King's Fund

Developing Primary Care in London

From 1990 to PCGs

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Executive summary

The aim of this work is to support primary care groups (PCGs) in developing primary care in London. It is directed at all those involved in primary care development, including members of PCGs, trusts and health authorities.

There is no single definition of primary care development. It is taken here to refer to the constellation of ideas, activities and policies which better enable those working in primary care to achieve the aims of the service. The central policy aims of PCGs have been spelled out – to improve primary care provision, to commission services and to contribute to wider health improvements, all in cost effective ways. However, the processes and mechanisms by which these tasks can be achieved are just starting to be elaborated. From the point of view of PCGs, any approach to primary care development must relate to their key tasks. It must also apply to primary care in its broadest sense, including community trusts, pharmacists and others.

In this light, this document suggests a pragmatic five part framework for primary care development, comprising the following areas:

- **Practice development** – including both people and buildings
- **Service development** – changes in the range and types of services offered
- **Professional development** – of medical and non–medical primary care staff
- **Organisational development** – practice teams and primary care organisations
- **Strategic development** – secondary care services and the functions of primary care which increasingly relate to activities beyond individual patient care and individual practices

In Chapter 2, we discuss various definitions of primary care and of quality in primary care and the different approaches to primary care development. PCGs need to spend some time agreeing their specific objectives with their constituents, including the public. A key message is that there has been, and will continue to be, a mixed economy of primary care development. Many different agencies over the past decade

have played a part in primary care development and whilst PCGs are now likely to have a central role, they will continue to operate in this mixed economy. Thus they need to work across organisational boundaries and with inputs from different agencies and sources. Primary care development takes place within a broad local health economy and is most successful when a 'whole system' approach is taken.

In Chapter 3 we look at some of the key features of London's population which are particularly relevant to primary care. There are longstanding inequalities in the health of Londoners and some groups, such as ethnic minorities or those with mental health problems, are both particularly disadvantaged and over-represented in London. PCGs will need to agree an approach to needs assessment and to deciding priorities locally. This will require meaningful lay involvement beyond the single lay member on each board.

In Chapter 4, we look at the characteristics of primary care, mainly general practice, in London. Inequalities in health are mirrored by inequalities in primary health care provision. There are longstanding problems of recruitment and retention of GPs and other primary care professionals and of poor quality premises. These variations need to be addressed and will require the potentially unpopular redistribution of resources between practices within PCGs.

Chapter 5 looks at service development in primary care. Among changes which have taken place in primary care over the past decade are the shifting of services between primary and secondary care and the development of new forms of out-of-hours care, both of which can be considered as approaches to demand management. These approaches require the multi-practice working which will be central to PCGs' success. As PCGs make the transition to primary care trusts (PCTs), there will be increased financial and organisational opportunities for the integration of services across boundaries with secondary care and social services.

Chapter 6 looks at the professional development of those working in primary care. In the past medical staff in primary care have had greater access to professional development than other groups, but successful clinical governance requires whole team involvement and thus wider access to professional development resources and

both practice-wide and PCG-wide approaches. Access to resources will be crucial and this requires work across PCG boundaries and with other organisations such as audit groups, academic departments and research and development networks.

In Chapter 7, organisational development in primary care is discussed. A central premise of this work is that there are important lessons to be learnt from other primary care innovations over the last decade, such as fundholding and total purchasing. From these we know that the success of PCGs is dependent on intensive organisational development at board level and across the PCG as a whole. This must address the way in which PCGs and the practices within them relate to many other organisations and individuals – including other practices, trusts, health authorities, local authorities and the public. Ways of working at the boundaries will be crucial – practices working together within PCGs as well as work between PCGs. This is dependent on a new sense of accountability and professional corporacy, which will underpin progression to PCT status. New primary care organisations such as Personal Medical Services (PMS) pilots also allow the emergence of new forms of accountability and new levels of control over the activities of primary care professionals.

Chapter 8 addresses strategic development in primary care. In order to meet their role for strategic tasks such as health improvement and the development of Primary Care Investment Plans (PCIPs), PCGs will need to work across sectoral boundaries, with the public and with other PCGs. This last point is crucial because it is inevitable that some areas of strategic development require a broader geographical and organisational base, perhaps even a pan-London approach.

Finally in Chapter 9, we draw some conclusions and make recommendations for early tasks for PCGs. Although PCGs are now at the centre of primary care development, this agenda operates at different levels – practice level, PCG level, supra-PCG level and pan-London level. PCGs are not the only organisations supporting primary care development, but they are well placed to act as local development agencies, bringing together inputs from other parties, such as practices, community trusts, academic departments, local authorities and others.

Key early tasks for PCGs include:

- **Achieving a consensus on the aims of primary care and on priorities locally among the board, their constituents and other stakeholders, including users. This implies the development of ways of communicating with constituents and stakeholders.**
- **Developing an approach to the redistribution of resources to less well-resourced practices.**
- **Agreeing a framework for the management of poorly-performing practitioners, a part of clinical governance.**
- **Developing an approach to health improvement and inequalities. This must include partnership working across sectoral boundaries and between PCGs.**

Acknowledgements

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1. Introduction

The aim of this document is to support primary care groups (PCGs) in developing primary care. It is based on an analysis of policies and trends in primary care development in London since 1990, including PCGs and other recent changes. The work is directed widely at those involved in primary care development in London, including members of PCGs, trusts and health authorities (HAs), professionals and educators in primary care.

The three key functions of PCGs have been explicitly defined (Secretary of State for England 1997) as:

- developing primary care and community health services
- improving the health of the community
- commissioning hospital services.

We take the view that primary care development goes beyond the provision of services within primary care to include the achievement of all the above functions. This work presents an approach to primary care development that recognises the key functions of PCGs and new imperatives such as clinical governance. Significant primary care development programmes have been under way nationally and in London, particularly since 1990. This work includes an analysis of the effects of these programmes and follows in part from earlier unpublished work by the London Commission at the King's Fund.

Chapter 2 presents some theoretical and practical approaches to the definition of both 'primary care' and 'development'. A framework is suggested for thinking about primary care development. This forms the basis for the rest of the document. Chapter 3 presents the context – some of the key characteristics of London's population. Chapters 4 to 8 discuss the components of the proposed framework for primary care development – practice development, development of services, professional

development, organisational development, and strategic development. In each case the impact on primary care in London of key policies since 1990 is analysed, as well as the implications for PCGs today. Finally, in Chapter 9 conclusions are drawn, including recommendations for PCGs and for primary care in London generally.

2. Approaches to primary care development

If PCGs and others are to work together on primary care development, this requires shared understanding about the meaning of the terms. This is part of identifying a common vision, which is essential to successful partnership working. In this Chapter we address quality in primary care and suggest a framework for development that reflects a broad definition of primary care.

2.1. What do we mean by primary care?

There is no single definition of either general practice or primary care and the terms are often used interchangeably. Inevitably activities and meanings change over time and interested parties develop labels and definitions to suit their own visions and ideologies. Definitions of primary care reflect its content, its relationship *vis à vis* hospital specialties, its location in the community rather than in hospital, its underlying philosophical or intellectual bases and its aims and roles.

An important consideration is the distinction between primary care and general practice. Lewis (1999) points out that until 1974 the term 'primary health care' was rarely used, but since then has gained in usage with increasing recognition of the ways in which health visitors, nurses and GPs should relate and work together. Primary care is a wider entity than general practice, encompassing the contributions made by non-medical health professionals and other organisations. However, many discussions about primary care are often effectively about general practice. This uniprofessional focus is undesirable because it gives pre-eminence to GPs and underemphasises the contributions of other primary health care professionals who play a part in patient care – such as nurses, health visitors and pharmacists. Clearly an approach is needed that reflects these different elements appropriately. In this respect, the GP-dominated but multiprofessional composition of PCG boards may be interpreted as a step in the right direction.

Toon (1994) identified three different models of general practice each supported by a different underlying philosophy: the **biomedical** model, which is the basis of scientific medicine; the **humanist** model, of which the Balint movement is a particularly well developed example; and the **preventive** or public health model. Toon has suggested that each of these assumes different aims for general practice and this has led to difficulties in deciding what constitutes good quality general practice.

Other definitions recognise the different dimensions of primary care. Vuori (1996) suggested that primary care is several things – a level of care, a set of activities, a strategy for organising health services and a philosophy for a health care system. Hughes and Gordon (1992) defined primary care very broadly as a network of services covering the whole spectrum of health and social care including, for instance, residential care.

Most pragmatic UK definitions include concepts of:

- the **site** or **level** of care (in the community and not in hospital)
- the **point of contact** (first)
- the **access** (direct)
- the **scope** (generalist) (Pedersen and Wilkin 1999).

Disagreements are often about the appropriateness of boundaries between primary care and other forms of care. While recent policy has stressed the need for a 'seamless service', some commentators have suggested that these seams and boundaries have important organisational meanings that need to be recognised (Heath 1998).

These arguments are relevant to the question 'what is primary care (or general practice) for?' Government policies during the 1980s and 1990s have sometimes shown a lack of clarity as to the underlying aims of primary care, instead being dominated by the need to control costs or introduce financial incentives to improve the quality of care (Department of Health 1989). More important than defining

primary care is achieving consensus about what we want it to achieve. As PCGs attempt to make strategic plans for their areas, early discussions should centre on the role of primary care and reflect a wide range of views.

2.2. Quality in primary care

There is unacceptable and longstanding variation in the quality of primary care in London. PCGs are expected to improve primary care provision and address variations in quality through clinical governance and service development. Clearly the aim of development is to improve quality. PCGs are challenged not only to improve quality but also to demonstrate this improvement. However, there are significant practical and methodological difficulties in assessing the quality of primary care. These problems are discussed only briefly in this document. They are covered in depth in another paper in this series by Greenhalgh and Eversley (1999). These authors point out that despite an increasing emphasis on population-based approaches to the measurement of quality, the search for a single national package of indicators is likely to be of limited value. The assessment of general practitioners' work requires a multidimensional framework that reflects the different perspectives of all the individuals and groups involved in primary care.

For PCGs, a major challenge is to address poor quality in practices with little inclination to improve. This is a problem that successive policy and professional initiatives have failed to resolve. The Royal College of General Practitioners has long been concerned with improving quality in primary care (RCGP 1985). However, the RCGP work is often perceived as 'preaching to the converted'. It has not generally addressed the problem of how to involve the practices and GPs performing least well. A response to this problem, proposed by the Department of Health in the 1980s, was the introduction of a financial incentive called a 'Good Practice Allowance' (Department of Health and Social Security 1986). This foundered amidst medico-political recriminations (Hart 1988). However, the GP Committee of the British Medical Association has recently accepted the linking of financial incentives to a 'basket' of quality-related performance indicators.

For PCGs, it remains to be seen whether the expected combination of peer pressure, 'sticks and carrots' and increased user involvement will succeed where previous initiatives have not. It is unlikely that PCGs will have the resources to use financial incentives extensively without significant redistribution between practices. This is likely to be resisted by practices that may be resource losers and possibly by local medical committees (LMCs). Successful clinical governance may be as much about developing new ways of working between practices as about using traditional tools such as audit (Roland *et al.* 1998). This is an area where working across PCGs and capitalising on existing experience and expertise, particularly in health authorities (HAs), is likely to be helpful.

2.3. What is primary care development?

Just as there is no single definition of primary care, there is no universal definition of primary care development. Pragmatically, the meaning used here is that primary care development refers to the constellation of ideas, activities and policies that better enable those working in primary care to achieve the aims of the service. This definition begs the questions as to what those aims are and, as mentioned above, the aims have changed over time and have not always been clear. Currently, the central policy aims of PCGs have been spelled out – to improve primary care provision, to commission services and to contribute to wider health improvements, all in cost effective ways (Secretary of State for England 1997). From the point of view of PCGs, any definition of primary care development must relate to these functions.

A framework for primary care development

In the absence of a single definition, this document suggests a five-part framework for primary care development:

- **practice** development – including both people and buildings
- **service** development – changes in the range and types of services offered
- **professional** development – medical and non-medical primary care staff

- **organisational** development – practice teams and primary care organisations
- **strategic** development – secondary care services and the functions of primary care that increasingly relate to activities beyond patient care and beyond practices

This framework provides a pragmatic approach that reflects the tasks of PCGs as well as trends and areas of development that have been particularly important over the last decade. It also reflects the recent history of primary care development in London and elsewhere. Too often policies fail to take into account the effects of previous policies, from which health care professionals and managers are still reeling.

This framework applies to primary care in its broadest sense, including community trusts, pharmacists and others. PCGs will need to take a similarly inclusive approach.

The mixed economy of primary care development

Central policy development in primary care has been extremely intensive during the late 1980s and the 1990s, in part motivated by a cost containment agenda but also by concerns over quality (Klein 1995). However, central policy is only one influence on primary care development. Most primary care development, with the exception of the commissioning function, predates this period. From the 1950s onwards, the input from the RCGP has been extremely significant and the period from the 1966 GP Charter to 1989 has been called the 'golden age' of general practice (Plamping 1996). The professional input into primary care development continues, for instance from the RCGP, from academic departments of General Practice and from medical audit advisory groups (MAAGs).

During the 1990s, the role of HAs and family health services authorities (FHSAs) in primary care development has been pre-eminent. From 1990, FHSAs were responsible for implementing many of the central policy directives and HA managers gained considerable experience in working with primary care professionals in a developmental way, sometimes with LMCs. Other organisations that have contributed to primary care development include community trusts, the voluntary sector and management consultants in the private sector.

Ways of working in primary care development

For PCGs, an important consideration will be to build on existing expertise in primary care development. London-specific initiatives such as the London Implementation Zone (LIZ) were catalysts for development. Although the results in terms of measurable quality improvements may have been disappointing, much was learnt about ways of working, such as engaging professional interest from even the least well performing practices. As a result of the creation of PCGs, much of the 'intelligence' around primary care development resides with middle ranking health authority managers who have now moved on to new posts, not all in PCGs.

As Iona Heath (1995) points out, the recurrent problem of lack of continuity comes from primary care management, not primary care health professionals. This contributes to the cynicism that GPs express towards managers.

PCGs' professional dominance may be seen as a way to engage health professionals who have previously been sceptical about management and primary care development, but these professionals may have less experience than HA managers. One problem will be the lack of a shared vision among PCG boards and members about the role of primary care. The Urban Health Partnership (UHP) has championed innovative 'whole system' approaches to development in the face of intractable ('wicked') problems in primary care in cities. Traditional change initiatives, often through short-term projects in one part of the system, generally fail to learn from earlier investment ('projectitis') or to deliver desired outcomes. The foci of the UHP's interventions are the connections between different parts of the whole health system (Harries *et al.* 1999). In their experience, successful partnership working can develop even without shared responsibility and vision, a state that may characterise the early days of PCGs (Pratt *et al.* 1998).

Finally, the Royal College of General Practitioners, among others, has promoted the role of action learning sets in primary care development that are person-central, mobilise resources and build networks (Billingham *et al.* 1999).

Key points

- As they approach primary care development, PCGs need to include the full range of primary care providers.
- PCGs need to achieve a consensus on the aims of primary care among their constituents, including the public.
- PCGs need to work across organisational boundaries and to build on existing expertise and the successes of earlier approaches to primary care development.

3. London's population

PCGs' roles depend on a population perspective more than has previously been required in primary care. Knowing the characteristics of their populations is essential to inform decisions about provision, commissioning and health improvement. In this section some of the unique characteristics of London's population are described and compared with the rest of the country. Of particular relevance to Londoners' needs for primary care are the age distribution of Londoners, their ethnic diversity and the level of social disadvantage in the capital. However, PCGs will be making decisions for their local populations. There will be a tension between relying on existing, often higher level, information and developing an understanding of local needs. In the final part of this Chapter some of the implications for PCGs of achieving a population perspective are discussed.

3.1. The demographic profile of Londoners

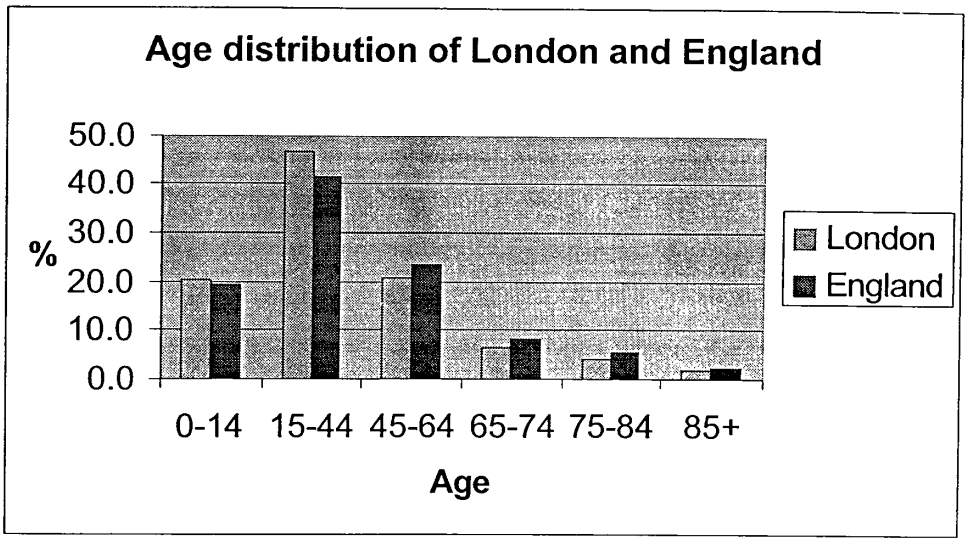
Age

London is home to one of the most diverse populations in the UK. Seven million people were living in the 32 London boroughs in 1996, amounting to 14 per cent of England's total population (Boyle and Hamblin 1997). It is estimated that London's population will grow by about 15,000 people per year over the next decade (Bardsley and Flatley 1998).

Figure 1 shows the age distribution of London and England based on a five-year population projection from 1996 to 2001. London has a greater proportion of young people aged 15–44 (67 per cent) than the rest of England (61 per cent). This is particularly true in inner London: in East London and the City 25 per cent of the population are under 15 and nearly 75 per cent are under 45. In contrast, outer London health authorities (HAs) have an older population – in Bromley 59 per cent are under 45. London imports younger people from the rest of the UK and abroad and exports older people mainly to the south east of England. Many of the health problems of Londoners are associated with a younger population, for example

substance misuse, mental ill health, HIV/AIDS and teenage pregnancy (Bardsley and Flatley 1998).

Figure 1: Age distribution of London and England based on a five-year population projection from 1996 to 2001



Data based on Public Health Common Data Set 1996. Department of Health. Five year population projection: mid 2001

Minority ethnic populations

Twenty six per cent of Londoners belong to minority ethnic groups. Almost half of the UK's minority ethnic population live in London, half of whom were born in the UK. In the 1991 Census, every borough recorded at least one minority community of more than 2,000 people from one of the nine major ethnic groups, many boroughs having seven or eight such communities (Bardsley and Hamm 1995). The HAs with the largest minority ethnic populations are East London and the City, and Ealing, Hammersmith and Hounslow. The largest black populations are found in Lambeth, Southwark and Lewisham (24 per cent) and East London and the City (20 per cent). The minority ethnic population in London is expected to increase by the year 2011 with a decrease in the white population. Different minority ethnic populations have specific health needs, partly because some illnesses are more prevalent in some

groups, such as stroke, coronary heart disease, diabetes and schizophrenia (Balarajan 1995, Nazroo 1997) and partly because of cultural and language differences that make access to health care difficult.

London also comprises a growing number of refugees and asylum seekers. About 43,000 applicants have been granted refugee status since 1989 and a further 54,700 were awaiting a Home Office decision in 1995 (Atkins and Flatley 1996). These groups are perhaps the most disadvantaged of any and present major challenges for health and social welfare services (Levenson 1999).

Social disadvantage

The health and health care needs of a population are related to its level of social disadvantage (Acheson 1998). Social disadvantage can be measured using a variety of composite socio-economic indicators, such as the Jarman UPA8, Townsend and Carstairs scores. The factors included in these indicators vary to some extent. As an example, the UPA8 measure is composed of the following factors:

- older people living alone
- children aged under five
- unemployment
- proportion recently moved
- lone parent households
- proportion of workforce unskilled
- overcrowding
- proportion minority ethnic groups

In 1991, deprivation in parts of London as measured by the UPA8 score was greater than in the rest of England (Boyle and Hamblin 1997). However, a notable feature within London is the great variation in socio-economic status. Overall, deprivation is greatest in eastern areas of London and 28 per cent of wards in London have UPA8 scores over 30, for which GPs attract deprivation payments. Examination of the ten most deprived wards in London shows that the contribution made by the component variables are not the same in areas with similar UPA8 scores.

For example, Holy Trinity in Tower Hamlets and St. Mary's in Greenwich have roughly the same UPA8 scores, but apart from unemployment, in Tower Hamlets the principal contributors are the number of minority ethnic groups and the level of overcrowding, whereas in Greenwich they are the number of lone parents and under fives. Thus socio-economic deprivation is not a single phenomenon and different deprived areas demand different services from London's health system. Similar considerations apply to homelessness, another measure of social disadvantage.

Homelessness tends to be concentrated in inner city areas and comprises complex populations, with different health needs (Pleace and Quilgars 1996). Measures of social disadvantage and standardised mortality ratios can be combined to produce indices of health care needs for acute and psychiatric care (Carr-Hill *et al.* 1994). Sixty per cent of London wards have higher than average psychiatric need, although these wards are not necessarily the most deprived in terms of the UPA8 (Boyle and Hamblin 1997).

3.2. The implications of London's population for PCGs

The population factors described in this Chapter imply particular health care needs. PCGs vary in size and include practices with very different populations. Boards will have to make health care decisions reflecting the needs of their whole population, although not all board members will have knowledge of their diversity. PCGs need public health skills and boards will have to decide the extent to which they will undertake needs assessment *de novo* locally. Needs assessment can be resource intensive, but the process of carrying it out in at least some areas may be educational for PCG boards in terms of developing a population perspective. A variety of methods can be used for needs assessment and some may be more appropriately carried out across several PCGs. Lay involvement needs to be deliberately developed, rather than relying on the limited lay membership of PCG boards. This is a particular priority for decisions that reflect the needs of the large and growing minority ethnic population. Furthermore, addressing inequalities may imply a redistribution of health care resources away from some of the less deprived practices, which may cause

discordance. Previously HAs have struggled with this dilemma and it is likely that PCGs will find this just as difficult.

Key points

- **PCGs will need to agree on their approach to local needs assessment, including the use of public health advice and the possibility of working jointly with other PCGs.**
- **Agreeing priorities requires a shared consensus among PCG members and stakeholders, including the public, on the ethics and values of health and health care provision.**
- **Lay involvement beyond the single lay member on each board is essential for PCGs to produce valid assessments of needs and priorities, particularly to reflect the needs of groups with poor access to health care such as minority ethnic groups.**

4. Practice development

Practice development is central to the PCG role of improving primary care provision. In this Chapter some of the specific areas of staff and premises development are outlined, and the implications for PCGs discussed.

The premises and staff working in primary care are fundamental to good quality primary care. However, variation in practice development across London is well established and is a significant challenge for PCGs. Less well developed practices are most likely to be in areas of greatest social deprivation. This trend persists despite a number of specific policy developments to address these problems during the 1990s (Lewis 1998). Experience from these provides evidence for PCGs on how to approach premises and staff development.

Policy developments of particular relevance include the following:

- **The 1990 contract** (Department of Health 1989) used financial incentives to promote changes in the numbers and range of staff employed and in services offered.
- **Fundholding** (Secretaries of State for Health, Wales, Northern Ireland, Scotland, 1989) and its variants such as Total Purchasing Pilots and Multifunds gave GPs budgets and led to changes in the type and numbers of staff and services provided, but were established more slowly in London than elsewhere.
- **Making London Better** was the Department of Health response to the Tomlinson report (1992). It generated a six-year programme of intensive primary care development in the London Initiative Zone (LIZ). Flexibility was introduced to a number of national regulations concerning the GP contract and the powers of health authorities to enable innovative solutions to entrenched problems of practice development. Expenditure on practice staff was increased by £41 million, on team development by £16 million and on premises by £165 million between 1993 and 1998 (Lewis 1998). The LIZ educational initiative (LIZEI) followed to address the issue of GP recruitment and retention.

- **The 'Turnberg report'** (1997) was a strategic review of London's health services that did not look in detail at primary care but did point out that, despite LIZ and LIZEI, very significant problems remained in the quality of practices compared with the rest of the country. It made recommendations to recruit and retain GPs, to expand the role of nurses in primary care and to improve premises.
- **PMS pilots** (Personal Medical Services pilots) 'went live' in 1998 (Department of Health 1996a). These encourage new forms of practice development with implications for the roles and responsibilities of practice staff. In particular, they offer the option of salaried service for GPs and wider roles for nurses.

4.1. The characteristics of general practitioners

Numbers and ages of GPs

There are important differences between London and the rest of the country with respect to the numbers and age distribution of GPs (Department of Health 1996b, Turnberg 1997, Boyle and Hamblin, 1997). London PCGs are faced with:

- larger overall average list sizes
- fewer GPs per head of population
- a growing population
- a falling number of GPs
- older GPs on average – 5 per cent over the age of 65 in London, compared with just 3 per cent in the rest of England.

These figures hide significant variability across London and each authority has a different profile. The age profile of GPs is a useful indicator of potential future changes in the provision of GPs. Fewer GPs are being recruited into the capital and PCGs will have to deal with a shrinking workforce in the foreseeable future.

Recruitment and retention of GPs

In inner cities across the UK there have been difficulties in recruiting and retaining newly qualified GPs in partnerships, but nowhere has the scale of the problem been as great as in London (Harris *et al.* 1993, Harrison and van Zwanenberg 1998). LIZ workforce flexibilities and the LIZEI programme were responses to these problems. The former provided financial incentives for GPs to take up single-handed and assistant posts. LIZEI was a programme of professional development with the aim of addressing the GP recruitment and retention problems in inner London. The approach is described more fully in Chapter 6. Essentially it allowed the development of a number of flexible schemes to attract young GPs to a combination of service and academic work, such as the London Academic Training Scheme.

For established principals, LIZEI allowed a range of opportunities to develop non-practice, non-clinical work and GPs have moved on from LIZEI schemes into a variety of posts including partnerships in London practices. A problem now is that funding for these approaches has ended and PCGs and HAs may find it difficult to continue them.

A number of other approaches have recently addressed the retention problem by recognising that independent contractor status is no longer desirable to many GPs, that alternative (salaried) options are needed and that careers have to allow for breaks, especially for women. The 'returner' scheme allows for a period of retraining for GPs who have been out of practice for some years. The 'retainer' scheme has recently been expanded to allow doctors who are only able to offer a few sessions to maintain their clinical skills.

More radically, PMS pilots established in 1997/98 allow GPs to leave the General Medical Services contract and enter a locally-negotiated contract to deliver personal medical services. This offers advantages for GPs in limiting their contractual and managerial commitments and agreeing appropriate remuneration. There were 14 PMS sites in London in the first wave and currently over 50 sites in the second wave of PMS pilots. It will be important to observe how PCGs support the development of PMS sites to further their own strategic aims.

Single-handed practice

The high proportion of single-handed and small practices is a distinctive characteristic of London's primary care. In 1997, 46 per cent of London practices were single-handed, as compared with 30 per cent in England (Lewis 1998). In LIZ, this picture has remained stable during the 1990s and small practices are likely to persist (Lewis 1998). Despite concerns that single-handedness may be associated with a poorer range of services and professional isolation, this model of practice is popular with some patients (Malbon *et al.* 1999) and can be consistent with high quality practice. The LIZ Collaborative Allowance offered financial rewards to single- and double-handed practices to form formal associations and to work together, but this ended with the LIZ programme on 31 March 1999. PCGs, as a vehicle for professional collaboration, may prove to be an important way of keeping the benefits of single-handed practice whilst addressing some of the disadvantages in relation to ancillary practice staff, for instance professional isolation and the loss of economies of scale.

4.2. The range and roles of non-medical primary care staff

There has been a significant growth in practice staff since 1987 and the introduction of the 1990 GP contract provided a catalyst for a change to the size and nature of the primary health care team. Between 1989 and 1997 there was a 61 per cent increase in practice staff whole time equivalent (wte) and a 118 per cent increase in practice nurses.

Nursing staff

Practice nurses play a central role in the provision of primary care (Bowling and Stilwell 1989, Twina *et al.* 1996). Both the numbers and the role of practice nurses have expanded, including the development of nurse practitioners. LIZ helped to address the relative paucity of practice nursing in London. In 1992, there were 0.31 nurses per GP in LIZ, fewer than in England as a whole, but by 1997 this figure had increased to 0.38, closing the staffing gap between LIZ and the rest of England (Lewis 1998). However, the level of practice nursing varies across London with practices in more deprived East London having fewer practice nurses per GP than elsewhere in London. In London practice nurses are often most difficult to recruit to smaller and

less developed practices and inner London has a relatively high turnover of practice nursing staff (Williams 1996). In addition, because GP list sizes are greater in London, access to practice nurses, when measured on a population basis rather than a GP basis, might still be lower in London than England as a whole (Lewis 1998).

Other staff

The LIZ primary care development projects have contributed to the development of a much broader range of staff working in and with GP practices. This includes counsellors, linkworkers (to work with minority ethnic groups), dieticians, chiropodists, physiotherapists and clerical and managerial staff. Again, as a result of LIZ initiatives, London now has more wte practice staff (non-nurse) per GP than England as a whole. In 1997 there were 2.01 wte practice staff per GP in London compared with 1.83 in England (Boyle and Hamblin 1997). This is a reversal of the position in 1990–91.

There has been no single 'aim' to this expansion of the primary health care team. The levers and influences behind the expansion of staff roles and numbers are various. They include financial incentives, professional development, the response to needs and demands and the shift of services from secondary to primary care discussed in the next Chapter. While in general this growth in the scope of the primary care team has been seen positively, there have been some reservations. The roles of non-medical staff may be relatively undefined. New roles may have been assigned to nurses without appropriate training (Ross *et al.* 1994).

The growth of counsellors in general practice has been particularly controversial. Counselling services may be valued by GPs in managing increasing numbers of patients with mental health problems but there are uncertainties about treatment outcomes (Corney 1996, King *et al.* 1994, Harvey *et al.* 1998). Some health authorities have been less willing to invest in these areas, in part due to a lack of data on effectiveness (Lambeth, Southwark and Lewisham 1998).

PCGs will need to develop ways of making decisions about new staff and services, balancing evidence for cost effectiveness against intense clinical pressures, especially

in traditionally underdeveloped areas such as mental health. For instance, many fundholders reacted to these pressures by buying in practice-based counselling services (Corney 1996) and PCGs must now decide whether to extend these across all practices or stop these services completely. Such decisions require reconciling complex evidence with political considerations such as the need to retain ex-fundholders' commitment to PCGs.

4.3. Premises

High quality premises are a cornerstone of effective primary care. Tomlinson (1992) recognised long-standing problems with poor quality premises in London. Consequently, improvement of premises ('getting the basics right') was one of the three main LIZ strategies to receive substantial investment (£165 million) (Lewis 1998). As a result, the percentage of London practices below minimum standard between 1992 and 1999 fell from 62 per cent to 32 per cent (Turnberg 1997, NHSE 1999). However, this improvement is balanced by the fact that by 1996 almost all practices in the rest of the country were of an acceptable standard and there was huge variation across London.

For example, in 1996, 69 per cent of practices in East London were below the minimum standard, compared with none in Croydon, although it is possible that such huge differences are in part due to the vagaries of data collection by different HAs. Persistently poor premises are likely to be a cause of lack of progress in other aspects of primary care development, such as team building. As well as HA schemes and LIZ, some financial investment into practice premises has come from GPs themselves. On occasion this has proved lucrative, but at times the personal financial risk involved has been a deterrent to investment by GPs.

4.4. Information technology

Information technology (IT) and computerisation are essential to good quality primary care. By 1992, approximately 70 per cent of practices nationally used

computers (Kernohan *et al.* 1995, Bradley 1993) but again London has been less developed than the rest of the country. Nevertheless by 1999 over 90 per cent of surgeries were computerised (NHSE 1999). However, we know relatively little about the way in which IT is actually used and the systems used in different sectors of the health service may not be compatible. The use of computers varies considerably from practice to practice (Applebee 1998). Ultimately all practices should be linked to the Internet but this may take several years. IT development is of importance for the management of clinical work, but also for audit, practice-based needs assessment and epidemiological research (de Lusignan *et al.* 1998). At both practice and PCG level, development of an IT strategy offers opportunities for links between practices, for education and for clinical governance.

4.5. PCGs and practice development

There have undoubtedly been improvements in structural aspects of practice development since 1990, especially through LIZ, although significantly deprived parts of London were not covered by LIZ. Overall, improvements have been slow, which reinforces the difficulties faced in London relative to the rest of the country. One problem is that the different areas of development are mutually dependent. Thus improvements in staffing levels may be limited by poor premises. In addition, the quality of primary care premises in London is not uniform, with lower standards in the more deprived areas of London. There is a risk of perpetuating an 'inverse care' effect whereby PCGs servicing the neediest populations may struggle most to establish themselves, in part due to lack of practice development (Arora and Gillam 1998).

For PCGs, the first stages of clinical governance will need to take into account the important variations in structural practice development both between and within PCGs. For instance, IT development will be a prerequisite for progress in areas such as audit and inter-practice work. Addressing these variations will require a variety of approaches. This is likely to involve redistribution of resources between practices and could be unpopular.

Key points

- In London, there are significant inequalities in the quality of practice premises and in staffing levels across London. Despite a decade of investment and progress, including initiatives such as LIZ, the capital compares poorly with the rest of the country.
- The first stages of clinical governance are likely to require significant practice development. Rectifying variations between practices will take time and resources. Failure to do so will perpetuate the inverse care law.
- Redistribution of resources between practices and the possible removal of services from fundholders are likely to be necessary but difficult to achieve for PCGs.

5. Service development

A major way in which primary care provision has developed at a practice level is through changes and expansions in services offered. As in other areas of primary care development, these changes resulted from a combination of different influences – some professionally led, others the consequence of local or national policy changes. The motivations have been varied, including the central policy imperative to contain costs, the linked view that some services provided in secondary care could be more appropriately provided in primary care, the concern with improving quality and professionals' concerns to improve their working conditions.

In this section the trends in some service developments that have been prominent since 1990 are examined. Previous policies such as fundholding have led to changes in service provision; PCGs and Primary Care Trusts (PCTs) will continue developments in this dimension. They offer the possibility of service developments shared between practices in a PCG and provide incentives for re-organising care between sectors as PCGs/Ts move towards budgets for the full spectrum of care.

5.1. Shifting services from secondary to primary care

A recent trend in service development has been the movement of services from secondary to primary care, sometimes called substitution, and the development of intermediate care between hospital and the community. However, patient and economic benefits have proved methodologically difficult to demonstrate. Trials are rarely randomised and the evidence rarely generalisable. PCGs and especially PCTs will need to consider carefully the organisational and economic implications of projects that affect this boundary. The boundary may become increasingly fluid, raising questions about the usefulness of the distinction between primary and secondary care. Previously, shifting costs into primary care was an incentive for HAs given that general medical services (GMS) were predominantly non-cash-limited at local level. This incentive will change as PCG/Ts adopt unified budgets.

Policies since 1990 have encouraged substitution. The 1990 contract introduced a specific payment for GPs to provide minor surgery for which their patients might previously have had to attend hospital. As a result, by 1991 73 per cent of GPs in England were on the minor surgery list (Harrison 1991). However, by 1997, only 56 per cent of GPs in the LIZ area were offering minor surgery compared with the national average of 81 per cent, although this gap has since narrowed (Lewis 1998). Fewer GPs in deprived areas provided the service (Boyle and Hamblin 1997).

Fundholding and Total Purchasing Pilots also encouraged service developments. Howie *et al.* (1995) reported that fundholding practices offered more services than they did before the scheme was introduced, mainly outreach clinics staffed by hospital clinicians. However, many initiatives failed to show evidence of improved patient care or cost effectiveness. For example, Gillam *et al.* (1995) showed that, although ophthalmic outreach was popular with both patients and GPs and effective in filtering demand for care in hospital, the unit cost per patient of outreach clinics was much higher than that of conventional outpatient treatment.

Substitution was one of the main aims of LIZ. A number of projects – including outreach clinics, hospital at home, providing specialist care in the primary care setting and placing GPs in accident and emergency (A&E) departments – were established through the LIZ scheme. Overall evaluation of these projects has produced mixed evidence. For example, Hensher (1995, 1997) looked at several LIZ schemes and found that hospital at home care and inpatient care combined was actually more costly than providing inpatient care. More generally, in a recent review of hospital at home schemes, Sheppherd and Iliffe (1998) concluded that the evidence remains equivocal and that further schemes should not be instituted until the completion of research currently under way. However, some LIZ schemes were economical. For example, the Wandsworth Intermediate Care Scheme demonstrated a growing throughput of patients over the two years and an overall reduction in costs such that the health authority has decided to continue this scheme (Yeo 1998). Placing GPs in A&E departments has been shown to be more successful; they tend to admit fewer patients and request fewer investigations than relatively inexperienced junior hospital doctors (Dale *et al.* 1996).

In LIZ substitution projects, difficulty releasing funds from the hospital sector following transfer of care is one reason why schemes 'failed' or ceased to operate (Lewis 1998). Significant costs are unlikely to be released unless whole wards are shut down. Given the relatively low up-take of these schemes, they are unlikely to attract enough patients to make them economically viable. Many of these LIZ initiatives have now ceased to operate and for others continued funding is uncertain.

5.2. Health promotion and disease prevention

The development of preventive services in general practice has been a notable feature of the 1990s and will remain important for PCGs, particularly in relation to clinical governance and the implementation of Health Improvement Programmes (HImPs). PCGs will have to address consistent variations related to socio-economic factors.

Until the 1990 contract, prevention was essentially a voluntary activity for general practices, although the RCGP has long encouraged activity of this sort (1983). The 1990 contract introduced a number of financial incentives concerning cervical screening, immunisation and child health surveillance, coronary heart disease prevention and chronic disease management (secondary and tertiary prevention). The financial incentives were effective in ensuring wide provision of services but these preventive measures attracted criticisms. These concerned the incomplete evidence for effectiveness for some of the interventions required, the bureaucratic burden of data collection and the lack of allowance made for patient choice (Morrell 1991).

Many preventive activities in general practice are performed by nurses rather than doctors, a factor associated with an increase in practice nurses following the 1990 contract. The financial incentives introduced then were followed by increases in rates of cervical screening and immunisation. In both London and in the rest of the country, a gradient exists showing that socio-economic deprivation is associated with lower rates of these activities, but this gradient is steeper in London. Overall, rates in London have consistently been lower than for the rest of the country, as shown in Table 1 (Boyle and Hamblin 1997). Factors explaining these differences include list inflation, population mobility and ethnicity (Majeed *et al.* 1994).

Table 1: Percentage of GPs reaching the higher target, 1994–95
(Boyle and Hamblin 1997).

	London	*Non-London*
Cervical cytology	56%	94%
Childhood immunisation	56%	86%
School-age booster	53%	86%

A similar picture applies to the provision of chronic disease management, with consistent variation between London and the rest of the country, as shown in Table 2. Underlying the LIZ average are significant variations between health authorities.

Table 2: Percentage of GP principals providing chronic disease management for asthma and diabetes in 1997
(Lewis 1998)

London (LIZ area)	*England*
85%	94%

Chronic disease management is a form of prevention that fits relatively easily into traditional clinical patterns of work. More particular difficulties followed the introduction of programmes for the primary prevention of coronary heart disease (CHD) in 1990, revised due to problems with the scheme in 1993 and again in 1996.

Due to poorly-thought-out incentive schemes introduced in 1990, by 1992 £80 million pounds had been spent on paying GPs for activities of dubious benefit (Ellis and Chisholm 1993). Furthermore, it was shown that an 'inverse care' law operated, both at individual patient and at population level, with those at greatest cardiovascular risk and of lowest socio-economic status least likely either to be offered or to attend for preventive services (Waller *et al.* 1990, Gillam 1992).

Currently there is little central guidance on the content of preventive services offered in general practice, and little available information on what is actually taking place in practice. However, there is now a wider acceptance that these are a core part of general practice (GMSC 1996) and a growing body of evidence around secondary

prevention of CHD in particular. Given HImP priorities, this area is likely to be an early priority for many PCGs.

5.3. Out-of-hours care

A major development during the past decade has been the expansion of out-of-hours services through inter-practice working. For PCGs, this successful example of multipractice organisation is highly relevant. PCGs need to ensure that over-arching developments in out-of-hours care relate to individual practices and to other parts of the NHS in a way that addresses the sometimes-conflicting requirements for access to and continuity of care, while maintaining quality.

GPs have 24-hour legal responsibility for the care of registered patients. Different pressures have resulted in revisions of the traditional model of out-of-hours care. GPs are reluctant to be personally on call for patients through the night, especially given the increase in out-of-hours calls over the last decades (Iliffe and Haig 1991). There were also concerns regarding the quality of care provided by deputising services (the 1990 contract introduced financial incentives to reduce their use) and the rise in attendances at accident and emergency departments. As a result, different approaches to out-of-hours care have been developed. In some areas, for instance Lambeth, Southwark and Lewisham, several different approaches were developed simultaneously in order to improve the out-of-hours service (Watkinson 1996). Such developments were facilitated when in 1995 the Department of Health established a £45 million fund for out-of-hours development and reformed the associated fee structure. Between 1993 and 1997 membership of the National Association of GP Co-operatives increased from 31 to 261, with a commensurate increase in London (NPCRDC 1998).

One of the most notable features of out-of-hours co-operatives has been the extent to which they have been initiated and led by GPs themselves, with relatively little external involvement. This is a potentially important model for PCGs, showing how voluntary inter-practice working can be successful when the benefits to participants are clear. A national evaluation of out-of-hours co-operatives has revealed that they

have much improved the quality of life of members and frequently provide a forum for educational activities (NPCRDC 1998). However, other findings are less positive. There has been a rise in demand on the co-operatives, financial constraints have limited some developments, there are concerns regarding the quality and lack of continuity of care and co-operatives have tended to be uniprofessional. Not all patients are satisfied with these new services (Salisbury 1997).

Out-of-hours co-operatives are part of a range of approaches to demand management. These include siting GPs in A&E departments and nurse-led telephone triage systems such as NHS Direct. Evaluation of nurse telephone triage systems has suggested that this may be a useful model but further evidence is needed (Lattimer *et al.* 1998, Munro *et al.* 1998).

5.4. Prescribing

Prescribing has attracted considerable attention from central policy makers and HAs over the past two decades, due to the inexorable rise in costs of prescribing in primary care and the variation in rates of drug expenditure between practices. These are factors that PCGs will have to address.

In 1985 the government introduced the 'limited list' as a way of controlling drug costs, to a mixed professional reception. However, from 1985 to 1995, the cost of drugs prescribed by GPs in the UK rose from 9.5 per cent of total NHS spending to 11 per cent, equivalent to nearly £4.5 billion in 1995 (Majeed and Head 1998). This represents 50 per cent of costs in primary care (National Prescribing Centre 1998). Since 1989, Health authorities have allocated GPs 'indicative prescribing budgets', increasingly capitation-based. Starting with GP fundholders, then Commissioning Pilots and now PCGs, there is a trend towards the complete cash-limiting of prescribing.

One of the government's expectations of fundholding was that it would reduce prescribing costs through cash limits and financial incentives. However, this did not happen, especially after the first one to two years of fundholding (Le Grand *et al.*

1998). In 1993 prescribing incentive schemes were introduced to improve the quality and cost effectiveness of prescribing by non-fundholders. In general, it has fallen to FHSAs (now HAs) to try to control and improve prescribing by GPs. A host of methods have been used, including the appointment of GP prescribing advisers, feedback of PACT prescribing data to individual GPs, the development of local formularies and generic prescribing, the development of policies to control prescribing at the interface between primary and secondary care and the use of guidelines. All these methods fall under the title of 'GP Prescribing Support'. They have generally used incentives rather than penalties and are essentially educational in nature. Although their effectiveness has not been conclusively demonstrated, certain approaches increase the likelihood of changing prescribing behaviour, such as brief, targeted, repeated visits (National Prescribing Centre 1998).

For PCGs, prescribing is an important starting point for clinical governance. It is an area in which GPs have already become accustomed to peer review and external scrutiny, with some evidence of successful behaviour change. PCGs should build on these existing experiences. One longstanding problem has been that high prescribing costs do not necessarily mean poor quality prescribing. In future, demographic and other factors may help PCGs weight prescribing budgets to reflect local needs (Majeed and Head 1998).

5.5. Service development and PCGs

For PCGs, service developments will be a part of their actions on health improvement and clinical governance and are likely to feature in their Primary Care Investment Plans (PCIPs). Financial incentives are a powerful but blunt tool, and the extent to which PCG/Ts are able to use their budgets to offer incentives to member GPs is not yet clear. In the past, financial incentives have successfully achieved an increase in activity but have not been as useful in ensuring the quality of that activity. The consistent differences between London and the rest of the country, and along the gradient of socio-economic deprivation, means that incentives (or penalties) that do not take into account factors underlying these differences (such as poor premises or

very mobile populations) will not address existing patterns of inequality in service provision and in health.

The benefits of shifting services from secondary to primary care have proved difficult to demonstrate. Access may be increased at the expense of service efficiency. Boundaries between primary and secondary care, between care provided by doctors or nurses and between health and social services are all moveable, but the impact of these changes on patient care has rarely been established. PCGs need to make decisions about how services are provided between sectors and the multi-agency composition of their boards should be useful to get the overview needed. As PCGs become PCTs, holding the budgets for patient care that cover the community, primary and secondary sectors of the NHS, the logic of these decisions will change as savings by cost shifting will not be available. There will be increased opportunities for the integration of services across boundaries and for collaboration between practices.

Rational approaches to decisions on provision of services require local needs assessment and service evaluations. PCGs will not have the capacity to carry out many of these themselves; they will have to rely on health authority and public health support and on central guidance such as National Service Frameworks. Lay involvement in these processes will be a particular challenge for PCGs not familiar with this area.

PCGs will have to address the extent to which service development creates demand rather than meets existing need. This was an issue raised when minor surgery incentives were introduced (Harrison 1991).

A persistent problem is the lack of agreement between stakeholders (including users) as to what constitutes appropriate and timely care for minor illness and injury (Roberts and Mays 1998). Specific problems with access to primary care need to be addressed in a way that builds on existing provision and responds to local needs. PMS pilots are improving access to care, for example by employing salaried doctors and nurses to provide services in different ways to specific groups. PCGs need to place the flexibilities offered by PMS in the context of their own strategic priorities. By

including non-cash-limited GMS monies, PMS offers the prospect of a truly unified budget and new incentives for demand management at practice level. PCTs are likely to extend the use of local contracts for these reasons.

Key points

- **Successful service development should reflect local needs assessment, service evaluation and lay involvement. In practice more pragmatic approaches will be needed.**
- **PCGs offer opportunities for multipractice working and service provision and Primary Care Trusts (PCTs) will offer increased opportunities for the integration of services across boundaries with secondary care and social services.**
- **Primary Care Investment Plants (PCIPs) should fund service developments in a way that does not perpetuate existing inequalities in health and health care.**

6. Professional development

Professional development allows health care practitioners to update and develop their skills and knowledge. The anticipated rewards include improvements in the quality of care and in professional satisfaction (Calman 1998). Professional development at practice and PCG level, of primary care professionals from all backgrounds, will underpin the achievements of PCGs. However, professional development processes have not always led to the benefits anticipated (Pendleton 1995).

Continuing professional development (CPD) is integral to clinical governance and to improving clinical effectiveness. PCGs are likely to have designated leads in education and training, possibly in addition to – and working closely with – the clinical governance leads. In order to adequately resource CPD, PCGs will need to develop an understanding of the complex relevant funding streams. They will need to successfully negotiate organisational and professional boundaries and build on the acquired expertise of existing approaches to professional development, for instance from health authorities, academic departments and clinical/medical audit groups. The recent re-structuring in the Thames Deaneries, so that GP clinical tutors are aligned to Primary Care Groups, underlines the importance of linking education and service needs (1999).

In the first part of this Chapter, recent approaches to professional development for postgraduate, undergraduate and non-medical members of the primary health care team are considered. In the second part, the role of evidence-based medicine as a mechanism for professional development is addressed.

6.1. Policy approaches to professional development

The importance of professional development in primary care, mainly through education and training and mainly but not exclusively for doctors, has been recognised in a number of national and London-specific policies since 1990, as shown in Table 3. The learning from these approaches is highly relevant to PCGs as they take on this agenda.

Table 3: Major policy initiatives since 1990 that have influenced professional development, education and training in primary care

1990	The *GP Contract* (NHS & Community Care Act) introduced the Post Graduate Education Allowance (PGEA) system to encourage GP principals to attend continuing medical education activities.
1993	GMC published *Tomorrow's Doctors* recommending a shift to community-based undergraduate education.
1995	*LIZ Education Initiatives* (LIZEI) introduced in inner London to facilitate GPs' access to education. In 1997 Turnberg's *London Strategic Review* recommended the continuation of LIZEI projects at least until their evaluation was complete
1998	*A First Class Service* – consultation document expanded on clinical governance following its introduction in *The New NHS*. Referred to 'lifelong learning' as a key component.
1998	The Chief Medical Officer's review of continuing professional development in general practice recommended practice professional development plans.

Postgraduate education

In 1990 the postgraduate education allowance (PGEA) was introduced as an incentive to GPs to take up continuing medical education. Only GP principals were eligible for the allowance, which they received on attendance at certain approved events or activities. Although GPs made use of this incentive it failed to win their hearts and minds and it excluded many members of the primary health care team such as non-principal GPs and practice nurses (Calman 1998). PGEA was usually obtained by attending lectures requiring little participation. These didactic methods have been shown to be ineffective in bringing about changes in practice (Gillam *et al.* 1999, Davis *et al.* 1992).

In London, large lists and single-handed practices are additional barriers to the uptake of educational initiatives. The LIZEI scheme was launched in 1995 in the hope that the provision of educational incentives would help to recruit new doctors, and refresh and retain those already practising in London. LIZEI was broader and more innovative

than the PGEA system. When the scheme ended in 1998, 85 per cent of GPs in LIZ (about 2000 in all) had taken part. There were four elements to LIZEI:

- developing community-based undergraduate education
- piloting variations in vocational training
- career development in education and research
- professional development within general practice

PCGs may be able to build on the momentum established by the LIZEI programme, perhaps using the infrastructure it created. The scheme was administered by local education boards, often with a multiprofessional membership. The board structure has worked better in some places than in others, depending on the quality of pre-existing relationships and power balances (Bowler *et al.* 1999). It fostered reflective practice, using techniques such as self-directed learning groups, peer-support groups, practice-based learning and mentoring. As well as clinical skills, topics included information technology, stress management and team building skills (Bowler *et al.* 1999). LIZEI was aimed primarily at GPs, but many post-LIZEI schemes have been extended to become multiprofessional (Entwistle 1998). A multiprofessional perspective is crucial to enable other members of the primary health care team to continue to develop their roles (Jones *et al.* 1997, Venning and Roland 1995). Some of the success of LIZEI is due to the fact that locum costs were covered, so that GPs really did have protected time to learn. This need for protected time should be recognised for all primary health care team members (Wallace and Heath 1999).

LIZEI cost about £34 million over three years (Bowler *et al.* 1999). There is some evidence to suggest that LIZEI has helped to both refresh and recruit GPs in London. As the scheme has now ended, the challenge for PCGs will be to maintain momentum in the absence of continuing extra funding. It will also be important to ensure that education and training resources are distributed equitably, and efforts are made to engage those who might not readily come forward, but who are likely to benefit from such opportunities.

The previous Chief Medical Officer's review of CPD in practice recommends that the PGEA system be abolished and replaced with practice professional development plans (PPDPs). These will take into account the training needs of all members of the primary health care team (Calman 1998), as well as clinical governance plans. PCGs are required to introduce the PPDP system to their member practices, which may prove challenging (Elwyn and Smail 1998).

PPDPs should be based on service development plans that have matched practice objectives to their patients' needs and should embrace personal, clinical and organisational development (Gillam *et al.* 1999). For PPDPs to be meaningful at all these levels implies an approach to team working which will be very new in most practices, and indeed for which there is little evidence of effectiveness. As discussed in the next Chapter, this may be an unrealistic expectation of the primary health care team (Plamping 1996).

Undergraduate education

There has been a marked change over the past decade as undergraduate education has moved out of hospitals and into the community, despite some resistance within traditional medical school hierarchies (Rees and Wass 1993). This trend is likely to continue and may have an impact on future GP recruitment. Over 400 GPs in North Thames have received training in undergraduate education under LIZEI, and all medical schools were involved in the Community Medical Education in North Thames (CeMENT) programme (Entwistle 1998).

Non-medical members of the primary care team

The last decade has seen changes in the membership of the primary health care team and changes in roles of existing members. For several reasons, including limited funds, professional development for non-medical members of the team has increased relatively slowly.

Professional support and training for nurses in general practice is often limited. As explained above, PGEA excluded non-medical members of the team although LIZEI has been implemented more broadly. Specific practice nursing courses exist, but

payment and study leave still largely depend on individual practices. GPs may be reluctant to release staff for training time away from the practice. There is a growing interest in the extended role of nurses, particularly nurse practitioners (Hibble 1995). However, uncertainty remains as to the qualifications appropriate for this role, not least within the UKCC. One way in which PCGs could address geographical inequality in nurse recruitment may be by offering increased professional development opportunities.

Professional development for other staff may be even more challenging. High quality management in primary care is now essential. As relationships between practices become increasingly important in enabling PCGs to work effectively, the role of the practice manager will grow and change. While there is a growing need for high quality practice managers, individuals vary greatly in terms of their skills and experience. PCGs (and PMS pilots) offer opportunities for cross-practice development and the creation of supra-practice structures that could meet the professional and personal development needs of practice managers as their role is extended.

Until now the costs of some professional development for non-medical practice staff have been met by health authorities. As PCGs develop, health authorities' primary care roles will lessen and the resources for these activities may be lost unless PCGs take deliberate action to prevent this. In part this need could potentially be met through practice professional development plans, as described above, linked to Primary Care Investment Plans (PCIPs), so that they have sufficient resources. In addition, the national levy for Non Medical Education and Training (NMET) is held by Regional Offices and educational consortia. These latter organisations are potentially important, comprising NHS employers, health authorities and GPs. They will control a large part of the NMET allocation. However, primary care representation on consortia has thus far been weak (Gillam *et al.* 1999). PCG involvement with consortia will be crucial if they are to obtain NMET funds for the professional development of non-medical members of the primary health care team. Inter-PCG collaboration will be essential to ensure that these resources are put to best use.

6.2. Professional development through evidence-based practice

Evidence-based medicine (EBM) aims to improve clinical effectiveness by applying evidence from research to clinical situations (Sweeney 1996). It incorporates activities such as audit and the development and use of guidelines which, in addition to quality improvement, have an important professional development role. These activities will be important components of PCGs' clinical governance programmes.

Since the early 1980s, audit has been a feature of well-developed practices, a trend fostered by the RCGP. Medical audit was introduced more widely following the 1989 white paper *Working for Patients*. Medical Audit Advisory groups (MAAGs) were established to oversee audit in primary care. The importance of involving other health care professionals was recognised. Audit was not a contractual obligation, but by 1994 it was estimated that nationally over 85 per cent of practices were involved in audit of some kind (Fraser and Baker 1997). In London, there were examples where the uptake was less than this; for example 78 per cent of practices in Kensington, Chelsea and Westminster (Dwyer 1994), and only 46 per cent in Camden and Islington despite a higher than average MAAG budget (McCartney 1995). The low uptake may be explained by the presence of a number of factors in London that have been found to inhibit audit elsewhere (Humphrey and Berrow 1994): These include:

- crowded or inadequate premises or alterations to premises
- single-handed practices: lack of staff and cost of computerisation
- partnership problems and changes
- quality of medical records.

The picture of clinical audit in London is mixed. For example, Camden and Islington MAAG found that multidisciplinary audit worked well but that it was difficult to involve 'audit-resistant' practices (McCartney 1995). This latter issue will be a major challenge for PCGs, which will include practices at differing stages of development and interest. By definition, the educational and developmental value of such activities

depends on the willing participation, interest and engagement of health professionals whose needs they are supposed to address.

The LIZEI scheme sponsored several guidelines projects, but, like audit, guideline development and implementation predated LIZEI. These include the Hackney collaborative clinical guidelines project started in 1991 and based in St Bartholomew's Academic Department of General Practice. This project worked with inner city non-training practices, many of which were single-handed (Feder *et al.* 1995), and showed that local guidelines, disseminated via practice-based education, could improve management of chronic diseases such as asthma and diabetes.

The project also showed that the use of simple prompts (such as a stamp with a checklist for annual reviews) contributed to improved management. Integrating guidelines into everyday practice is increasingly likely to involve electronic prompts and computer-aided decision-making support systems such as Prodigy (Langlands 1998). In London this may take longer to achieve because of the number of practices not yet computerised (Turnberg 1997), a further challenge for PCGs.

6.3. Professional development and PCGs

Professional development needs to take place at both practice and PCG level. PCGs will effectively become local development agencies for primary care professionals. Understanding and gaining access to the different funding streams such as NMET and the medical and dental education levy (MADEL) is therefore essential. However, the focus may be larger than individual PCGs, mirroring the former LIZEI board coverage. Such cross-PCG working will allow economies of scale. Clinical governance and education/training leads will have a central co-ordinating and facilitative role for constituent practices and with other organisations such as audit groups. There is now a strong body of evidence about the effectiveness of different educational approaches and about the ways of effectively engaging primary care professionals in London. At a PCG level, professional development is part of clinical governance and should be linked to PCIPs and to HImPs. This will mean identifying shared priority areas and using PCIPs to allocate resources for professional development and quality initiatives

in these areas. At a practice level, practice professional development plans also need to be linked to these. Effective PPDPs require a degree of organisational development and team working that will be new for many practices.

Key points

- **PCGs need to understand the complex funding streams for professional development.**
- **Professional development should be linked to clinical governance, HImPs and PCIPs. This involves agreeing priority areas and identifying resources to fund professional development, clinical governance and health improvement in these areas.**
- **Work will be needed across PCG boundaries to maximise the opportunities for professional development.**
- **Successful practice professional development plans are dependent on multi-organisational development and team working.**

7. Organisational development

This Chapter is in two parts. The first part looks at how general practice has developed as teams and organisations. PCGs are new organisations with new ways of working and this has implications for the way they develop at many different levels: within the board, between the board and others (constituent practices, the public, other organisations) and within constituent primary health care teams. The second looks at an important aspect of organisational development – accountability. This is particularly relevant in the present climate amid concern over health professionals' competence, with regard to PCGs' clinical governance role and in relation to the future transition from PCG to PCT.

7.1. Organisational and team development

From primary health care team to primary care organisation

The idea of the primary health care team as the organisational basis for primary care is long-standing. Following the 1990 contract, well-organised practices that provided a full range of the newly recompensed services could substantially improve their income. As described in Chapter 4, staff numbers and types grew rapidly. As a result, during the 1990s, the average practice team became a substantial organisation in its own right and a cadre of senior practice managers began to emerge. The team was further augmented by other community professionals 'attached' by community trusts and by a variable degree of integration between general practice and wider primary care services. However, it has been suggested that the team is not an appropriate basis for development. This is because it is '*unconnected from the funding mechanisms which drive change and is not a sufficiently robust organisational form to support strategic decision making*' (Plamping 1996). Thus the team is best thought of as a way of delivering complex care. Developmentally, it is more useful to think in terms of primary care organisations, which can include practices and partnerships of different sizes, coalitions between practices and between practices and other (primary care) organisations. Such organisations have developmental needs *as organisations*, as distinct from practice, service or professional development needs.

Fundholding and commissioning – developing management skills

GP Fundholding required significant organisational development within primary care. Fundholding made available resources to bolster management skills within practices and enabled them to cope with new commissioning roles and service developments at practice level. The descendants of fundholding, such as Multifunds, Total Purchasing Pilots and GP Commissioning Pilots, expanded primary care organisational development to include relationships between practices. The evaluation of GP commissioning pilots showed that they undertook sophisticated organisational and managerial development (Regen *et al.* 1999). This included establishing arrangements that distinguished between strategic and operational roles, and setting up smaller executive groups. The evaluation also demonstrated the need for high quality dedicated management support and team building at board level. These lessons are highly pertinent to PCGs.

LIZ – overcoming barriers to organisational development in London practices

LIZ had a significant impact on the development of primary health care teams but a number of London-specific structural factors inhibited progress. First, the quality of premises was such that many GPs practised from surgeries that were incapable of housing a team sufficient for even a limited general medical service, let alone comprehensive primary care (London Health Planning Consortium 1981). Second, singlehandedness limited the size and range of team membership. Third, comparatively low levels of GP fundholding in London meant that fewer practices had the ability to directly influence and integrate nursing teams between practices and community trusts (although non-fundholders did develop other means of negotiating with the community trusts and working with health authorities). As a result the LIZ Collaborative Allowance for small practices was designed to address some of the limitations of small isolated practices by fostering alliances between them.

PMS – radical organisational change in primary care

Potentially the most significant organisational change in primary care provision is Personal Medical Services (PMS) pilots. The NHS (Primary Care) Act of 1997 made possible local contracts for general practice services. They were intended to make primary care services more sensitive to local needs by allowing HAs to negotiate with

general practices or other providers to deliver a specified range of primary and community services. These contracts opened the way to direct employment of community nurses and other non-medical professionals by general practices and to community trusts providing all primary care services, including the employment of salaried GPs in nurse-led or community trust-owned pilots. Freeing doctors from business responsibilities was felt to be one way of improving services to priority groups in deprived areas and addressing recruitment and retention issues (Lewis *et al.* 1998). Interest in PMS has grown, with over 50 applicants from London in the second wave.

PCGs and organisational development

PCGs have much to learn regarding organisational development. Many of the PCG board members, including GPs, may have little experience in this area. The organisational aspects of commissioning have been researched through the evaluation of Total Purchasing Pilots and GP Commissioning Pilots. These have shown how important organisational development is in terms of functioning and achieving objectives, and that larger organisations have more complex developmental requirements with higher resource needs. Early learning from the evaluation of PMS pilots also suggests that these underwent a necessary and intensive phase of development, something that PCGs will have to invest in (Lewis *et al.* 1998). PCGs will need to determine the appropriate balance of services between health sectors, collectively manage a unified budget and primary care investment plan, hold responsibility for clinical governance and relate to other organisations both in and outside the health service. These tasks imply a sophisticated organisational process with PCG boards functioning as teams and dividing labour in accordance with their skills. This will require resources, not least time.

Recent work from the King's Fund on organisational standards for PCGs aims to assist in their development (King's Fund/Health Quality Service 1999). The impact of this approach rests in the way in which these (or other) standards are used, involving many members of a PCG board in a process of agreeing aims and monitoring progress, rather than merely delegating one individual to 'tick boxes'. In addition, PCGs are based on practices working in groups with other practices. This implies organisational

development at inter-practice level, for which models do exist (such as out-of-hours co-operatives), with the proviso that these have voluntary rather than compulsory membership and a single clear objective rather than a complex strategic agenda to address. Finally there is also a need for PCGs and practices to develop as organisations in relation to the public and users.

7.2. Accountability

The creation of PCGs entails new pathways of accountability and responsibility. Those working in primary care organisations must work within two accountability frameworks – as professionals and as public servants.

Professional accountability

Traditionally, GP principals are subject to two main forms of compulsory and externally regulated accountability, both of which have recently undergone reform. As registered medical practitioners they are accountable clinically and ethically to the General Medical Council (GMC), and as independent contractors they are accountable for their performance against the terms of the national contract. GMC involvement has historically been reserved for those cases where there is substantial evidence of transgression. However, following recent events such as the Bristol Royal Infirmary inquiry, and under the leadership of Sir Donald Irvine, the GMC has agreed a continual process of revalidation for all doctors, and introduced procedures for the support and management of poorly performing doctors.

The GP contract and independent contractor status

The roles of GPs remain remarkably ill defined, with little detailed in the national contract. Their independent contractor status is seen by many GPs as a way of protecting professional autonomy but, in reality, the meaning of 'independence' is not always clear. The 1990 contract was imposed, despite the preservation of independent contractor status (Lewis 1997). The 1990 contract introduced greater central direction in relation to the clinical duties expected of GPs and also saw the introduction of managerial forms of accountability, such as Annual Reports (Department of Health 1989). Nevertheless, the GP contract remains unusual in its

lack of specificity about the services to be provided. This has the advantage of allowing flexibility and innovation but weakens the national contract as the prime form of accountability for GPs.

Alternatives to the national contract and independent contractor status

Some alternatives to the national contract do exist. Unlike GPs, community trusts are held to account through the development of local contracts/service agreements by health authorities and GP fundholders. The introduction of PMS Pilots has allowed general medical services to be defined by local contracts, which replace the national contract. This provides the potential for locally sensitive service specification and the introduction of new quality standards as contractual obligations. PMS pilots have also introduced salaried GPs who have the responsibilities of GP principals but are managed as employees and do not have independent contractor status (Lewis *et al.* 1998). Independent contractor status and a national contract may remain the most popular model with the majority of GPs, at least in the short and medium term. However, as PCGs move to PCT status, this may imply a change in the relationship of member GPs with the Trust board and in their employment status.

Other professional accountability mechanisms

Aside from the national contract and the GMC, GPs are subject to a number of other accountability mechanisms, such as complaints procedures, audit and forms of self-regulation. Some health authorities have developed voluntary local quality frameworks in addition to the national GP contract (Lewis 1998). Practice professional development plans (PPDPs) will be a further form of voluntary accountability, defining personal and practice level standards. Accountability goes far beyond an assurance of basic competence and financial probity, especially as primary care functions have expanded to include commissioning. GP Fundholding introduced a new accountability framework to guide the commissioning role of primary care (NHSE 1995). This also reflected a form of compulsory external regulation albeit in a voluntary scheme. While GP fundholding has been abolished, these ideas persist in the central guidance on the framework that will govern the functions of PCGs, although this is weakened by its emphasis on financial accountability.

Professional accountability in PCGs

PCGs provide a new accountability structure for primary care professionals. A strength of this form of organisation is its potential to end professional isolation and develop greater communication among local primary care professionals. Peer pressure will be a key mechanism, but it is not yet clear what sanctions PCGs will employ to ensure compliance. In addition to an increased degree of collective organisation locally, new central structures address poor practice, such as increased direction on clinical matters through the establishment of the National Institute for Clinical Excellence and the Commission for Health Improvement. PCGs are 'inclusive', that is all GPs are members of a PCG whether or not they wish to be. PCGs corporately hold a unified budget for their population and are responsible for developing a unified approach to clinical governance. Consequently traditionally independent GPs will be responsible not just for their own actions, but for those of their peers. While this arrangement does not provide a clear solution to the problem of how to ensure individuals' compliance with group decisions, it does provide a strong incentive to find one, with the underlying assumption that this will include and increase in peer pressure.

From PCGs to PCTs – accountability as public servants

PCGs have responsibility for improving the health of their populations. This implies accountability as public servants, but the relationship between PCG board members and the population is not clear – are their 'constituents' the public or their member practices and professionals? The composition of PCG boards and the way in which most members are (s)elected suggest that PCGs are essentially professional organisations. However, the composition of PCT boards and executives suggests more democratic and accountable organisations, with greater representation for local authorities and the public. They imply some loss of power and dominance for member professionals, particularly GPs, relative to PCGs, and this may deter some PCGs from making the transition.

Key points

- **PCGs' performance in their new roles are dependent on investment in organisational development at board level.**
- **Departures from independent contractor status such as PMS allow the emergence of new forms of accountability in primary care and new levels of control over the activities undertaken by primary care professionals.**
- **The transition from PCG to PCT means a change of emphasis from member practices to the public as constituents, with consequent implications for accountability. The differences in composition between PCG and PCT boards reflect this.**

8. Strategic development

PCGs' roles include the development of secondary care services and health improvement for their populations. These functions relate to activities beyond practices and beyond individual patient care. To achieve these requires PCG boards and constituent practices to develop ways of thinking and working strategically. This Chapter explores these challenges.

8.1. Primary care commissioning

Since 1990, policies have promoted the involvement of primary care in the commissioning of secondary care services (Mulligan 1998). PCGs are the latest stage in this evolution, with the important difference that they compulsorily include all GPs. As well as the organisational development aspects described in the last Chapter, fundholding and other primary care commissioning models offered GPs opportunities to become involved in resource and rationing issues and connected their clinical behaviour with its financial implications (Mays & Dixon 1996). These are now some of the roles of PCGs. A central aim was to control costs, although it has proved difficult to demonstrate that this was achieved (Le Grand 1998).

Fundholding

GP fundholding was introduced by the NHS and Community Care Act 1990. It began in 1991 with 300 practices covering seven per cent of the population of England in the scheme. By April 1996, there were 3,700 practices involved covering 52 per cent of the population (Mays 1998). Uptake of fundholding in London lagged behind other areas in the country, especially in the early years, and there was a wide differential in take-up across the London health authorities. Evidence is patchy on whether 'two-tierism' in access to services was widespread as a result of fundholding (Goodwin 1998). This concern is part of the rationale for the universal nature of PCGs.

Multifunds

Multifunds (groups of GP fundholders who formed an independent organisation for the administration and management of their fundholding activities) began to form in 1995/96, with nearly a third of all fundholders in England eventually being part of a multifund (Audit Commission 1996). Multifunds tended to emerge in less affluent areas where smaller fundholding practices recognised the merits of grouping together. According to Smith *et al.* (1998), Multifunds had more impact on prescribing, the provision of extended primary care services, referrals and inpatient waiting times than other commissioning arrangements, such as locality commissioning. The multifund model provides an example for PCGs of the way in which groups of practices can work together to organise their management arrangements centrally.

Total purchasing

Total Purchasing Pilots (TPPs) were made up of single practice fundholders or groups of fundholding practices. Most of the 88 TPPs were found in rural, affluent areas, although approximately 15 per cent were in large town or cities, of which seven were in London (Mays *et al.* 1998, Malbon *et al.* 1998). TPPs' main successes were in developing services within primary care, rather than commissioning for services in the secondary sector. They were also innovative in terms of crossing traditional health and social care boundaries, for example by setting up a multidisciplinary day centre at the local community hospital (Killoran *et al.* 1999). The evaluation of TPPs provided evidence on the investment required to establish organisational structures and a sense of corporacy among GPs. This is not something that can generally be achieved in the first year, especially by bigger groups.

GP commissioning pilots

GP Commissioning groups came into being in April 1998 as groups of largely non-fundholding practices. The aim of the GP commissioning groups was to make HA purchasing more locally sensitive to variations in needs and patients' views, using GPs as the main source of information. London had the greatest number of GP commissioning pilots in a single region. GP commissioning was envisaged as a way of overcoming inequities associated with fundholding by involving all GPs in shaping services. GP commissioning groups were able to influence service changes and

developments (Regen *et al.* 1999). Research by the Primary Care Support Force in London (1996) claimed that GP involvement in the commissioning process ended unnecessary duplication of some services.

PCGs – lessons for commissioning

PCGs are the organisational descendants of fundholding, Multifunds, TPPs and commissioning groups and there is much to learn from the evaluations of these earlier forms of commissioning. The take-up of fundholding, Multifunds and Total Purchasing was lower in London than elsewhere so experience of budget holding will be limited in London. Having previous experience of fundholding was recognised as a key determinant of the rate of development by TPPs (Mays *et al.* 1998). However, a number of GP Commissioning groups in London had begun to develop the required organisational structure for commissioning in primary care (Regen *et al.* 1999). Commissioning has tended to focus on services at an individual or practice level, rather than at a wider population level. For example, few fundholders or TPPs undertook any formal needs assessment (Le Grand *et al,* 1998), although Smith *et al.* (1998) found that GP commissioning groups were more likely to have contributed to health needs assessment. In most cases, decisions tended to be made by individual practitioners using their local knowledge. Total Purchasers suggested that holding a budget encouraged them to think more about the whole process of health care, rather than just seeing their patient within the confines of general practice (Malbon 1998).

As PCGs become PCTs, they will have increasing budgetary control over all GMS and hospital and community health services. This is an incentive to make the best use of resources wherever patients receive their treatment and to look at the inter-relationship of all health services and the potential to substitute one form of care for another. However, an issue that might preclude a wider population approach is the tension that PCGs will face between commissioning for their entire populations, and responding to the needs and wants of individual patients. PCGs will need to agree robust ways of prioritising some health services. Many of the financial decisions that PCGs make are forming part of their Primary Care Investment Plans, which require more complex planning and strategic thinking than was required in previous primary care commissioning organisations.

8.2. Commissioning for health improvement

Health care is only one, often not the most important, determinant of health. Other factors such as housing, employment, income, education and lifestyle influence health status. The Independent Inquiry into Inequalities in Health emphasises the links between health and social inequalities (Acheson 1998). Often, the people most marginalised, such as the unemployed, the homeless, refugees and minority ethnic groups, suffer worse health than other groups – and generally have poorer access to health services (Tudor Hart 1971).

For the first time, the advent of PCGs gives primary care professionals explicit responsibility for improving the health of their populations beyond their registered lists. This is one of the most unfamiliar tasks for primary care professionals. Previously, this responsibility has tended to lie with public health physicians commonly working in health authorities, with little involvement of primary care professionals.

Earlier models of primary care commissioning paid little attention to wider health improvement, and to some extent perpetuated inequalities in health through differential access to health care, particularly as GP fundholders often tended to be based in areas with more affluent and healthier populations (Goodwin 1998, Audit Commission 1996). Alternative models to GP Fundholding, such as locality commissioning groups that advised the Health Authority, were found to have more input into health needs assessment (Smith *et al.* 1998). PCGs include all practices, so theoretically should help to reduce inequalities in access to health care. In reality, this will require consistency in clinical performance and redistribution of resources between practices.

A common justification for a primary care-led NHS is that, because GPs are 'closer' to their population, they will be purchase more appropriately than health authorities. However, it is important to understand the difference between demands and needs. Some people with great health needs, such as the severely mentally ill, the homeless and refugees, are under-represented as patients in general practice, either because they

are less likely to be registered, or feel less able to use the services provided. These groups are all present in London in greater proportions than in the rest of the country (Bardsley *et al.* 1998, Edwards and Flatley 1998). For example, a barrier to uptake of primary health care services for some minority ethnic groups is the absence of a female GP in the practice (Acheson 1998). The South Thames report on inequalities showed that the lowest proportions of female practitioners were in inner London, where minority ethnic groups were most concentrated (Lewis 1998).

As PCGs take on the role of health improvement, they need to develop an approach to health needs assessment at a population level. They need to be able to work in partnership with other sectors such as local government and voluntary organisations. The importance of joint working has been emphasised in *Partnership in Action* (Department of Health 1998b). PCGs need to contribute their local Health Improvement Programmes (HImPs). Their decisions must be framed in the context of the central priorities set out in the National Priorities Guidance (Department of Health 1998) and Saving Lives (Secretary of State for Health 1999). Where Health Action Zones exist (Brent, Camden and Islington, East London and the City and Lambeth, Southwark and Lewisham), PCGs will at least need to be involved, at best be integral partners.

This list of requirements is daunting. A feature that may support commissioning for health is the multiprofessional nature of the PCG board. However, the presence of a single social services representative and one lay person on each board may be too tokenistic to foster true partnerships. A particular limitation of needs assessment at practice level is the lack of good information, especially in London where list inflation and poor IT infrastructure are particularly problematic. For example, a study in Camden and Islington in 1994 showed that practice-based information was not adequate for needs assessment purposes (Scobie 1995). Partnership working is time-intensive (Smith 1998) and new to many doctors. There are already good examples of joint working to enhance primary care-led commissioning, for instance in mental health (McGarrell 1998, Haffenden 1997), but a national survey commissioned by the Association of Directors of Social Services in 1997 found that GPs were frequently

identified as the *'weak link in the collaborative chain'* (Hudson 1998). The task of meaningfully involving users is likely to be even more unfamiliar and challenging.

8.3. Beyond PCGs – strategic development in London

One of the strengths of PCGs is their basis in a local community. This allows a more intimate and responsive relationship with their patients and other stakeholders than would be possible were they to serve populations of several hundred thousand, as health authorities do. Yet this narrower focus brings with it the problem of ensuring strategic coherence for developments that extend beyond the boundaries of individual PCGs.

Thus there is a need for pan-PCG collaboration and strategic planning as well as a continuing role for health authorities in planning local health economies. There are already many tasks for which PCGs are responsible that cannot be effectively discharged in isolation. For example, Primary Care Investment Plans must demonstrate action on workforce planning and the development of education and training strategies. This will require concerted action across a much wider organisation and population base than that of an individual PCG. For recruitment, local labour markets for nurses and GPs will transcend PCG boundaries. There is a trend for the configuration of London's community trusts towards fewer, larger trusts. The formation of PCTs will therefore need to be carefully managed, taking account of the aspirations and needs of neighbouring PCGs. Unilateral action by one PCG could destabilise the primary care base of others and implies the need for a London-wide strategy.

Another area that extends beyond individual PCGs is that of research and development. PCGs need to engage with Primary Care Research and Development Networks and academic departments. These are already involved in this agenda and have a continuing strategic role to play in R&D in primary care in London.

London has already experimented with capital-wide agencies to assist in the development of primary care, including the London Implementation Group, the

Primary Care Support Force and the London LMCs Taskforce. The London Regional Office will bring the performance management of London's health services under one roof, but the role of the NHS Executive in primary care development is open to debate. Health authorities have found the earlier model of the Primary Care Support Force a helpful one (Lewis 1998) and some grouping (whether a free-standing development agency or a coalition of health authority and PCG interests) might be useful to share good practice and maintain a London-wide overview.

Key points

- **Earlier forms of primary care commissioning demonstrated the need for PCGs to invest time and other resources in organisational development at board and whole PCG level.**
- **Health improvement requires PCGs and practices to work in unfamiliar ways, including needs assessment, partnership working across sectoral boundaries and lay involvement.**
- **Strategic primary care development, including HImP and PCIP development, requires an approach that locates PCGs in a wider geographical context.**

9. Conclusions

This document has presented a five part framework for primary care development, comprising:

- practice development
- service development
- professional development
- organisational development
- strategic development

These different areas of development reflect the broad roles and activities of primary care and thus the key tasks of PCGs:

- developing primary care provision
- health improvement
- commissioning services

The crucial task of clinical governance is subsumed within these, particularly the first.

The development agenda for primary care operates at different levels – practice level, PCG level, supra-PCG level and pan-London level. PCGs are not the only organisations supporting primary care development, but they are well placed to act as local development agencies, bringing inputs from other parties together, such as practices, community trusts, academic departments, local authorities and others. Amongst the key early tasks for PCGs are:

- Achieving a consensus on the aims of primary care and on priorities locally among the board, their constituents and other stakeholders, including users. This implies the development of ways of communicating with constituents and stakeholders.
- Developing an approach to the less well-resourced practices, requiring redistribution of resources.
- Agreeing a framework for the management of poorly performing practitioners, a part of clinical governance.
- Developing an approach to health improvement and inequalities. This will include partnership working across sectoral boundaries.

The success of PCGs in these and other tasks is dependent on intensive organisational development at board level and across the PCG as a whole. This must address the way in which PCGs and the practices within them relate to many other organisations and individuals – including other practices, trusts, health authorities, local authorities and the public. Ways of working at organisational boundaries will be crucial, both at the level of practices working together within PCGs and working between PCGs. This is dependent on a new sense of professional corporacy, which will underpin progression to PCT status.

Many areas of primary care development cannot be achieved simply through the action of individual PCGs. They depend on action taken together with other agencies, sometimes at a pan-London level. Issues such as inequalities, education and workforce planning are only a few examples. An overall London strategy for primary care will help to provide a lever to changes at this level.

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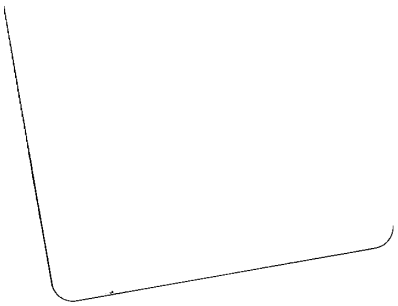

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