COPC. *My interest in computers is something that I have to constantly tame in a sense because I feel there's a great tendency that it will draw me away from clinical things.* (GP)

COPC *gave us the opportunity of really thinking about how we recorded things.* (Practice Manager)

COPC *focused our attention on the important information that [the computer] would hold ... and we were able to use it in a way that might not have been that obvious to us initially.* (GP)

I think, having had the COPC *training, it's given me more confidence and drive to do things with the computer.* (GP)

One result of the increased acceptance of computers, including the improved level of data entry, was that practices began to enjoy doing searches to instigate a variety of audit procedures.

So all of a sudden it happened ... what it showed was that we can have the freedom actually to look at things we want to look at and do ourselves, and it doesn't have to be something the Department of Health has said from on high. (GP)

I certainly feel that putting information on the computer is vital, it's necessary to audit the data that we collect. (Practice Nurse)

COPC helped expose difficulties with data entry and analysis. For example, one practice took a long time to complete an analysis. This was partly due to the insistence by the doctor involved that he wanted to work it out himself, rather than invite in help from the public health department.

When I sit and think about it, I wonder why it's taken so long ... We were taught how to use Epi-info, and I think we have the tools that we needed from that. What it needed was somebody, and it ended up being me, actually sitting down and playing with it.

I think if I'd got some help, and there were certain stages where I seemed to get blocked, if I'd rung someone up or if someone had come to the building, they might have done it very quickly. But in fact I've learned a lot myself by just sitting down and playing with it. (GP)

Certain types of data are difficult to classify for the computer.

We can put occupations on the computer. But you have to put each occupation on yourself. It's not classified in any systematic form. What we couldn't measure, we couldn't put on the form. (GP)

Similarly, the computer was found wanting in the practice trying to measure psychiatric morbidity.

The Read codes are just so crude ... for mental illness or anything. You can get nothing out of it really ... stress, depression and psychosis as far as I can see. And none of those describes the work we do, I think. (GP)

COPC helped some participants understand for the first time why systematic data collection is important for patients:

A lot of our activity needs immediate feedback so it can influence behaviour. Because if you don't feed it back you get stuck in a behaviour pattern. That to me was the central, most important thing from COPC. The simple thing is, if you give information to people, they naturally will change their behaviour, provided that information is put in a way that's easily accessible. A very good example is the PACT data. There is no financial advantage in prescribing generically and yet as soon as PACT came in, and fed back doctor by doctor what their generic prescribing was, it has increased month by month in proportion. (GP)

Similarly, they learned that the laborious feedback of data to public health departments can produce reports which are relevant to them.

We've just got our own personal feedback from the national morbidity survey in 1991. How this practice compares with the rest of the country. And, interestingly enough, in the area that we are looking at in the COPC project, our consultation rate for people with mental illness that isn't psychosis is five times the national average. So we are doing something here about attracting the sort of people that ... It means that the COPC project is aimed at something that is a real issue here. (GP)

COPC, by helping people to be involved in decisions about how they used computers, overcame deep-seated prejudices.

I really think if we hadn't done the COPC project we wouldn't have got the terminals in, and they wouldn't be using it at all ... there were three out of our six partners who were very resistant and I never thought we would get them even switching it on. Now two of those three are converts. (Practice Manager)

Adding value to health promotion

Practices feel ownership of COPC. They don't feel any loyalty or commitment to banding. They are doing it because it's a hoop to jump through to earn money. I think in our area it's not been ever regarded as a positive thing to be doing. (FHSA Manager)

The recent history of contractual changes has left both PHCTs and FHSAs uncertain as to the value of the banding scheme. COPC was seen as a 'bottom-up' incentive and more valid for that reason.

In one practice key birthdays were chosen for targeting screening in their COPC project. Having limited this to patients aged 40 and 50 years they hope to improve awareness among those patients at risk of CHD as the programme progresses and new patients enter the target group.

> *I think that the idea of just checking people every three years willy-nilly is a total waste of time. But I think that in the ages that we have picked, 40 and 50, they coincide with the onset of illnesses, people being concerned about their health, so I think there is definitely a point in picking people at those two particular ages.* (GP)

With guidance from their local public health department, they constructed a questionnaire which would obtain all the information they felt they required. This went beyond the requirements of Band 3.

> *We're trying to record much more about interventions for* COPC. *We're trying to document that we have offered dietary advice, smoking cessation advice, advice about exercise ... whereas for the health screen, that's much scaled down.* (Practice Nurse)

COPC was felt to have greater potential for adjustment than the more rigid banding scheme. A focus on local priorities was recognised as necessary and could be mediated by COPC.

> *One wants to start by looking at health promotion and saying, 'Well, is it of any value at all? Is it of any local interest and, if so, what are the limitations and how could it be improved in the future?'* (PHP)

Increased contact with health authority staff

> *I am aware of* GPs *actually talking to the health authority in various different ways that didn't exist at the time of* COPC *... I think between* GPs *and purchasers there is better communication. Different sorts of things going on that weren't going on then, and I think that's going on in parallel with* COPC. (PHP)

> *I also think that the FHSA is changing. Whereas perhaps in the past they were seen as being just a nuisance and enforcers, now much more they are trying to put across that they are there to help. And they've got facilitators who are there to advise.* (Practice Manager)

But, as health authorities regroup, there continues to be fear and lack of clarity about future arrangements:

> *Our relations with the DHA have changed enormously just because the DHA have changed enormously ... Before no one ever knew what the department of public health*

did the whole time. Now we feel that they send us orders ... 'Thou can and cannot' ... the FHSA feels like it's about to be subsumed in this joint commission, and it's about to be caught between the health authority and the FHSA, and we're worried about what effect that will have, because in a way we have always felt that the FHSA have to an extent fought our corner. (GP)

Some FHSA managers saw COPC as a vehicle for tighter control over practice development.

We will argue that every practice should be basing its proposals, basing its plans and activities on the needs of its patients ... COPC, I suppose, is the right framework to help them do that, although it's a fuzzy framework. (FHSA Manager)

This attitude created problems with public health departments where, having introduced and supported COPC, they were still leading the enterprise.

I think we tended to agree it was a public health initiative and that they should lead it, whatever that meant. I still feel we should have led it, with the public health department as advisers to us as purchasers of health care ... P [PHP] felt I was being too managerial about it all. He felt 'Here. You can't demand to have reports done by a certain time' ... all this kind of thing. And I say 'Yes I can, because I won't give them any money unless they do' and that's the way we work here. I mean, if I'm going to give this amount of money to COPC, I want in return evidence that the work is going on. (FHSA Manager)

But this managerial style was unacceptable in other places.

Managerial roles and GPs don't really go together very well. I mean you can't insist on anything. You can negotiate. I think we are being encouraged to have a standard approach by our members because they feel that's what is required but ... It would be good to say, 'You come on this course before you get this', but actually you also have to abide by the Red Book, and there's not much in the Red Book you can hold them to. We don't really want to be regarded as a policing authority, we'd rather be regarded as an enabling organisation. Although I think some GPs like to hate us. It suits them to have an enemy. (FHSA Manager)

Increased sense of autonomy

I think the main effect of this government, the changes, has been that we have less control over what we do, and the effect of that is that it makes us – it makes me – feel more helpless. I've gone on the commissioning thing because I want to try and affect things a bit and say what I think is right and wrong. Because I think what a lot of doctors do is they sort of cave in and they do the minimum. COPC is trying to get back a bit of that control. (GP)

Two fundholding teams were among the most active in terms of change and involvement in new projects – for various reasons. The first was their direct control over resources. They were able to redistribute their workload, sometimes in revolutionary ways in comparison to non-fundholders.

One reason why we went fundholding was so we could shift one budget to another to pay for our staff. It [the reallocation formula] affects us in as much as there will be capitation for a start, so we might lose thousands of pounds because we're very top heavy on staff. But we can actually move our budget ... what we save on drugs we can use to pay our staff ... That was the ideology behind going fundholding anyway, to keep the team together because otherwise you're going to be sacking people and we couldn't. (GP)

Related to this increased control over the team is greater integration between practice and community staff. This allowed the adaptation of work patterns to meet the perceived needs of the practice population.

The nice thing that has happened with fundholding is that we have had a lot more involvement from attached staff: the district nurses and the health visitors. They're much more involved and it feels much more part of the team. Although they're employed by the health authority, their work and their objectives have been encouraged to be part of our practice plans. (Practice Manager)

This flexibility facilitated COPC activities.

It helps being fundholding if only because you can then say, 'Well OK, I'll get my community nurses to do this bit of data collection and do this intervention', and you've got more direct control over what your team does. And you can link it to business planning and you can say, 'Now we've discovered diabetes is a big problem, we can do this' ... and you can decide on how to do it. (FHSA Manager)

For all these benefits the question of attribution arises. Many other changes will have taken place in these teams over the duration of the project.

It's difficult to say whether we would have developed as a team as cohesively as we have done if COPC hadn't been there, because we don't know. It was there and it happened at a very crucial time within the development of what's been happening over the last few years. Because the movements that have been made have all come together. The fact that we've moved here, the fundholding, the fact that we've changed management and COPC, they've all happened together. It's difficult to say they've happened because of COPC, but certainly COPC has done no harm, it's enhanced the team. (Health Visitor)

Finally, as evidence of occasionally dramatic impact, three staff attributed major career changes to interest generated through COPC. Two general practitioners left their practices to embark on training in public health while one FHSA manager began an MSc in community medicine.

Summary

Health authorities varied in terms of their ability and willingness to support and foster COPC. Two of the four health commissions are committed to expanding their programmes. Practices derived benefit from participating in COPC. In all eleven practices, evidence of health gains for some patients were obtained. Two practices were embarking on new projects.

Chapter 6

Generalisability

This chapter is divided into two sections. The first considers factors hindering and facilitating expansion of COPC projects on health authority sites. Thus far, 'roll-out' has been limited.

The second section examines the costs of the pilot project. Many of the developmental costs were non-recurrent and would not therefore be borne on new sites. Using two completed projects, an attempt has been made to price benefits to patients. This gives a broad indication of the likely costs of mounting a local programme to interested purchasers.

Expansion

Two of the four sites decided to expand the programme on the basis of the experiences of their pilot practices. Factors affecting these decisions and subsequent experience are considered for each site in turn.

Northumberland

A combination of the departure of the leading managerial champion of COPC, the scale of the projected costs of expansion and the limited enthusiasm of pilot teams decided the medical adviser against large scale expansion. Northumberland Health already have several initiatives under way which are seen as addressing the same developmental imperatives.

The awkward problem of how to handle the existing COPC projects remains. The Prudhoe team are dispirited at the lack of interest that has been shown. The Health Commission hope that the learning will be re-invested in their participation in the new locality commissioning group.

Sheffield

A similar combination of factors decided the future of the programme here. A more determined effort was made to provide co-ordinated support with the establishment of a steering group. The public health directorate made greater efforts here than on any other site to provide dedicated support to projects. Their lead was viewed negatively by key managers within the organisation. Their antipathy and unwillingness to provide further funding was significant. The projects were not seen as providing early 'value for money'. As in Northumberland, other local initiatives were seen as covering much the same ground as COPC. In Sheffield, the interest generated by fundholding and the direct incentives this provided for more imaginative resource management in primary care were of far greater interest.

Winchester

The decision to extend the COPC programme on this site can be attributed to many factors. Though leadership of the steering group frequently changed, it came to rest with an enthusiastic manager with a feel for 'hands-on' developmental work with practices. She made key changes to membership of the group that reflected her interests. These included drafting in an enthusiastic and experienced trainer, a public health doctor with a special interest working in the primary care directorate and champions from one of the more successful pilot practices. Four members of the group attended a 'Training the Trainers' workshop at the King's Fund College in 1994. They made what they felt to be essential adaptations to the workshop schedule. In the words of the GP involved, they wanted to 'free up the programme with less emphasis on some of the technical bits to try and ensure that practices did not get too bogged down with very detailed plans or too much data collection'. This meant jettisoning some of the epidemiological theory and adopting a less disciplined approach to the detailed problem assessment. This allowed some shortening of the programme. The training was led by the two PHCT members. It remains to be seen how this will affect the progress of the three new practices.

A further factor differentiating the Winchester site was attention to regular six-monthly follow-up. At these afternoon workshops, teams presented progress updates and mapped out the future. These were important as a means of sharing experience, injecting new ideas and monitoring activity in an unthreatening way. They also provided a natural entry point for new teams. A concrete introduction to the practicalities of COPC was more effective than theory on the page or from the mouths of FHSA managers.

In addition to flexible adaptation of the training module, the steering group has ensured much greater clarity regarding the support that new PHCTs can expect. Following the pre-workshop visit, they will receive three follow-up visits from their local facilitator and sums not exceeding £2,000 to cover additional project expenses. Though places on this workshop were offered to all practices, some care went into the choice of participants. The new practices include a fundholding practice at the centre of the Andover Multi-Fund to which the Commission is keen to lend support.

Enfield & Haringey

The last of the pilot sites to receive training, it was the first to expand the programme. Many of the same determinants were influential.

The COPC support group was ably co-ordinated by a manager with practical experience of primary care development. The group was led from the FHSA. Against a background of much change in the parent authorities, the support group managed to remain reasonably stable in terms of membership. Public health support was enlisted but little used. The lead manager herself undertook a Master's degree in public health during the period of the pilot project and was therefore able to use this expertise. In particular, COPC has been set in a strategic context alongside other initiatives to develop needs assessment in primary care.

The progress of local projects as elsewhere has been mixed and again not all participants retained interest in COPC. However, one local GP has lent visible support. The team have been flexible in their choice of practices for a second and third wave of training encouraging both well-developed fundholders and single-handed practices to participate. The desire to use COPC to address the problems of underdeveloped practices was strong. Finally, the group has benefited from facing fewer financial constraints. The availability of Tomlinson monies over which the lead manager had discretionary control relieved some of the problems faced on other sites.

Factors facilitating and inhibiting expansion are summarised in the following chapter. Decisions on extending the programme seemed to hinge largely on the momentum gathered by a local steering group. Where commitment to the group was sustained and where leadership was enthusiastic, the decision on roll out seemed almost to 'take itself'.

Costs and cost-effectiveness

Detailed information was collected on the costs of COPC from two practices in two geographical sites, and on the costs of two health commissions and the national support required to implement the programme in these practices. Data were also collected on the health priorities identified in the epidemiological assessment undertaken by each practice, and the size of the population at which the intervention was targeted. By reference to other cost-effectiveness studies published in these areas, it was then possible to assess the amount of health-related change that each COPC project would have had to achieve in order to attain a level of cost-effectiveness broadly comparable with other accepted health interventions.

Results

Table 18 summarises costs attributable to the COPC projects considered in this evaluation. Total costs incurred by the King's Fund were £76,972, but only one-third of the costs associated with the preparation of training materials, and two thirds of other project start-up staff time, were allocated to the eleven practices. Thus King's Fund expenditure related to the eleven practices was £60,708, or £5519 per practice.

Next, the table shows expenditure by each of the relevant DHAs/FHSAs. Taking an example, Winchester Health Commission spent a total of £8620 on COPC, and these costs were allocated equally between the three primary health care teams in that area: £2873 per PHCT.

The table next shows expenditure directly by each PHCT, and then the total costs attributable to that PHCT including King's Fund and DHA/FHSA expenditure. Pursuing the example of the PHCTs in the Winchester area, one spent a total of £6505 directly, but the additional allocation of expenditures by the King's Fund and DHAs/FHSAs brings this total to £14,898.

Table 18 Costs of COPC at national, district and practice levels

Agency	*Costs of project start up (£)*	*Workshop costs (£)*	*Post-workshop maintenance costs (£)*	*Total costs (£)*
King's Fund: total	27,890	23,154	25,928	76,972
King's Fund: allocated to 11 practices	11,626	23,154	25,928	60,708
Winchester HC: total	1490	4130	3000	8620
Winchester HC cost per practice	497	1377	1000	2873
Stockbridge PHCT	372	2650	3483	6505
Stockbridge, including KF & HC costs	1926	6132	6840	14,898
Alresford PHCT	60	35	5387	5482
Alresford, including KF & HC costs	1614	3517	8744	13874
Enfield & Haringey HC: total	2503	14,850	21,181	38,534
Enfield & Haringey HC cost per practice	834	4950	7060	12,845
Bounds Green PHCT	30	20	17,902	17,952
Bounds Green, including KF & HC costs	1921	7075	27,319	36,316
Dukes Avenue PHCT	7082	350	11,880	19,312
Dukes Avenue, including KF & HC costs	8973	7405	21,297	37,675
Average direct expenditure per PHCT	1886	764	9663	12,313
King's Fund costs per practice	1057	2105	2357	5519
Health Commission/FHSA costs per practice	666	3163	4030	7859
Average total expenditure PHCT	3609	6032	16,050	25,691

Finally, the table shows expenditure on community-oriented primary care averaged across the primary health care teams included in the evaluation. On average, each PHCT spent £1886 on project start-up activities, £764 on workshops, and £9663 on post-workshop maintenance costs associated with their COPC projects, a total of £12,313 per practice. When King's Fund and DHA/FHSA expenditures are added, these figures increase to £3609 on project start-up, £6032 on workshops, and £16,050 on post-workshop maintenance costs, a total of £25,691 per practice.

As noted earlier, it is difficult to quantify the health impact of such activities, but it is possible to estimate the impact such data would need to have in order to be cost-effective. To do this, existing cost-effectiveness studies were identified in the areas in which COPC interventions were aimed: smoking reduction and heart disease.

Table 19 summarises cost-effectiveness studies under each of these headings (Cummings *et al.* 1989, Oster *et al.* 1986, Williams 1987, Cantor *et al.* 1985, Cretin 1977, Kinosian & Eisenberg 1988, Kristiansen *et al.* 1991, Nissinen *et al.* 1986). Three studies are listed where the objective was to get people to quit smoking by means of educational interventions and a nicotine gum adjunct. The average cost per life year gained across these three studies was £1753. A further seven studies are listed where some form of educational intervention was used to lower risk factors for heart disease. Across these studies, the average cost per life year gained was £4999.

Taking the smoking example first, if a primary health care practice spends an average of £25,691 on improving ways of combatting cigarette smoking, then by averting the loss

Table 19 Selected cost-effectiveness results from previous studies

Cost-effectiveness register number	*Intervention*	*Target group*	*Cost per life-year gained*
Educational interventions aimed at smoking cessation			
Cummings *et al.* 1989 (40)	Cost-effectiveness of counselling smokers to quit	m 45–50	683
Oster *et al.* 1986 (143)	Cost-effectiveness of nicotine gum as adjunct to physician's advice to stop smoking	m 60–64	4326 (mid-range estimate)
Williams 1987 (208)	Opportunistic advice by GP to people aged over 40 to quit smoking	40+	250
Educational interventions aimed at heart diseases			
Cantor *et al.* 1985 (29(2))	Use of exit interviews and small group discussions to assist hypertensive compliance		697
Cretin 1997 (39(3))	Screening of serum cholesterol in 10-year old children and selective dietary therapy	10+	3957
Kinosian & Eisenberg 1988 (112(2))	Oat bran to asymptomatic men to reduce serum cholesterol	m 48	8110
Kristiansen *et al.* 1991 (121(1))	Population based promotion of healthier eating habits	m 40–49	13
Kristiansen *et al.* 1991 (121(2))	Generic dietary treatment to reduce total serum cholesterol	m 40–49	13606
Nissinen *et al.* 1986 (139)	Opportunistic screening to reduce hypertension	35–65	8405
SMAC 1990 (175(2))	Opportunistic screening of GP attenders, testing of serum cholesterol and dietary advice	40–69	207

of (25,691/1753=) 15 life years, the programme would attain a level of cost-effectiveness comparable with other interventions in this area. If smoking reduces life expectancy on average by four years (Cummings *et al.* 1989), then each project would have to result in at least four smokers quitting. The practices completing the COPC cycle recorded larger numbers of smokers quitting.

Turning to heart disease, by the same logic, if a community oriented primary care project involves expenditure of £25,691 on improving ways of combatting heart disease, then by averting the loss of (25,691/4999 =) 5 life years, the programme's cost-effectiveness would be broadly comparable with other interventions in this area. This would equate with perhaps one premature death being averted (SMAC 1990).

In both instances the levels of cost-effectiveness against which the COPC projects are being assessed are in fact substantially better than 'average'. One recently published cost-effectiveness 'league table' suggested that interventions attaining a cost-effectiveness level of less than £7500 could be considered highly cost-effective (DoH 1991).

Implications

On average, £25,691 was spent directly or in support of each practice. Putting this cost estimate alongside information on the cost-effectiveness of a range of other interventions offered by the NHS, the health gain that each project would have to yield to be considered cost-effective is very low.

Within this framework, decision-makers can at least consider whether these required levels of effectiveness are plausible, or whether other uses of the resources would yield more health benefits. For example, £25,691 would enable a physiotherapist to be employed, which might yield more health benefit and therefore improved cost-effectiveness.

The costs of COPC can also be viewed in the context of fundholding. No attempt has yet been made to subject fundholding to rigorous economic evaluation but the standard fundholding management allowance starts at approximately £37,000 – well in excess of the costs identified in this study.

Summary

On all sites, the impact of COPC at an authority level was difficult to assess. Attempts to expand the programme where circumstances allowed have so far been piecemeal. It is too early to say how successful they will be. The economic evaluation was reassuring although it confirmed what is already known: simple preventive interventions are highly cost-beneficial.

Chapter 7

The balance sheet

In this chapter the main findings are summarised. The COPC pilot programme has not realised all the aspirations of the original participants but significant partial successes have been achieved.

Successes

COPC as an educational process

Some teams learned enough about basic epidemiological principles to apply these to other problems. In that PHCTs participating in COPC projects are now receiving better training, the evaluation may underestimate the impact of COPC.

For some participants, the epidemiological principles were new learning; for others, the rediscovery of long-buried facts. Individuals taking a direct lead did learn new skills, such as in the use of statistical packages to enter and analyse data, in the design of questionnaires, in motivational interviewing, in other behavioural change techniques or in more specialised areas (e.g. the management of incontinence). '*Those of us who put most in, got most out*'.' (HV) COPC also broadened understanding of the nature of commissioning.

However, signs of the application of COPC principles to other problems were present to different degrees in different practices. At one extreme, one practice was using the language of COPC as a starting point in all team discussions about new projects and priorities; at the other extreme, the passage of time seemed rapidly to be erasing any consciousness of COPC.

New learning for health authorities

For health authority staff involved, COPC increased their understanding of primary care. In limited respects COPC projects did inform purchasing. The technical complexities and limitations of practice information were better understood. The achievements of practices tackling ischaemic heart disease were used to help practices struggling with the requirements of Band 3.

The two more innovative projects attracted much attention and support from managers responsible for purchasing community continence and mental health services.

Projects did not deliver the information that health authorities thought they wanted for contracting purposes but commissioning is about managing relationships. COPC enhanced relations with public health doctors and managers with responsibility for service development. Health authority staff exploited new personal contacts to fill places on planning groups/committees or for ad hoc views on particular purchasing decisions or service developments.

Improved teamworking

Many participants were surprisingly ignorant of one another's roles, expertise and special knowledge. Participants clearly derived benefit from new opportunities to work together on patient-centred tasks. In most teams, core groups managed to maintain some links following the workshop. Several practices established regular team meetings following the workshops, some for the first time.

A planning framework

In two entrepreneurial practices, COPC provided a framework for all new initiatives. Both these practices were fundholders. For non-fundholders, COPC provided a means of setting health promotion priorities.

Health gains

Quantitative evidence had been obtained by early 1995 in all practices (Table 17, on p.48). COPC projects yielded benefits to patients in terms of changes in risk factor prevalence. Other benefits were more difficult to measure. These were both direct (e.g. the impact of community-based health promotion activity or specific clinics on individuals outside the target age range) and indirect (e.g. the value of establishing protocols and improved information systems). Several interviewees drew attention to positive feedback from patients. For example, at Dukes Avenue, patients had been impressed by the personal touch of a birthday card. Similarly, the Heeley Green counselling initiative had changed patients' perceptions of the practice as a whole.

A recurrent theme across all practices as their projects unfolded was the tension between the supposed rigour of the COPC model and their own pragmatism. This was most evident at two stages: the detailed problem assessment and evaluation. These two stages are linked with the former providing baseline data for the latter. The need for painstaking data collection was emphasised at the workshops. By contrast, several practices felt that in retrospect too much energy had been dissipated collecting information (for example, on smoking habits in Stockbridge or continence in Alresford) that could have been gleaned from a literature review. Prevalence figures for their own population could simply have been calculated by applying rates derived from national studies. PHCTs were not keen to spend much energy on activities of no direct benefits to their patients. Indeed, time dedicated to detailed problem assessment alone was difficult to justify to colleagues.

The evaluation phase presented different problems. The small size of practice populations determines that statistically significant changes in most outcome measures are unlikely to be detected for any but the most common conditions or behaviours. Even for projects aiming to reduce cardiovascular risk factors, the relatively short time-scale militated against detecting change. The Heeley Green project exposed the particular difficulties of assessing mental health interventions where the morbidity addressed and the intervention themselves are difficult to define. The particular problems facing practices interested in applying a COPC model to mental health has provided the rationale for a new module. The incontinence project combined all these problems: small numbers, the

difficulties of quantifying symptom severity and the lack of robust outcome measures. Both these projects called for more qualitative evaluation. Where much evidence already existed for the effectiveness of an intervention (e.g. advice to stop smoking), some teams were disinclined to investigate their own effectiveness.

Paradoxically, the superficial nature of many community diagnoses and the subjectivity of prioritisation generated less concern. Rigour at these earlier stages may be of greater importance.

While an academic public health physician might view these projects as unforgivably crude, they were not so regarded by participants who rarely have opportunities to expose their work to this discipline.

Improved information handling

Most teams were genuinely shocked at how little useful data they could abstract from the mass that they enter on their computers. COPC precipitated the collation of health data for the first time in many of the pilot practices.

Relating ward-based census data to practice populations is difficult, particularly in urban areas. The PHCTs were inclined to jump to superficial conclusions when care was not taken to explain the theoretical limitations of data.

Health promotion

Several of the pilot projects amounted to 'extended Band 3 projects'. However, these practices have established shared disease definitions, collected more extensive process data and analysed the impact of their interventions. This is highly likely to have increased their effectiveness. To qualify for banding payments, practices needed only to submit data.

The banding scheme has been widely criticised as futile data collection and has now been amended. Practices now have more discretion in the choice of projects. Apart from allowing them to address local health priorities, a sense of ownership may result in work of better quality.

The training experience

The workshops were highly rated by participants. The first three sessions (the epidemiological introduction, community diagnosis and prioritisation modules) had most impact. The ideas were timely. All practice teams appreciated the opportunity to share detailed personal knowledge of their practices. The presentations of practice profiles were one of the most enjoyable parts of the workshop, and all teams were able to prioritise from their list of problems. The workshops developed new understanding and helped familiarise teams with a new language.

Limitations

Internalising the 'philosophy'

Most practice teams did not come to regard the principles of COPC as central to their way of working. The utilitarian values underpinning COPC are at odds with the deontological emphasis on the rights of individuals that characterises the traditional doctor/patient relationship.

'Doctors do not like prioritising. They feel threatened by it.' (DHA manager)

Profiling

The construction of community profiles was piecemeal. The range of data produced by both practices and health authorities was limited. Full advantage was not taken of the opportunity to introduce PHCTs to available information sources. Though provided with a structure around which a comprehensive profile can be built, the teams did not seek to preserve or build on the work they had done. Two years on, most community diagnoses remained limited at best to a couple of pages of unsorted recollections brought together at the time of the workshop. These did not provide the basis for systematic re-entry of the COPC cycle. Most practices selected follow-up projects on a highly subjective basis.

Community orientation

Many practice teams made little contact with patients or their representatives at any stage of their projects. Confusion over what it means to be 'community-oriented' weakened COPC's claim to be a distinctive approach. For individual PHCT members, the words meant many different things. A debate within the King's Fund over whether or not to rechristen COPC as P(population)OPC reflected these ambiguities.

Lack of PHCT interest

Most teams attempted to involve other members on returning to their practices. However, the scale of this task was greatly underestimated by both participants and presenters. Only one practice integrated COPC into its routine workings. Practices that were more successful at developing COPC were already well integrated with enthusiastic leaders. In eight out of the eleven practices, responsibility for COPC was delegated to one individual, usually a practice nurse or health visitor. Dedicated individuals completed tasks but did not tend to disperse ownership and responsibility.

Health benefits

The sum of measured benefits to patients was limited. In five practices, these benefits were confined to improvement in cardiovascular risk factors. Furthermore, with the advent of the banding scheme and without control practices, the additional benefit from COPC may be more limited. The key differences may be in how benefits are assessed and recorded. Success was difficult to sustain. A factor limiting expansion of COPC has been lack of evidence for its cost-effectiveness.

COPC did not inform DHA/FHSA's purchasing

In the early days of the reforms, many health authorities struggled to find the data required to inform their assessments of need. Previously untapped stores of general practice morbidity data were still regarded as holding the key to purchasing at both practice and authority level. COPC opened up the prospect of collaborative access to these data. The failure of projects to meet these expectations was a major factor dampening enthusiasm for COPC among some managers.

Initial expectations were unrealistic. General practice provides no simple solution to the information problems of purchasing authorities. The lack of standardised disease definitions, unsystematic and inconsistent data recording systems and incompatible software make the interpretation of raw data difficult. Until PHCTs themselves begin to use and value these data, their quality will not improve. The trend to lead purchasing from primary care provides further incentives to develop information systems.

Prerequisites

Several factors helped to determine the success of COPC projects on the four sites. These included the following.

Multi-disciplinary support

An active steering group bringing together disciplines from different parts of the authority and primary care was a notable feature of successful projects. Many hidden benefits of COPC derived from hitherto-neglected networking opportunities these groups afforded. The problems of communications between different directorates within a health authority are worsening with the formation of larger commissions. Core contributors included managers from the FHSA and community trust, health promotion and public health specialists.

The level of commitment from senior managers

Visible support was both a determinant and a consequence of successful projects. To function well, steering groups required the co-operation of staff from commissioning, finance and public health directorates. Tight control over defined budgets, though rare, facilitated forward planning.

Participation from public health practitioners

The active involvement of staff with a public health perspective accelerated the progress of projects particularly in the early stages, e.g. in designing data collection instruments. Negative perceptions of public health within health authorities reflected lack of inter-departmental collaboration and hindered progress.

Local champions in practice teams

The presence of an early enthusiast among the health professionals helped to focus the work of the support group. Their enthusiasm was mutually reinforcing. The tasks of recruiting new teams and of running follow-up workshops was also greatly eased.

A strategic framework for primary care development

These were emerging over the period of the pilot project. A clear vision of the future of primary care-led purchasing was bound to influence perceptions of COPC. Where, for example in Sheffield, fundholders were seen as leading the fray, COPC was relegated to a lesser role. For other health authorities, COPC took its place alongside a range of different approaches to need assessment. The existence of many other successful initiatives inevitably 'crowded out' COPC.

Visible early successes

Success feeds on itself. Progressive projects and practices attracted attention and support. This underlined the importance of a sense of realism about what could be achieved when selecting projects.

Flexibility

Many participants came to regard the 'Israeli approach' as too rigid. Too much time could be spent on elaborate data collection at the expense of service development. The ability to adapt the schedule when devising new workshops and flexibility in application of the principles helped to sustain interest.

Staff turnover

Development was easier to sustain where team membership was stable. Both authorities and primary health care teams experienced a rapid turnover of staff with the disappearance of many senior members. Experienced staff are often repositories of useful information when health needs are being assessed.

The nature of the primary health care team

As we have seen, various team characteristics were associated with steadier progress. Some teams were more responsive to change and opportunities for innovation than others. (*'They don't have to be fundholders but it helps.'* FHSA Manager) Poor premises and limited use of computers were hindering factors. Some individuals more readily grasped the distinction between COPC and research: that they were embarking on a short feedback loop rather than hypothesis testing. Other conventional factors associated with effective teamworking included effective leadership (from either a general practitioner or practice manager), and the presence of a thorough operational manager (setting objectives, running meetings, monitoring progress). In the last analysis, the ethos or 'feel' of a successful practice will always defy comprehensive analysis.

The following factors may inhibit expansion of the COPC programme nationally.

Financial

There are growing demands on health authority budgets with continuing uncertainty over fundholding allocations and pressure to translate new investment into direct patient care. Development monies for new initiatives like COPC are difficult to find.

There are no immediate financial incentives for undertaking this work.

> *Assessing communities' needs and then applying yourself to that isn't something that GPs can do in the context of their daily work in the way that things are organised now, because there just isn't sufficient time and resources available to do it.* (GP)

Organisational

Despite the rhetoric of primary care-led purchasing, the move to unified commissions has hampered primary care development over the last two years. The pace of change was reflected in the rapid turnover of health authority staff. Many managers faced uncertain futures. Many strong operational managers with detailed knowledge of the Red Book have already lost their jobs. On one site, three different managers took lead responsibility for COPC over two years. This lack of continuity affected their commitment to new projects. This has also been a period of instability and high turnover for the practices. General practitioners, practice managers and community nursing staff were most affected. This inevitably influenced the progress of projects.

Professional

The shift of professional power in favour of general practitioners carries with it the danger that one set of professional priorities will replace another. The poor morale and sense of overload in general practice also impede new developments.

> *There is so much being foisted upon primary health care at the moment... Last year there was this government push to have got the basics right. We were supposed to have achieved that within a year. Now we've got to move onto substitution ... meaning shifting secondary care services over to primary care and our practitioners are saying, 'No thanks, we don't want to. We are not ready yet. We can't cope with stuff which is primary care which doesn't need to go anywhere else. We haven't got the space to take on all that stuff'.* (FHSA manager)

Lack of effectiveness evidence

In stressing the distinction of COPC from research, the need to choose projects for which there is evidence of effectiveness limits choice. There is a particular shortage of evidence on the effectiveness of many forms of health promotion.

Expectations

COPC was expected to provide solutions to several different problems: GP training, the shortage of public health skills in general practice, the cultural divide between FHSAs and DHAs, different primary care development agendas. COPC is a synthesis that requires complementary working of professionals from several different backgrounds. Furthermore, COPC may bring the right people together but to no avail if the wider system remains dysfunctional.

The project paradigm

Authorities and practices often regard developmental initiatives as one-off projects. While initiatives have some of the characteristics of projects, conventional models of project management may be inappropriate. Objectives are often multiple, complex and hard to quantify. Resource allocations are time-limited. Health outcomes cannot easily be measured within the timescale of projects at practice level. All these projects required long-term changes in PHCT and patient behaviour. An evaluation that focused exclusively on the measurable product of projects would be setting itself up to fail.

> *I think that would be easier for the health authorities, once they become one health authority, to start seeing it as a whole and to work better in a more co-ordinated way with general practice. I personally don't think there's a role for lots of little projects any more. I think we can see that the lots of little projects only made it to first base.* (DHA manager)

> *One of the drawbacks of the* COPC *is that it creates a kind of mind set that is a 'project'. And that you do this project, and that there are all those millions of other projects that aren't being done. Then you do another project and over the 30 years of your working life you've perhaps done about four* COPC *projects.* (GP)

Summary

The COPC workshops were productive learning experiences. The projects had a beneficial impact on the teams involved. Their overall impact on the health of patients was difficult to measure over the timescale of the evaluation but there was quantified evidence of benefits on all sites. Participants assimilated the population-oriented principles underpinning COPC to variable degrees. There were few wholehearted converts. Visible support from both senior managers and GP champions were among several factors determining the success of the programme on different sites.

Chapter 8

Ways forward

Has COPC a place in the UK? COPC is best seen as an inclusive set of general principles. It may not provide a radically different way of delivering health services but how does it complement existing developments?

This section describes various activities with which COPC overlaps. The projects are heterogeneous in terms of their aim, scale and scope. They have been selected because they share common features with COPC. They aim to improve service quality. They encourage primary health care teams to look in greater detail at the processes of their work. They develop understanding of the factors influencing the health of practices' populations.

Medical audit

In the six years since the formation of MAAGs, general practice audit has greatly increased in quality and quantity. More practices are doing it, the range of practice team members involved has widened as have the topics audited. Skills have improved and fear of audit has diminished (Griew and Mortlock 1993, Humphrey and Hughes 1992). The most dynamic MAAGs created new networks between practitioners and management, diminishing isolation and breaking down long-standing professional barriers.

However, most audit groups are still predominantly medical in their professional membership. MAAGs endorsed the aim of including the whole practice team but there remains little evidence that multi-disciplinary audit is widespread (COG 1994). FHSAs were keen to ensure that national and local priorities were reflected in MAAGs' work. While common agendas are beginning to emerge, audit groups remain committed to respecting the rights of practices to choose their own audit topics (Humphrey 1993).

The audit process involves the following steps:

- choosing a topic;
- defining a problem;
- stating the aims;
- choosing of methods;
- designing the project;
- analysing results;
- deciding on changes required.

The real challenge of clinical audit is in the handling of people, especially those whose everyday clinical performance is being scrutinised, in ways they may find threatening. Essential for success are skills in guideline and protocol construction, in the handling, analysis and presentation of data, and the managerial skills to manage change in a practice unit (Newton *et al.* 1992).

Audit and COPC aim to develop similar skills. A systematic approach to needs assessment in determining the choice of project distinguishes COPC from conventional audit. However, the arbitrary nature of COPC project choice in reality, the move to encourage more consumer involvement in audit at all stages and more formalised links between audit groups and FHSAs obscures any distinction. COPC may indeed be *'no more than glorified audit'* but audit groups and their facilitators should find the package useful.

Team-building workshops

Teamwork in primary care is not a new concept. The 1965 charter for family practice in conjunction with the move towards the attachment of community nursing staff to practices brought the issue of teamwork onto the primary health care agenda (Hasler 1992). An extensive literature notes the advantages of teamwork in primary care (Waine 1992). A team approach leads to higher levels of communication regarding patients' state of health and thereby avoids duplication of services and conflicting advice to patients. Teamwork has been identified by professionals as a more satisfying way of working (Lambert 1991). Potential disadvantages include the division of individual professional responsibility for patients and the possibility of personality clashes between colleagues (Martin *et al.* 1985).

Recent evidence suggests that a high proportion of practice teams do not function well (Lawrence 1988). This is particularly so where teams have no agreed objectives (Poulton and West 1993). For teamworking is invariably part of a wider problem in which the management of practice units is deficient. Dysfunctional partnerships are major obstacles to corporate planning, decision-making, teamworking and quality assurance (Poulton *et al.* 1980).

There have been a number of PHCT development initiatives aiming to identify barriers to teamwork and team objectives for the future. In most cases this has been achieved through training events organised by individual practices (Adelaide Medical Centre 1991), representatives of interested bodies (e.g. a local community unit, FHSA or LMC) (Haggard 1990) or outside management consultants (Pratt 1990). The Health Education Authority's (HEA) Primary Health Care Team Workshop programme is the best known (Lambert *et al.* 1991). Its original team-building workshops had the following aims:

– to provide an opportunity for the PHCT to plan health promotion activities;
– to encourage understanding of the roles and skills of each discipline represented;
– to recognise the main professional resources available in the community.

The workshop strategy was to be diffused through the development of Local Organising Teams (LOTs). The HEA thus moved early on from workshops with practices to workshops for those likely to plan, organise and run local events. These teams needed a broad combination of skills and expertise and included nurse managers, health promotion officers, public health doctors, practice nurses and managers as well as general practitioners. Notwithstanding the organisational turbulence of recent years, successive evaluations have suggested that the LOT strategy has provided a valued framework through which multi-agency planning groups can support a range of PHCT activities. To date, over 400 workshops have been held across the country (HEA 1995). While interprofessional collaboration is notoriously difficult to assess (Pearson and Jones 1994), there is plenty of anecdotal evidence that participation in the LOT workshops can enhance communication in PHCTs and that LOTs themselves have enhanced liaison between PHCTs and local managers (Dark 1994, Turner and Singleton 1994).

The COPC workshop model with follow-up is closely akin to the HEA team-building workshop programme. Similar problems have been encountered:

1. The effects of partial team-building – It is not possible for obvious logistical reasons to involve all members of the team in the workshop. This can create a 'them and us' situation when teams' representatives return to base.

> *When we had come back from the course there was a definite sort of those that had been, and those that hadn't, and that was sort of divisive almost.* (Practice Manager)

> *It's like a lot of these things, the people who are most enthusiastic went along to the thing anyway in the first place, and the people who were least enthusiastic didn't. And that's not a bad thing necessarily in that you always need a balance in general practice anyway.* (GP)

2. Problems on re-entry – Being able to step outside the normal routine is an important factor in the success of these workshops but returning to normality on the following Monday morning can be a deflating experience.

> *I think people think the project is a good idea. But it was very difficult for the four of us who went on the course to transfer the idea of the principle to the rest of the team.* (Practice Manager)

3. Sustaining the initiative – PHCTs need prompting if they are to re-visit project protocols, evaluations, etc. They will need to recreate the intimacy of the original workshop to rekindle enthusiasm. This may mean follow-up events or repeated workshops for other members of the team.

> *My reservations are really because I think that the way COPC is sold is that by definition it is everybody. And that side of it hasn't really taken off here. That was what made me very enthusiastic when I was first involved with it. I think also to be honest, there's a lot of apathy because there's so much on anyway ... When things are hard, you don't want any extra work on your plate.* (GP)

4. Sustaining the organisers – Multi-disciplinary working creates synergy but all teams eventually start to exhaust their fund of new ideas. Unplanned staff turnover can sap commitment to the LOT. The HEA Oxford unit have taken on a critical networking function, arranging national training events and publishing a regular newsletter.

5. Securing financial backing – The budget holders in health commissions prefer an early yield on their investment. The nebulous benefits of improved teamworking need to be reflected in tangible health-related outcomes benefiting patients.

6. Broadening the repertoire – The initial workshops focused heavily on theoretical approaches to teamwork and exclusively encouraged health promotion projects. Subsequent experience suggests that teams need greater discretion in their choice of topics. Many LOTs have broadened the focus of workshops to encompass needs assessment, audit, consumer involvement and a range of other quality assurance initiatives.

Despite the views of some managers, not all practices need to participate in team-building initiatives prior to involvement in COPC. Dysfunctional teams will struggle to achieve COPC objectives and may benefit but for many teams additional time out is an unnecessary luxury. Indeed, the COPC training materials can easily be included among the resources of an experienced LOT without the need for specialised induction (personal communication, Aislinn O'Dwyer).

Health promotion

The banding scheme was widely criticised (Cooper 1995). Many general practitioners regarded the scheme as futile, labour-intensive data collection. The new scheme resulted in more equitable distribution of payments but this was unrelated to measures of practice population health need (Langham *et al.* 1995). More research is required on the costs and benefits of different intervention strategies before a rational system of financial incentives can be constructed.

The banding scheme had other unfortunate consequences in reinforcing limited notions of the scope of health promotion among general practitioners. Health promotion is often equated with clinic-based activities to reduce cardiovascular risk (Charlton *et al.*). Ways are needed of providing PHCTs with greater discretion in their choice of local priorities and encouraging interventions that involve them with the community in more imaginative ways.

On the other hand, early evidence suggested that the quality of data returned in the first year of the scheme was better than many anticipated (Gillam *et al.* 1996). For most practices, these data could form the basis for productive year-on-year audit allowing local monitoring of Health of the Nation attainments. This was often the first occasion on which practices had analysed their own health-related data.

COPC provides the added value of a baseline assessment against which to identify a local priority. In contrast to the banding scheme, COPC inculcates care in the collection

of data. Finally, audit or any assessment of the impact of interventions was not required for banding payments.

Fundholding

Early entrants to the fundholding scheme were self-selected volunteers not necessarily typical of their fellow practitioners. Many came from well organised practices in middle-class areas. With many other changes occurring at the same time, it is difficult to isolate the specific effect of fundholding. Many of the alleged benefits, shifting the balance of power away from hospital consultants and increased responsiveness on the part of hospital management (Willis 1992, Newton *et al.* 1993), have been made by GPs involved in non-fundholding groups (Moore and Dalziel 1993, Black *et al.* 1994, Graffy and Williams 1994). Studies which look at the experience of fundholders alone with no control group may reach false conclusions.

Mature fundholders have rapidly evolved greater awareness of the inefficiencies generated at the primary/secondary care interface. More effective clinical resource management in primary care is the key to the success of the reforms. Fundholders have demonstrated the importance of combining sensitive local knowledge of patients' needs and the resources to effect immediate change (Ham and Shapiro 1995).

Undergraduate and postgraduate training do not equip doctors for their new planning and resource management responsibilities. Given the scope of the standard fund, it is not surprising that fundholders often seem most interested in exacting changes from acute units. (*'They are more interested in the mote in their brother/sister provider's eyes than the beam in their own'*. DHA Manager) They may have little interest in strategic planning or the complexities of joint commissioning with social services departments. Fund management should be rooted in a baseline assessment of the practice population's needs. The expansion of fundholding has exposed the need for knowledge and skills that can only partly accrue from experience (Leese *et al.* 1994, Bowie and Spurgeon 1994).

Several observations are pertinent to the development of COPC. Firstly, it has divided the medical profession as no other development of the last few years. These divisions surfaced at all stages of the COPC pilot project. Secondly, the start-up costs of fundholding are considerable. The infrastructural investment in information technology and management allowances constitute changes in the culture and fabric of practices against which involvement in other projects can appear trivial. Thirdly, the very success of fundholding has exposed its weaknesses. Fundholders with two or three years experience of budgetary planning acknowledge key skills deficits. Fundholding practices provided the most fertile ground for COPC. Finally, some of the technical difficulties faced in devising budgets for fundholders or monitoring their activities derive from small denominators and apply to COPC.

Fundholding practices in this pilot project demonstrated that COPC can provide the framework through which outreach work and direct approaches to the community can broaden their understanding of patients' needs and hasten the development of more

appropriate services. One pilot FHSA believed COPC held the key to developing fundholding teams sensitivity to the needs of their practice population. They are encouraging all potential fundholders to participate in COPC workshops.

> *What I would see as the next step for COPC is probably getting them [fundholders] to attend a COPC training or at least understand the approach, so that they would begin to link what they see in the practice and what the needs are with what they can then go out and buy. So in that way we'll start to get more sensitive practice teams and configurations that suit the public rather than just one of the general practitioners...* (FHSA Manager)

Locality commissioning

Growth in the coverage of fundholding practices slowed with successive waves. Many eligible practices have already opted to fundhold. Those that have not are often either too small or otherwise underdeveloped. Many general practitioners remain implacably opposed to fundholding for various practical and ethical reasons.

The move to involve more general practitioners in commissioning could only be sustained through the development of fundholding consortia or locality planning/commissioning groups (Ham and Shapiro 1995). These require practices to adopt a less individualistic approach to planning.

Locality-based approaches exhibit a wide range of definitions, approaches, functions and management arrangements (Ham 1993). These options (see Figure 3) have been subject to little critical evaluation but locality planning groups and practice-based alternatives to fundholding can effect change (Shapiro 1994). They are more likely to engage with community trust and social services managers as they also operate at locality level. Without the budgetary 'teeth' of fundholders, participants may become frustrated in the absence of early changes. They have to learn to accept longer time-scales (OPM 1994). Reliable information is a critical prerequisite. Participating practices may have to develop standardised approaches to data collection (Graffy and Williams 1994).

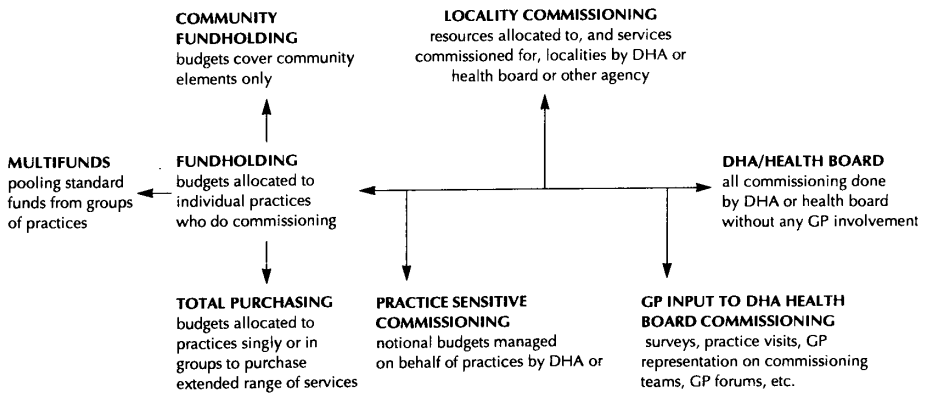


Figure 3 Commissioning care: options for GPs

COPC may therefore be of relevance to newly formed commissioning groups. Experience suggests that the model can be adapted to help them achieve important early tasks, for example the development of a locality profile with a list of planning priorities.

Involving the community

Community participation is a process in which local people are actively involved in discussion and activities to identify their needs and bring about improvements in the health of the community. It is not a new concept. The Royal College of General Practitioners has long encouraged patient participation in general practice (Heritage 1994, Pritchard 1993). The growth in consumerism as reflected in charter initiatives, attempts to render fundholders accountable and the development of audit are further encouraging the direct involvement of patients.

Community participation in primary care can take many forms: e.g. patient participation groups, self-help groups, community development projects, etc. However, the concept of community participation is poorly understood by most people working in primary care (Gooding 1991). Health professionals have not been trained to promote community involvement. Work with a variety of groups representing different community interest is frequently challenging and demands managerial skills of a high order. Health professionals may need to relinquish established attitudes and behaviours in order to the meet the challenge of encouraging local people to help in the organisational setting. Doctors need to be confident in the management of their practice. Without this confidence, it is hard to invite potentially critical feedback from patients.

Many managers were disappointed by the lack of community participation in the COPC pilot projects. Only those practices with traditions of patient involvement actively involved their communities. The ambivalence of workshop presenters regarding the need for community involvement and the lack of clarity regarding the meaning of the phrase 'community oriented' was reflected in the interviews. In the eyes of many participants, this ambiguity weakened the impact of COPC while making the process less threatening.

Change at both the individual and community level is likeliest where patients share responsibility for planning and management decisions (Murray *et al.* 1995). The skills required to engage the community both in meaningful dialogue regarding their perception of needs and in harnessing resources beyond the health service to meet those needs have not been given sufficient attention. A supplementary COPC module on community participation has been developed to address this deficit.

Summary

COPC is best seen as an inclusive set of general principles providing the basis for the development of new forms of joint learning. COPC can complement developmental initiatives sharing many of the same aims. The training package should be of value to those with an interest in both undergraduate and postgraduate education.

Since completion of the work described here, a further trilogy of White Papers have been published (Secretary of State, 1996 a,b,c). Of most significance for the future development of primary care, Choice & Opportunity paves the way for new forms of primary care organisation. Experimental alternatives to the single national contract for general practitioners are to be piloted. Particularly in inner city areas, these pilots have the potential to offer more flexible and appropriate services (Coulter A & Mays N, 1997). Whatever the future for health professionals and managers in primary care, the need for skills in planning and local strategy development will intensify. The principles underpinning Community Oriented Primary Care are be of enduring relevance.

References

Abramson J (1983). Training for community-oriented primary care. *Israeli Journal of Medical Science* 19: 764–7.

Abramson JH, Gofin J, Hoop C *et al.* (1981). Evaluation of a community programme for the control of cardiovascular risks factors: the CHAD programme in Jerusalem. *Israeli Journal of Medical Science* 17: 201–212.

Acheson D (1988). *Public health in England – the report of the committee of the enquiry into the future development of the public health function*. London: Her Majesty's Stationery Office, CM289.

Acheson D (1981). *Primary health care in Inner London. Report of a study group*. London: Health Planning Consortium.

Adelaide Medical Centre PHCT (1991). A primary health care team manifesto. *British Journal of General Practice* 41: 31–3.

Annual Report of the General Medical Services Committee (1994). London: British Medical Association.

Argyris C (1993). *On organisation learning*. Cambridge, Mass: Blackwell.

Ashton J (1977). The Peckham Pioneer Health Centre: a reappraisal. *Community Health* 8: 132–137.

Ashton J, Seymour H (1988). *The new public health*. Milton Keynes: Open University Press.

Ashton J (1990). Public health and primary care: towards a common agenda. *Public Health* 104: 387–398.

Audit Commission (1993). *Practice makes perfect: the role of the family health services authority*. The Audit Commission for Local Authorities and the National Health Service in England and Wales, London.

Audit Commission (1996). What the doctor ordered. Fundholding: the main report. London: HMSO.

Bailey J, Black M, Wilkin D (1994). Specialist outreach clinics in general practice. *British Medical Journal* 308: 1083–6.

Bain J (1990). General practices and the new contract. 1. Reactions and impact. *British Medical Journal* 300: 1247–50.

Bain J (1992). Budget holding in Calverton: one year on. *British Medical Journal* 304: 971–3.

Bain J (1994). Fundholding: a two tier system? *British Medical Journal* 309: 396–9.

Baker R (1988). *Practice assessment and quality of care.* Occasional Paper 3, London: Royal College of General Practitioners.

Baker R (1990). Development of a questionnaire to assess patients' satisfaction with consultations in general practice. *British Journal of General Practice* 40: 487–90.

Baker R (1995). Clinical audit in primary health care: towards quality assurance. *British Medical Journal* 310: 413.

Barnes J (1992). *Health promotion in general practice – the new approach.* National Health Service Management Executive, Department of Health: 6 November.

Basch P (1990). *Textbook of international health.* New York: Oxford University Press, Chapter 7.

Berridge V (1991). *A history of public health.* London: Oxford University Press, Chapter 3.

Black D, Birchall A, Trimble I (1994). Non-fundholding in Nottingham: a vision of the future. *British Medical Journal* 309: 930–2.

Black N (1994). Why we need qualitative research. *Journal of Epidemiology & Community Health* 48: 425–6.

Blakeway-Phillips C (1993). What organisational audit has got to offer primary care. *Primary Care Management* 5: 7–8.

Boufford JI, Shonubi P (1986). *Community-oriented primary care. Training for urban practice.* New York: Praeger Publishers.

Bowie C, Spurgeon R (1994). Better data needed for analysis. *British Medical Journal* 309: 34.

Bowling A (1991). Needs assessment. City & Hackney Health Authority, Needs Assessment Unit.

Brabeman T, Mora F (1987). Training positions for community-oriented primary care in Latin America. Model programmes in Mexico, Nicaragua and Costa Rica. *American Journal of Public Health* 77: 485–90.

Bradlow J, Coulter A (1993). Effect of fundholding and indicative prescribing schemes on general practitioners' prescribing costs. *British Medical Journal* 307: 1186–9.

Brody H (1992). Philosophic approaches. In: Crabtree B, Miller W, eds. *Doing qualitative research: multiple strategies.* London: Sage.

Burr A, Walker R, Stent S (1992). Impact of fundholding on general practice prescribing patterns. *Pharmaceutical Journal,* October 24, (suppl).

Butland G (1992). Showing continued progress: FHSAs two years on. *Primary Health Care Management* 2: 5–6.

Cantley C, Smith G (1985). Assessing health care: a study in organisational evaluation. Milton Keynes: Open University Press.

Cantor JC, Morisky DE, Green LW *et al.* (1995). Cost-effectiveness of educational interventions to improve patient outcomes in blood pressure control. *Preventative Medicine* 14: 782–800.

Cassel JC (1955). A comprehensive health program among South African Zulus. In: Paul B (ed): *Health, Culture, and Community*. New York: Russell Sage Foundation 15–42.

Charlton BG, Calvert N, White M *et al.* (1994). Health promotion priorities for general practice: constructing and using 'indicative prevalences'. *British Medical Journal* 308: 1019–1022.

Clinical Information Consultancy (1994). *Collecting health information from general practices. A brief introduction to the MIQUEST approach*. Reading, CIC.

Clinical Outcomes Group (1994). *Clinical audit in primary health care*. Report by Clinical Audit Working Group. Dept of Health.

Cooper C (1995). Health promotion schemes set for overhaul. *Doctor*, 8th June.

Corney R (1994). Experiences of first wave general practice fundholders in South East Thames Regional Health Authority. *British Journal of General Practice* 44: 34–7.

Coulter A (1992). Fundholding general practices: early successes but will they last? *British Medical Journal* 304: 397–8.

Coulter A, Bradlow J (1993). Effect of NHS reforms on general practitioners' referral patterns. *British Medical Journal* 306: 433–7.

Coulter A, Brown S, Daniels A (1989). Computer held chronic disease registers in general practice: a validation study. *Journal of Epidemiology and Community Health* 25–28.

Coulter A, Mays N (1997). Deregulating primary care. *BMJ* 314: 510–13.

Cretin JA (1977). CBA of treatment and prevention of myocardial infarction. *Health Services Research* 12: 174.

Crump B, Gibbon J, Drummond M, Hawkes R, Marchment M (1991). Fundholding in general practice and financial risk. *British Medical Journal* 302: 1582–4.

Cummings SR, Rubin SM, Oster G (1989). The cost-effectiveness of counselling smokers to quit. *Journal of the American Medical Association* 261: 75–79.

Dark P (1994). *The Primary Health Care Team Workshop Programme in South West Thames*. NHSE South Thames: London.

Davey-Smith G (1991). Second thoughts on the Jarman Index. *British Medical Journal* 302: 359–360.

Day P (1992). The State, the NHS and general practice. *Journal of Public Health Policy* 13: 165–79.

Day P, Klein R (1989). The NHS reforms. *The Millbank Quarterly* 67: 1–34.

Day P, Klein R (1991). Variations in budgets of fundholding practices. *British Medical Journal* 303: 168–70.

Department of Health (1990). *Medical audit in the family practitioner services*. Health Circular HC(FP)(90). 8. London: Department of Health.

Department of Health (1990). *National Health Service General Medical Services*. Statement of Fees and Allowances. September.

Department of Health (1991). *The Patient's Charter*. London: Her Majesty's Stationery Office.

Department of Health (1992). *The Health of the Nation: a strategy for health in England*. London: Her Majesty's Stationery Office.

Department of Health (1994). *Register of cost-effectiveness studies*. London: Department of Health, Economics and Operational Research Division.

Department of Health and the Welsh Office (1989). *General practice in the National Health Service: a new contract*. London.

Department of Health/Department of Social Security/Welsh Office/Scottish Office (1990). *Caring for People*. London: Her Majesty's Stationery Office.

Dixon J (1994). Can there be fair funding for fundholding practices? *British Medical Journal* 308: 772–775.

Dixon J, Dinwoodie M, Hodson D, Dodd S, Poltorak T, Garrett C, Rice P, Doncaster I, Williams M (1994). Distribution of NHS funds between fundholding and non-fundholding practices. *British Medical Journal* 309: 30–4.

Dixon J, Welch HG (1991). Priority-setting: lessons from Oregon. *Lancet* 37: 891–894.

Dubos R (1959). *Mirage of health*. George, Allen & Unwin, London.

The Economist (1994). Freedom and community – the politics of the restoration. 24 December, 65–8.

Eddy D as quoted in Smith A (1991). Where is the wisdom ...? The poverty of medical evidence. *British Medical Journal* 303: 798–799.

Foster A (1991). *FHSAs – today's and tomorrow's priorities*. Family Health Services Management Unit. National Health Service Management Executive. February.

Fowler G, Mant D (1990). Health checks for adults. *British Medical Journal* 300: 1318–1320.

Fox T (1960). The case for personal care. *Lancet* 1: 743–60.

Frankel S, Williams M, Nanchalal K, Coast J (1990). *Total hip and knee joint replacement*. DHA Project, Report 2. University of Bristol.

Fullard E, Fowler G, Gray J (1987). Promoting prevention in primary care. A controlled trial of a low technology, low cost approach. *British Medical Journal* 194: 1080–1082.

Geiger HJ (1983). The meaning of community-oriented primary care in an American context. In: Connor E, Mullan F, eds. *Community-oriented primary care: new directors for health services delivery: conference proceedings*. Washington, D.C.: National Academy Press.

General Medical Council (1993). *Tomorrow's doctors. Recommendations on undergraduate medical education*. London: GMC.

Gillam S, Allen J (1994). The use of benefits programmes in community health care settings. *Primary Care Management* 4: 8–9.

Gillam S, Langham S, Coshall C, Headley M, Thorogood M (1996). *In the kingdom of the blind? Assessing the general practice health promotion banding returns*. Submitted for publication.

Gillam S, McCartney P, Thorogood M (1996). Health promotion in primary care: evidence or expediency. *British Medical Journal* 312: 324–325.

Gillam S, Plamping D, McClenahan J *et al.* (1994). *Community-oriented primary care*. King's Fund, London.

Gillam SJ (1992). Assessing populations' health needs: the general practitioner's contribution. *British Journal of General Practice* 42: 404.

Gillam SJ (1993). Provision of health promotion clinics in relation to population need: another example of the inverse care law? *British Journal of General Practice* 42: 54–6.

Glennerster H, Matsaganis M, Owens P (1994). *Implementing GP fundholding: wild card or winning hand?* Buckingham: Open University Press.

Gooding S (1991). *Community participation in general practice*. MSc thesis. London: King's College.

Gordis L (1973). Effectiveness of comprehensive care programs in preventing rheumatic fever. *New England Journal of Medicine* 289: 331–335.

Graffy J, Williams J (1994). Purchasing for all: an alternative to fundholding. *British Medical Journal* 308: 391–4.

Greenlick MR, Lamb SJ, Carpenter TM *et al.* (1983). Kaiser–Permanente's Medicare Plus project: the successful medicare prospective payments demonstration. *Health Care Financial Review* 4: 85–97.

Gregson BA, Cartlidge A, Bond J (1991). *Interprofessional collaboration in primary health care organisations*. Occasional Paper 52. London: Royal College of General Practitioners.

Griew K, Mortlock M (1993). A study of MAAG organisation and function. *Audit Trends* 1, 89–93.

Grimshaw JM, Russell IT (1994). Achieving health gain through clinical guidelines II: ensuring that guidelines change medical practice. *Quality in Health Care* 3: 45–52.

Grol R, Mesker P, Schellevis F (1988). *Peer review in general practice: methods, standards, protocols*. Nijmegen: University Department of General Practice.

Haggard E (1990). Making the team work. *Health Service Journal* 12 April: 367–8.

Ham C (1993). *Locality purchasing*. Discussion Paper 34. Institute of Health Services Management, University of Birmingham.

Ham C, Shapiro J (1995). The future of fundholding. *British Medical Journal* 310: 1150–1151.

Handyside S (1994). Morale in general practice: is change the problem or the solution? *British Medical Journal* 308: 32–34.

Hannay DR (1993). Primary care and public health: too far apart. *British Medical Journal* 307: 1076–78.

Harris A (1994). Specialist outreach clinics. *British Medical Journal* 308: 1053.

Harris J (1987). Qualifying the value of life. *Journal of Medical Ethics* 13: 117–123.

Hasler J (1992). The primary health care team: history and contractual farces. *British Medical Journal* 305: 232–4.

Health Education Authority, Primary Care Unit (1995). *Network*. Oxford: Health Education Authority, June.

Health Resources and Services Administration, Maternal and Child Health Bureau (1994). *Primary health care for children and adolescents: definition and attributes*. Rockville, MD: HRSA.

Heritage Z (1994). *Community participation in primary care*. Occasional Paper 64. London: Royal College of General Practitioners.

Honigsbaum F (1995). *General practice – past, future and present*. Discussion Paper 33. University of Birmingham, Health Services Management Centre.

Hopp C (1983). A community programme in primary care for control of cardiovascular risks factors: steps in programme development. *Israeli Journal of Medical Science* 19: 748–751.

Hopton JL, Dlugolecka M (1995). Need and demand for primary health care: a comparative survey approach. *British Medical Journal* 310: 1369–73.

Howell J, Fisher F, Morgan DR *et al.* (1992). *Stress and the medical profession*. London: British Medical Association.

Howie J, Heaney D, Maxwell M (1994). Evaluating care of patients reporting pain in fundholding practices. *British Medical Journal* 309: 705–10.

Howie J, Heaney D, Maxwell M (1995). Observations on the care of patients with selected health problems in fundholding practices in Scotland in 1990 and 1992. *British Journal of General Practice* 45: 121–126.

Hsiao W, Braun P, Dunn D *et al.* (1988). Results and policy implications of the resource-based relative value study. *New England Journal of Medicine* 319: 881–88.

Hughes J, Gordon P (1993). *Hospitals and primary care – breaking the boundaries*. London: King's Fund Centre.

Hughes J, Humphrey C (1990). *Medical audit in general practice, a practice guide to the literature*. London: King's Fund Centre.

Humphrey C, Hughes J (1992). *Audit and development in primary care*. Medical Audit Series 5. London: King's Fund Centre.

Humphrey C (1993). Developing the role of medical audit advisory groups. *Quality in Health Care* 2: 232–8.

Hunt SM, McEwan J, McKenna SP (1986). *Measuring health status*. London: Croom Helm.

Hunter D (1994). Are we being effective? *Health Service Journal* 16 June 23.

Huntington J (1993). From FPC to FHSA to ... health commission? *British Medical Journal* 306.

Illich I (1975). *Medical nemesis – the expropriation of health*. New York: Marion Boyars.

Institute of Medicine (1984). *Community-oriented primary care: a practical assessment*. Volume 1, The Committee Reports. Washington, DC: National Academic Press.

Institute of Medicine (1984). *Community-oriented primary care: practical assessment*. Volume 2, The Case Studies. Washington, DC: National Academy Press.

Irvine D (1990). Standards in general practice: the quality initiative revisited. *British Journal of General Practice* 40: 75–77.

Irvine D (1994). Organisational audit in primary health care: working with the professionals. *King's Fund News*, June: 6–7.

Irvine DH (1990). *Managing for quality in general practice*. London: King's Fund Centre.

Jarman B (ed). (1988). *Primary care*. London: Heinemann.

Jarman B (1984). Underprivileged areas: validation and distribution of scores. *British Medical Journal* 229: 1587–92.

Johnson JC (1990). *Selecting ethnographic informants*. London: Sage.

Joule N (1992). *User involvement in medical audit*. The Greater London Association of Community Health Councils: London.

Kaprio L (1979). *Primary health care in Europe*. Copenhagen, Regional Office for Europe. World Health Organization.

Kark SL (1974). *Epidemiology and community medicine*. New York: Appleton-Century-Crofts.

Kark SL (1974). From medicine in the community to community medicine. *Journal of the American Medical Association* 228: 1585–86.

Kark SL (1981). *Community-oriented primary health care*. New York: Appleton-Century-Crofts.

Kark SL, Kark E (1983). An alternative strategy in community health care: community-oriented primary health care. *Israeli Journal of Medical Science* 19: 707–13.

Kark SL, Kark E, Abramson JH, Gofin J, eds (1993). *Atencion primaria orientada a la comunidad*. Barcelona, Spain: DOYMA.

Kickbusch I (1986). Health promotion strategies for action. *Canadian Journal of Public Health* 77: 321–326.

Kimball H, Young P (1994). A statement on the generalist physician from the American Boards of Family Practice and Internal Medicine. *Journal of the American Medical Association* 271: 315–6.

Kinosian BP, Eisenberg JM (1988). Cutting into cholesterol: cost-effective alternatives for treating hypercholesterolemia. *Journal of the American Medical Association* 259: 2249–54.

Kirkup B, Forster D (1990). How will health needs be measured in districts? Implications of variations in hospital use. *Journal of Public Health Medicine* 12: 45–50.

Kristiansen IS, Eggen AE, and Thelle DS (1991). Cost effectiveness of incremental programmes for lowering serum cholesterol: is individual intervention worth while? *British Medical Journal* 302: 1119–1122.

Lalonde M (1974). *A new perspective on the health of Canadians*. Canada: Ministry of Supply and Services.

Lambert D (1991). Developing primary health care teams. *Primary Health Care Management* 12: 2–3.

Lambert D, Spratley J, Killoran A (1991). *Primary health care team workshop manual: a guide to planning and managing workshops for primary health care teams*. London: Health Education Authority.

Langham S, Gillam S, Thorogood M (1995). The carrot, the stick and the general practitioner. How has changing financial incentives affected health promotion activity in general practice? *British Journal of General Practice* 45: 665–668.

Lawrence M (1988). All together now. *Journal of the Royal College of General Practitioners* 38: 296–302.

Le Grand J (1994). Evaluating the NHS reforms. In: R Robinson, J Le Grand (eds). *Evaluating the NHS reforms*. London: King's Fund Institute.

Leese B, Drummond M, Hawkes R (1994). *Medical technology in general practice in the UK: will fundholding make a difference?* York: Centre for Health Economics, Discussion Paper 122.

Light D (1994). Managed care: false and real solutions. *Lancet* 344: 1197–9.

Locker D, Dunt D (1987). Theoretical and methodological issues in sociological studies in consumer satisfaction with medical care. *Soc Sci Med* 12: 283–292.

Lord Dawson of Penn (1920). *Interim report on the future provisions of medical and allied services. UK Ministry of Health. Consultative Council on Medical and Allied Services*. London: Her Majesty's Stationery Office.

Loudon I (1981). *Medical care and the general practitioner 1750–1850*. Oxford: Clarendon Press.

McBride M, Metcalfe D (1995). General practitioner' low morale: reasons and solutions. *British Journal of General Practice* 394: 227–228.

MacDonald J (1993). *Primary health care: medicine in its place*. London: Earthscan.

McKeown T (1976). *The role of medicine – dream, mirage, nemesis*. London, Nuffield Provincial Hospitals Trust.

Mant D, Anderson P (1985). Community general practitioner. *Lancet* II: 1114–1117.

Mant D, Tullock A (1987). Completeness of chronic disease registration in general practice. *British Medical Journal* 294: 224–224.

Martin P, Moulds A, Kerrigan P (1985). *Towards better practice*. Library of General Practice, Vol 9.

Maxwell M, Heaney D, Howie J, Noble S (1993). General practice fundholding: observations on prescribing patterns and costs using the defined daily dose method. *British Medical Journal* 307: 1190–4.

Medical Care Research Unit (1993). *Monitoring the provision and staffing of designated health promotion clinics in general practice*. Report to the Department of Health.

Metcalfe D (1989). Audit in general practice. *British Medical Journal* 299: 1293–1294.

Metcalfe DH (1990). Measurement of outcomes in general practice. In: Hopkins A, Costain D. *Measuring the outcomes of medical care*. London: Royal College of Physicians/King's Fund Centre for Health Services Development.

Miller RH, Luft HS (1994). Managed care plan performance since 1980: a literature analysis. *Journal of the American Medical Association* 11: 145–49.

Moore L, Dalziel M (1993). Making the internal market work: a case for managed change. *British Medical Journal* 307: 1270–2.

Morrell DC (1991). Role of research in development of organisation and structure of general practice. *British Medical Journal* 302: 1313–6.

Murray E, Modell M (1995). General practice: the ideal place to teach general medicine? Student perceptions of a community based junior medical firm. *Family Practice* 12: 266.

Murray S, Tapson J, Turnbull L *et al.* (1994). Listening to local voices adapting rapid appraisal to assess health and social needs in general practice. *British Medical Journal* 308: 698–700.

Murray SA, Graham LJ (1995). Practice based health needs assessment: use of four methods in a small neighbourhood. *British Medical Journal* 310: 1443–8.

National Health Service Management Executive (1992). *Local voices: The views of local people in purchasing for health*. London, National Health Service Management Executive.

Newman C (1957). *The evolution of medical education in the nineteenth century*. London: Oxford University Press, pp 134–93.

Newton J, Fraser M, Robinson J, Wainwright D (1993). Fundholding in Northern region: the first year. *British Medical Journal* 306: 375–8.

Newton S, Hutchinson A, Steen N *et al.* (1992). Educational potential of medical audit: observations from a study of small groups setting standards. *Quality in Health Care* 1: 256–259.

NHS Executive (1994). *Developing NHS purchasing and GP fundholding*. London: Department of Health.

NHS Executive (1994). *Towards a primary care-led NHS: an accountability framework for GP fundholding*. EL(94)92. Leeds: NHSE, December.

NHS Executive (1996). *Clinical effectiveness reference pack*. London: Department of Health.

NHS Management Executive (1991). *Assessing health care needs*. A DHA Project Discussion Paper, EL(91)41, May.

NHS Management Executive (1993). FHSL(93). 25 *GP contract health promotion package: amendments to the statement of fees and allowances*. London: Department of Health.

NHS Management Executive (1993). *Improving clinical effectiveness*. EL (93)115. Leeds.

NHSME (1992). *First Steps for the NHS. Recommendations of the Health of the Nation Focus Groups*. National Health Service Management Executive, Leeds.

NHSME (1993). *National Health Service Priorities and Planning Guidance 1993/4*. EL(92). 47.

Nissinen A, Tuomilehto J, Kottke T, Puska P (1986). Cost-effectiveness of the North Karelia hypertension programme. *Medical Care* 24: 767.

The North of England Study of Standards and Performance in General Practice (1992). Medical audit in practice. II: Effects on the health of patients with common childhood conditions. *British Medical Journal* 304: 1484–8.

Nutting P, Connor E (1986). Community-oriented primary care: an integrated model for practice, research and evaluation. *American Journal of Preventive Medicine* 2: 140–47.

Nutting P, Wood M, Conner EM (1985). Community-oriented primary care in the United States. Status report. *Journal of the American Medical Association* 253: 1763–6.

O'Connor TJ (1989). Is community-oriented primary care a viable concept in actual practice? *Journal of Family Practice* 28: 206–208.

Oakley P (1989). *Community involvement in health development, an examination of the critical issues*. Geneva: World Health Organization.

Office for Public Management (1994). *The North East Westminster Locality Purchasing Project. an evaluation report*. London: OPM.

Office of Population Censuses and Surveys (1994). *General Household Survey 1992*. London, Her Majesty's Stationery Office.

Office of Public Management (1994). *An Evaluation of the North East Westminster Project*. London: OPM.

Ong BN, Humphris G (1990). Partners in need. *Health Service Journal* 7: 1002–3.

Ong BN, Humphris G, Annett H, Rifkin S (1991). Rapid appraisal in an urban setting – an example from the developed world. *Social Science & Medicine* 32(8): 909–15.

Oster G, Huse DM, Delea TE, Colditz MB (1986). Cost-effectiveness of nicotine gum as an adjunct to physician's advice against cigarette smoking. *Journal of the American Medical Association* 256: 1315–1318.

Oswald NT (1989). Why not base medical education in general practice? *Lancet* 2: 148–149.

Palti H, Adler B, Reshef A (1977). Semi-longitudinal study of food intake, anaemia rate and body measurements of 6–24 month old children in a Jerusalem community. *American Journal of Clinical Nutrition* 30: 268–274.

Palti H, Adler B, Woolf N (1977). An epidemiological study of haemoglobin in infancy in Jerusalem: the effect of social factors in the relation to physical growth. *Acta Paediatrica Scandinavia* 66: 513–7.

Palti H, Zilber N, Kark SL (1982). The community-oriented early intervention programme integrated in a primary preventive child health service – evaluation of activities and effectiveness. *Community Medicine* 4: 302–14.

Pearse IH, Crocker LH (1943). *The Peckham Experiment*. London: Allen & Unwin.

Pearson P, Jones K (1994). The primary health care non-team? *British Medical Journal* 309: 1387–1388.

Peeke A (1993). *Waiting times for GP fundholder procedures*. Oxford: Performance Monitoring Department, Oxford Regional Health Authority.

Petchey R (1994). Exploratory study of general practitioners' orientations to general practice and responses to change. *British Journal of General Practice* 44: 551–555.

Peterson M J (1978). *The medical profession in mid-Victorian London*. Berkeley and Los Angeles, California, and London: University of California Press, p29.

Pickles W (1939). *Epidemiology in county practice*. Bristol: John Wright. (Republished London, Royal College of General Practitioners 1994).

Pollock A, Majeed A (1995). Community-oriented primary care. *British Medical Journal* 310: 481–2.

Pollock A, Pfeffer N (1993). Doors of perception. *Health Service Journal*, 2 September: 26–28.

Poulton B, West M (1992). *Effective multidisciplinary teamwork in primary care*. MRC/ERC Social and Applied Psychology Unit, University of Sheffield.

Poulton BC, West MA (1993). Effective multidisciplinary teamwork in primary health care. *Journal of Advanced Nursing* 18, 918–925.

Poulton BC, West MA, Hall RH (1980). Effectiveness theory and organisational effectiveness. *Journal of Applied Behavioural Science* 16: 536–545.

Pratt, J (1995). *Practitioners and practices. A conflict of values?* Oxford: Radcliffe Medical Press.

Pratt, R (1990). *Improving teamwork in general practice*. Royal College of General Practitioners, Connection 12: 10–11.

Primary health care in inner London: report of a study group (Chairman Professor Donald Acheson). (1981). London: Health Planning Consortium.

Pringle M, Hobbs R (1991). Large computer databases in general practice. *British Medical Journal* 302: 742–743.

Pritchard P (1993). *Partnership with patients*. London, Royal College of General Practitioners.

Research for Health (1993). Dept of Health, Leeds, June.

Rhoades ER, D'Angelo AJ, Hurburt WB (1987). The Indian Health Service record achievement. *Public Health Reports* 102: 356–360.

Robson J, Falshaw M and the 'Health East Enders Project' (1995). Audit of preventive activities in 16 inner London practices using a validated measure of patient population, the 'active patient' denominator. *British Journal of General Practice* 45: 463–466.

Rogers D (1982). Community-oriented primary care. *Journal of the American Medical Association* 23848: 1622–25.

Roland M, Coulter A (eds). (1993). *Hospital referrals*. Oxford: Oxford University Press.

Rose G (1992). *The strategy of preventive medicine*. Oxford: Oxford University Press.

Russell EM (1988). Community medicine and primary care in Scotland. *Community Medicine* 10: 112–16.

Sanders D, Coulter A, McPherson K (1989). *Variations in hospital admission rates: a review of the literature*. London: King's Fund.

Schieber G, Poullier J P, Greenwald L (1994). Health system performance in OECD countries, 1980–1992. *Health Affairs*, Fall 100–112.

Scott-Samuel A (1991). *Total participation, total health – the Peckham health centre*. Edinburgh: Scottish Academic Press.

Secretary of State for Health (1989). *Working for Patients*. London: Her Majesty's Stationery Office CM 555.78.

Secretary of State for Health (1996a). *Choice and Opportunity. Primary care: the future*. London: Stationery Office, Cm 3390.

Secretary of State for Health (1996b). *Primary Care: delivering the future*. London: Stationery Office, Cm 3512.

Secretary of State for Health (1996c). *The National Health Service. A service with ambitions*. London: Stationery Office, Cm 3425.

Secretary of State for Social Services (1986). *Primary health care: an agenda for discussion*. London: Her Majesty's Stationery Office Cmd 9771.

Secretary of State for Social Services (1987). *Promoting better health*. London: Her Majesty's Stationery Office Cm 249.

Shanks J, Khera JS, Fish S (1995). Better ways of assessing health needs in primary care. *British Medical Journal* 310: 480–1.

Shapiro J (1994). *Shared purchasing and collaborative commissioning within the NHS*. Birmingham: National Association of Health Authorities and Trusts.

Shaw CD (1980). Aspects of audit: the background. *British Medical Journal* 1: 1256–1258.

Sheldon T, Seith P, Borowitz M, Martin S, Carr Hill R (1994). Attempt at deriving a formula for setting general practitioner fundholding budgets. *British Medical Journal* 309: 1059–64.

SMAC (Standing Medical Advisory Committee) (1990). *Blood cholesterol testing: the cost-effectiveness of opportunistic cholesterol testing*. DHSS, London.

Smith R (1991). Rationing: the search for sunlight. *British Medical Journal* 303: 1561–2.

Spencer J (1993). Audit in general practice: where do we go from here? *Quality in Health Care* 2: 183–188.

Spratley J (1989). *Disease prevention and health promotion in public health care. Team workshops organised by the Health Education Authority. Evaluation report*. Public Health Division, Health Education Authority.

Starfield B (1992). *Primary care. Concept, evaluation and policy*. New York: Oxford University Press.

Starfield B (1994). Is primary care essential? *Lancet* 344: 1129–1133.

Stott NC, Davis RH (1979). The exceptional potential in each primary care consultation. *Journal of the Royal College of General Practitioners* 29: 201–205.

Strong PM (1992). The case for qualitative research. *International Journal of Pharmacy Practice* 1: 185–6.

Tomlinson B (1992). *Report of the inquiry into London's health service, medical education and research*. London: Her Majesty's Stationery Office.

Toon P (1994). *What is good general practice?* Occasional Paper 65. London: Royal College of General Practitioners.

Tudor Hart JH (1988). *A new kind of doctor*. London: Merlin Press.

Tudor Hart JH (1994). *The National Health Service past, present & future*. London: Socialist Health Association

Turner A, Singleton N (1994). *Primary health care team workshops – do they achieve their objectives?* Department of Public Health, Mid Downs Health Authority, October.

UNICEF/UNFPA/OPS/ONS/MINSAP (1991). *Cuba's Family Doctor Programme*. Havana, Cuba. March 12–16.

Vuori H (1984). Primary health care in Europe – problems and solutions. *Community Medicine* 6: 221–31.

Waine C (1992). The primary care team. *British Journal of General Practice* 42: 498–499.

White K L (1991). *Healing the schism. Epidemiology, medicine and the public's health*. New York: Springer-Verlag.

White KL, Williams TF, Greenberg BG (1961). The ecology of medical care. *New England Journal of Medicine* 265: 885–92.

Whitty P, Jones I (1992). Public health heresy: a challenge to the purchasing orthodoxy. *British Medical Journal* 304: 1039–41.

Williams A (1987). Screening for risk of CHD: is it a wise use of resources? In: M Oliver, M Ashley-Miller and D Wood (Eds), *Screening for Risk of Coronary Heart Disease*. Chichester: John Wiley.

Williams S (1994). COPC and needs assessment. *Primary Care Management* 3: 10–12.

Willis A (1992). Who needs fundholding? *Health Services Journal* 30 April, 24–6.

World Health Organization (1978). *Alma Ata 1977, primary health care*. Geneva: WHO, UNICEF.

World Health Organization (1981). *Global strategy for health for all by the year 2000*. Geneva, WHO.

Wright RA (1993). Community-oriented primary care. The cornerstone of health care reform. *Journal of the American Medical Association* 269: 2544–2547.

Appendix

International experience

The principles of COPC were first formally delineated by Sydney Kark (Kark 1974). His ideas grew out of the experience of attempting to provide appropriate services in materially deprived areas of rural South Africa. They were refined following his subsequent emigration to Israel (Kark and Kark 1983, Abramson 1983). Colleagues at the School of Social Medicine, Haddassah Medical Organisation, Jerusalem where Kark was Professor of Social Medicine remain among the principal exponents of COPC. With the imprimatur of the World Health Organisation, programmes have been initiated in many parts of Africa, Asia and South America (Kark 1981).

COPC in Israel

Abramson, Epstein and others have maintained the strong COPC tradition at the Haddassah Medical Organisation in Jerusalem. From the health centre in Kiryat Hovel which is attached to the teaching hospital, COPC has been taught since the 1960s. Salaried physicians and nurses give primary care to a defined population in this Jewish neighbourhood of western Jerusalem by arrangement with Kupat Holim, the Health Insurance Institution of the General Federation of Labour and the Jerusalem City Health Department. Several preventive community health programmes have been coordinated from the health centre. These have been concerned with child growth and development, antenatal care, the health behaviour of school children, the control of cardiovascular disease and the care of house-bound patients, for example (Kark and Kark 1983, Palti *et al.* 1977).

The largest programme involved multiple risk factor interventions to address the 'Community Syndrome of Heart Disease and Diabetes' (CHAD). (Hopp 1983, Abramson 1981). Evaluations at ten year intervals have demonstrated a reduction in the prevalence of cigarette smoking and hypertension with minimal effect on the target population's mean body mass index or serum cholesterol. The PROD programme (Promotion of Growth and Development) targeted at women and children aged between 0 and 5 years was initiated in 1972 (Palti *et al.* 1977). The beneficial impact of various interventions on anaemia in pregnancy and childhood, breast feeding and cognitive development has been described (Palti *et al.* 1982).

COPC in the USA

The other main focus for COPC activities has been the United States (Geiger 1983). COPC has served as the conceptual basis for many publicly-funded programmes over the last three decades. The growing national concern with rising health care costs has renewed interest in primary care as a means of rationalising the use of high cost secondary care (Wright 1993, Miller and Luft 1994). The potential applicability of COPC in many other practice environments is becoming more apparent. A major study

was undertaken by the Institute of Medicine in Washington in the early 1980s to describe its feasibility, marginal costs and potential impact (IOM 1984). Seven study sites were selected in a non-random of manner from a pool of 147 practice sites to represent a cross-section of practice environments. The sites differed in terms of the dominator population served, in the organisation and financing of the primary care programme. Variations in these characteristics was reflected in the particular expression of the COPC model at each site (Nutting *et al.* 1985).

The organisation of financing was critical. Successful progress required the financial base to support the programme as many COPC activities are not reimbursable as direct patient services. Although in the USA, the concepts of COPC have been directed primarily at the care of poverty groups, several practices operate in middle class communities. The study found examples of COPC in many sectors of the US health care system, well beyond the publicly funded programmes addressing underserved populations.

Commitment to COPC by the practitioner rather than by the community was the driving force maintaining regular activities. Each of the study sites had at least one physician who was an enthusiastic advocate of COPC principles and who continually challenged the organisation to maintain a focus on the health needs of the entire community. COPC could thrive even in practices where family physicians were indifferent but at least one local champion was necessary.

Community involvement, though abundant, tended to be focused on operational issues for the health care facility itself such as opening hours and patient satisfaction. Attention was directed primarily at issues affecting 'the numerator' of active patients rather than health issues affecting the entire denominator community. Despite the widespread use of quantitative techniques for which computerised databases were essential, all sites initially identified health problems based on the subjective impressions of both practitioner and consumer groups.

There was a disappointing lack of data on health outcomes achieved (O'Connor 1989). Reports from the community health centres, the Indian health service and Kaiser-Permanente, suggested important changes in the health care and health status of recipient communities that might be attributable to the COPC functions. However, with the possible exception of some work from Kaiser (Greenlick *et al.* 1983), these studies did not attempt to describe the marginal costs required to achieve the observed impact. The need to adapt appropriate techniques of demography, epidemiology and evaluative research in a form useful to the practice under primary care conditions was evident. The development of the necessary quantitative tools was seen as an important next step in the application of the COPC model.

Despite regular endorsements of COPC's potential, the research and development agenda laid down in the Institute of Medicine's report has yet to be addressed.

Experience elsewhere

In general, medical schools throughout the world have not yet recognised the desirability of population-based approaches to the provision of health services. A notable exception is McMaster University in Ontario which has attempted since its inception to integrate the skills of population medicine with those of clinical practice (Starfield 1992). The Rockefeller Foundation in the United States has used this model to encourage the development of programmes in many medical schools throughout the world.

Several Latin American countries are actively pursuing an agenda for COPC. In Cuba, family physicians have been trained since the mid-1980s to spend half their time in the community providing services in organisations such as schools, day care centres and factories collecting information on the community health care needs. They are expected to document the frequency of health problems in their practices and plan their clinical work to address population needs (UNICEF 1991). In Mexico, Costa Rica, Nicaragua and several other countries medical education is directed at training physicians in this way. Work in the community is part of the curriculum during each year of medical training (Brabeman and Mora 1987). There is also a burgeoning COPC network in the Galician region of Spain (Kark *et al.* 1993).

COPC aims to promote better health through the early identification of problems. Although COPC is a well-established approach worldwide, it has attracted little attention in the UK.

This report describes the evaluation of a pilot programme initiated by the King's Fund, to measure the effectiveness of COPC in the UK. The aim is for primary health care teams to gain a broader understanding of patients' needs so that more appropriate services can be developed. The evaluation of the programme focuses on: the success of the pilot projects; the development of an appropriate training package; the cost-effectiveness of COPC; its comparison with other initiatives and its future development.

This report, one in a series from the King's Fund, is a major resource for primary health care teams wishing to adopt a COPC approach.

Related titles

Community-Oriented Primary Care – A resource for developers
Community Development and Involvement in Primary Care –
A guide to involving the community in COPC
COCP Depression & Anxiety Intervention Guide

ISBN 1-85717-154-3