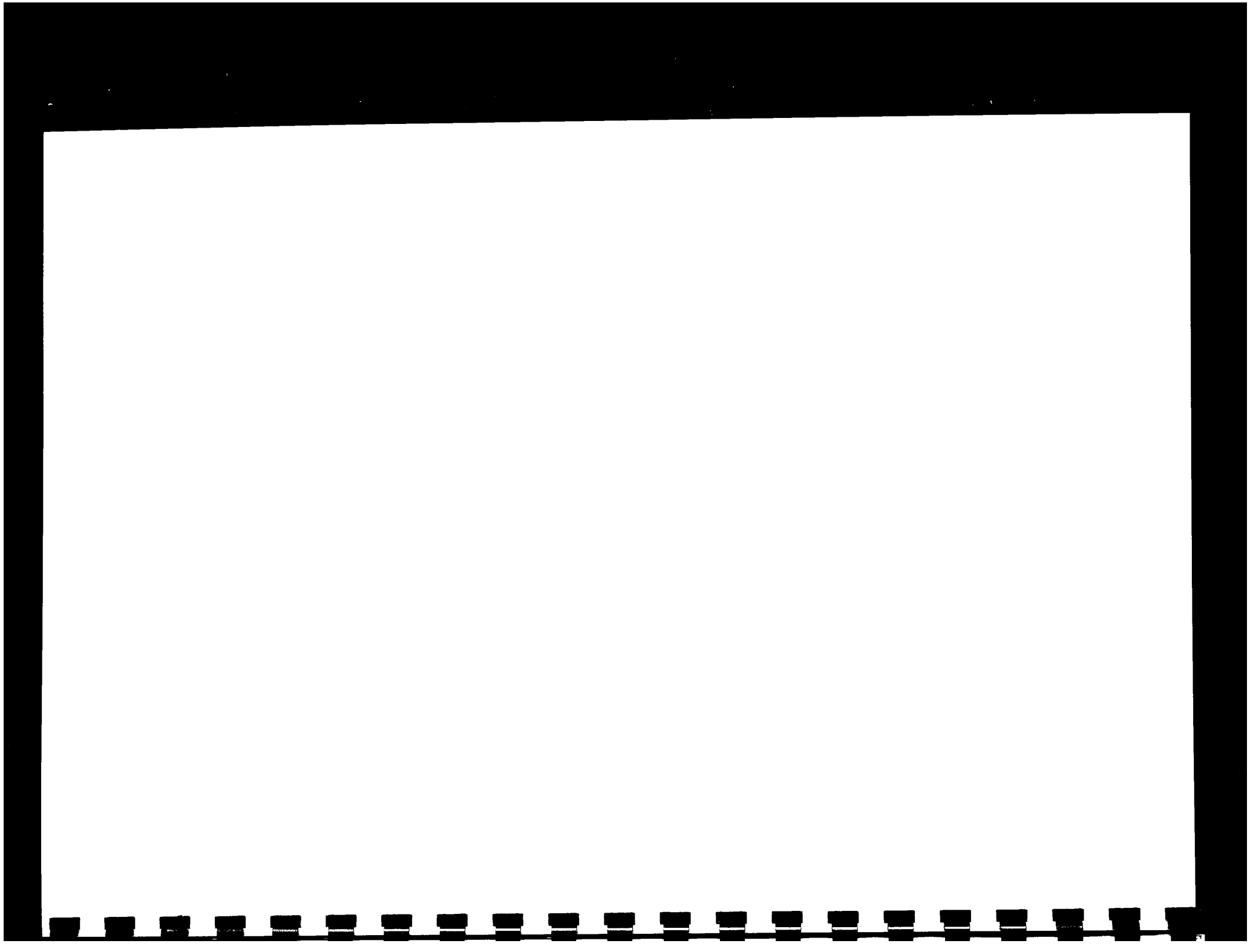
King's Fund
Management College

PARTNERS AND PATHWAYS FOR DEVELOPING PRIMARY CARE

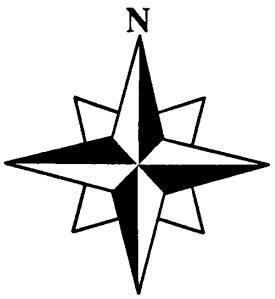
Reflections of the experience of the South Thames (East) Primary Care Strategies Learning Network, 1994/5

11–13 Cavendish Square
London
W1M 0AN

Telephone 0171 307 2400
Fax 0171 307 2809



CONTENTS



I. THE INVITATION EXTENDED

As part of the extensive consultations undertaken by one pair of Health Authorities preparing their Primary Health Care Strategy, a large meeting was organised to debate the motion, "This house believes in a primary-care led NHS".

Before the debate began, a show of hands suggested a majority for the proposition. Speaking for it, an influential GP Fundholder presented an articulate case to reinforce these sentiments. Nevertheless, at the end the majority had shifted against.

Informal soundings suggested that many of those present had been put off by a sense that 'primary-care led' could easily mean domination of the NHS by a narrow medical model.

Fortunately the GP concerned was sensitive to this feedback and keen to rethink his approach. Indeed, fired up by this experience he immediately set out to persuade his colleagues that the Fund-holding practice's 'Policy Board' should be extended to ensure proper involvement of other professions and bring in a 'user' perspective.

Another Health Authority has been keen to work effectively with different kinds of GP alliance (some Fund-holding, some non Fund-holding, some mixed) which have emerged over the past three years. It created BODS - the Bootstrap Organisation Development Seminar - as one vehicle for addressing issued emerging in these relationships and developing the skills of both GP leaders and the key managers involved.

The first BODS meeting, involving eight people including chairmen from the main alliances and an LMC representative, identified an agenda for future work.

The second BODS meeting also involved eight people, all DHA staff, who were able to share their experiences of working with different alliances and consider common dilemmas.

It was intended to continue this work at the third meeting, but by now there were 17 people participating, drawn from the DHA and FHSA shortly after the appointment of a single chief executive. The agenda changed therefore to focus on what staff from the two Authorities understood by primary care development and their different ways of relating to GPs.

By the fourth BODS meeting, there were 30 managers present and the focus was on the design of the new organisation which would support the now emerging Joint Commissioning Authority.

At the fifth, there were 40 staff present, shortly after all were selected/allocated to roles in the new Commissioning Directorates, which are to include locality teams combining former DHA and FHSA functions. Team building was the main priority.

Six months on, the next BODS meeting is planning to engage the locality teams in addressing the agenda for working with GPs identified at its first meeting.

These are just two of the 'stories' we shared as participants in the Primary Care Strategies Learning Network. Each illustrates features of the difficult challenges we have all faced in moving forward the primary care agenda in our Authorities. In the first, we see the possibly differing meanings implicit in the national policies which have been propagating the notion of a primary-care led NHS. We also see the value of debate among different stakeholders in articulating these differences and, as in this example, prompting fresh efforts at positive innovation. In the second, we see how large-scale organisational changes can distract attention from the work required to implement concrete improvements in services in partnership with providers. However we also see how these same changes can help fashion new ways of working which offer the promise of faster progress in the medium term - with the caveat that there must be adequate investment in developing the new relationships and skills required on both 'sides' to make this partnership a reality.

From other local stories we were able to explore:

- specific improvements different Authorities are seeking to achieve in primary care provision.
- ways of bringing two statutory Authorities together and gaining board level impetus for primary care development.
- levers available to the new Joint Commissioning Authorities to promote service changes.
- implications of devolving both commissioning and service development as locally as possible.
- the necessity to work with (and accept) considerable diversity across our Districts in responding to: the needs of small populations, different forms of micro-commissioning, the different characteristics of provider organisations and the considerable diversity within general practice itself.
- the ways our different partners in primary care development are approaching this partnership, in the light, for example, of current pressures on general practice and what is known about consumer perspectives on primary care.

Thus we began to illuminate the uncertainty, complexity and diversity of the challenges involved in developing primary health care: challenges which we have 'survived' to continue the struggle in the coming year.

Learning Together

The vehicle for this process of exploration and mutual aid was a Learning Network, sponsored by the former SETRHA and facilitated by two King's Fund Fellows. Fifteen of us (drawn from all but one of the DHAs/FHSAs in South Thames, East) participated, admittedly with differential attendance, in a series of bi-monthly meetings from Spring, 1994 until Summer, 1995.

The main stimulus to creating this Learning Network was the requirement in the Corporate Contract for all our Authorities to produce jointly a strategy for developing primary care. We were all managers with responsibilities for this task, mostly as primary care commissioning managers in the DHA, primary care development managers in the FHSA, or public health doctors.

Over this period some but not yet all of our Authorities have produced, consulted on, and adopted formal primary care strategies through processes involving systematic review of existing services, careful analysis of what is known about service effectiveness and extensive discussion with interested parties. This work has had the merit of building bridges across DHA/FHSAs, gaining an Authority level mandate for service development and committing varying levels of resources for investment in change.

Beyond published statements, we have also been learning what it means to establish a strategy which will achieve real improvements in primary health care in the medium-term across our districts.

We have learnt that:

- shaping and delivering improvements involves Health Authorities in establishing effective partnerships with a wide range of other interests, particularly of course, primary care providers, working from very different types and sizes of organisation.
- there is much to be done in further developing the approaches, methods and skills required to enable public involvement in reviewing existing services and influencing development priorities.
- significant change involves making connections between activities at all the different levels of the primary care team, localities and the Authorities as a whole.
- working with, and across these dispersed networks of provision requires proper investment in management, credible staff 'on the ground' and a real understanding of the different DHA and FHSA functions which are being brought together in the new Joint Commissioning Authorities.
- it also requires well-formulated work programmes organised around clear priorities and benchmarks, realistically tuned to what is feasible having regard to the pressures on providers (notably GPs) and the time it takes to establish better ways of working.
- this variety of activity needs increasingly to be driven by both a broadly shared definition of what is meant by primary care and an always evolving vision of what provision should become into the next century.
- 'strategy' needs to be understood therefore neither as a high-level set of intentions nor as a linear progression of steps in a plan, but rather as increasingly concerted action across the local systems of commissioning and providing agencies to define desirable aspirations and mobilise changes through the most promising pathways.

As a consequence, we are beginning to see:

◊ development of new commissioning organisations with the capacity to work in these ways.
◊ complementary growth in the capacity of primary care teams to contribute to informed service development.
◊ stronger partnership between Commissioning Authorities and clinical leaders in implementing change.
◊ gradual accumulation of real change on the ground in delivering the basics of primary care, innovating to meet diverse needs and bringing more services close to people's homes.

In the context of wider changes in health and social care we are in no doubt however about how much remains to be done in developing primary care appropriate to future opportunities and needs. We also recognise how much there is to learn about how to achieve this.

This Paper

Reflecting on our experience in the Learning Network, we have therefore prepared this Working Paper: first, to capture lessons from the last year in a form which might be useful to readers and second, as a resource to further learning. It is an invitation to others to join us in exploring this challenge further both in our own Joint Commissioning Authorities and across South Thames. In particular we hope colleagues will test our examples and insights against their own experiences with a view to further enhancing all our capacities for informed action.

We are conscious that since we are all managers in the Health Authorities, the way we have presented our experience is biased accordingly. We also recognise that further progress depends on successful partnership with other stakeholders, starting from different perspectives. We have designed this Paper as a stimulus to local dialogue among the different parties to primary care development.

The Working Paper is in five parts:

⇒ Following this introduction, Part Two reports the results of a survey of all the Authorities represented in the Network, designed to identify progress, highlights and lessons from their work on primary health care during the year. This includes notes on significant developments and references/contact points for readers seeking further information.

⇒ We found various metaphors helpful in shaping our discussions: one of the most frequent was that of explorers setting out from different places to find routes across an unfamiliar political, organisational and service landscape in which we needed to link-up at various points to exploit particular opportunities or overcome significant barriers. No picture can do justice to this landscape, not least because some of the hills, (or perhaps they are swamps?) are still covered in mist. Part Three offers a map of the terrain as we currently understand this, identifying both partners on the journey and some of the well-trod pathways.

⇒ Part Four expands on this map by drawing together the main insights we have gained about how best to establish fourteen key elements in effective strategies. We envisage Parts Three and Four together as resources for a round-table dialogue, among relevant managers within the Joint Commissioning Authorities, or - in a more challenging form - among representatives of the key stakeholders, designed both to promote understanding of where different people are 'coming from' and to examine what is involved in getting different elements of the local strategy in place.

⇒ In conclusion, we return to our continuing refrain on the importance of investing in learning together to develop effective leadership for a 'primary care led NHS'.

Why not join us in the next phase of exploration?

II. PROGRESS, HIGHLIGHTS AND LESSONS FROM "TRAVELLING HOPEFULLY" IN 1994/5

The Learning Network concluded its work by conducting a review of the progress, highlights and lessons from efforts to establish and implement well formulated strategies for improving primary health care during the year. This review was in two parts:

- the first sought specific information on what had been achieved and how: responses were received from all but one Health Commission (i.e. covering 5 DHAs and 4 FHSAs from the 11 Health Authorities in the region.)
- the second sought a more interpretative commentary on the lessons from these efforts for this year's (1995/6) work by the Joint Commissioning Authorities now being established throughout the region: lead managers from eight authorities contributed to this part of the review.

This survey and its responses represent a modest form of inquiry and, of course, the 'evidence' is based on managers' views. Nevertheless the information proved illuminating and might also promote further mutual aid among interested Authorities and their staff.

Progress by Authority

Respondents were asked to:

i. summarise key features in the delivery of primary care which have been a focus for strategic attention in 1994/5
ii. summarise key changes in the ways their Authority/ies are going about developing and implementing a strategy to improve primary care
iii. provide references to accessible documents which enlarge on (i) and (ii)

BROMLEY HEALTH
Progress, substance • Development of Primary Care Development Strategy in discussion with the Local Medical Committee. There is £590,000 to support implementation of the Primary Care Development Strategy. • Development of a model of Locality Commissioning • Continued development and evaluation of Locality Projects focusing upon joint purchasing of services • Development of Partnerships for Change (jointly with East Sussex) • Development of policies to support the management of GMS cash limit. This will include the introduction of practice budgets
Progress, process • Acknowledgement of the pressures in primary care and financial support to alleviate these pressures as agreed with the LMC. • Number of objectives to ensure movement towards the vision outlined in Primary Care Development Strategy • Use of multidisciplinary and expert groups to develop a view on some of the unanswered areas, highlighted in the strategy • Implementation of the role of Clinical Commissioning Directors in directing purchasing intentions
Documentation • Primary Care Development Strategy • Partnerships for Change • GMS Policies • Locality Commissioning
Availability and contact • Directorate of Primary and Community Care Bromley Health Global House 10 Station Approach, Hayes Kent BR2 7EH Tel: 0181 462 2211 • Robin Lorimer, Director

EAST SUSSEX DHA/FHSA (joint response)

Progress, substance

- Greater participation and involvement of public in delivery of self-care and informal care of others, plus commissioning process for 2° care.
- Developing 1° care teams.
- Developing 1° care practitioners as providers and as commissioners/purchasers.
- Personal and organisational development of 1° care practitioners

Progress, process

- Ran a 6-month discrete project to pull a strategy together.
- Held 2 stakeholder conferences plus working parties and interviews
- Strategy document launched early June 95 for widespread consultation backed by presentations to many small and large, formal and informal representative groups. (Process ended Aug 95 and 1st year implementation plan followed.)

Documentation

- A strategy for the development of primary health care in East Sussex, 1995-2000

Availability and contacts

- East Sussex FHSA
  Springman House
  8 North Street
  Lewes, East Sussex
  BN7 2PB Tel: 01273 485300

- Dr Peter Brambleby, Project Manager and Consultant in Public Health
  East Sussex HA
  Rutherford Business Park, Marley Lane
  Battle, East Sussex
  TN33 0EZ Tel: 01424 772277

LAMBETH, SOUTHWARK AND LEWISHAM HEALTH COMMISSION

Documentation on progress in substance and processes

- The Primary Care Strategy - Project Objectives and Plan for Delivery

  This details the process followed to develop the strategy. Beginning in April 1994, we have attempted to open up a process of debate with local people and providers of services about the future of primary care locally. This has involved identifying priorities, needs and ways of meeting them and reviewing different options for the future.

- The Primary Health Care Strategy Baseline

  This contains the background information and supporting evidence for the Strategy. It describes the need for primary care, the current range of service provision, the outcome of the debate and consultation process to date, a review of previous strategic work affecting primary care and financial information.

- The Future of Primary Health Care in South East London - A Consultation Document

  This is the product of the discussions held over the last year. It provides, together with the baseline document, a picture of provision and describes how primary care might develop and how change can be achieved over the next 5 to 10 years. It also outlines a series of plans for implementation.

Availability and contact

- Hemantha Perera
  Primary Care Implementation Manager
  Lambeth, Southwark and Lewisham Health Commission
  1 Lower Marsh, London SE1 7RY Tel: 0171 716 7000

EAST KENT DHA/KENT FHSA (joint response)
Progress, substance • Strengthening locality commissioning and GP led purchasing • Improving basic primary care provision in line with the FHSA strategy.
Progress, process • Detailed attention to developing a sound information base for decision-making • Comprehensive audit of all GP premises • Review of policies on practice staff reimbursement
Documentation • A strategy for primary care in Kent (February 1995)
Availability and contact Mark Outhwaite, Chief Executive East Kent Health Authority Protea House Waterloo Crescent Marine Parade Dover CT17 9BW Tel: 01304 227 227

WEST KENT HEALTH AUTHORITY (now part of the West Kent Joint Commissioning Authority)
Progress, substance • Geographical focus on one locality (Swale) - primary care and community hospitals • Management of chronic disease notably diabetes and primary/secondary care relationships • Minor injuries units • Child and adolescent mental health, and also adult mental health
Progress, process • Working party headed by Non-Executive Director to look at public consultation (previous seminar suggested importance of focussed relevant consultation) • Both Authority strategies are tentative at this stage in advance of April 1996 • Increasing closer working with general practitioner groups either as purchasing consortia or fundholders • Clear common pathway now identified whereby purchasing consortia, fundholding fora and joint purchasing groups relate to the old District GP Sub-committees of the Local Medical Committee
Contact • Dr Richard Swann, Consultant in Public Health Medicine West Kent Health Authority, Preston Hall, Aylesford Kent ME 20 7NY Tel: 01622 710161

Highlights

With a view to promoting the sharing of experience and mutual aid across South Thames (East), respondents were invited to identify up to three specific 'highlights' from progress in their Authorities which might be of wider interest. These are summarised, with contact people, in the following table .

1.	Primary care development strategy: Bromley This document defined primary care broadly to include all primary care practitioners. A broad strategic direction is outlined in terms of service and provider development. A number of short term objectives are identified for achievement in 1995/6. In addition questions are raised to be addressed during this time. The strategy will be revised in the year culminating in objectives for 1996/97 and 1997/98. Contact: Debbie Bamford, Assistant Director Primary and Community Care, Bromley Health, Global House, 10 Station Approach, Hayes, Kent BR2 7EH Tel: 0181 462 2211
2.	Locality commissioning: Bromley Nine part time Clinical Commissioning Directors have been appointed to contribute to decisions made by Bromley Health including Chair of LMC. The CCDs are working general practitioners. Eight have been appointed from a particular geographical area. It is hoped that this will increase dialogue between Bromley Health and GPs, enhance commissioning decisions and complement our dialogue with the LMC. Contact: Kevin Barton, Director of Commissioning, Acute Services, Bromley Health , Global House, 10 Station Approach, Hayes, Kent BR2 7EH Tel: 0181 462 2211
3.	Partnerships for change: Bromley This is the result of a research project commissioned to create a framework for the development of primary care. Working with focus groups and local events, facilitators have been trained to elicit some answers to questions posed in the Primary Care Strategy. This has been developed with East Sussex FHSA. Contact: Robin Lorimer, Director of Commissioning, Primary and Community Care, Bromley Health Global House, 10 Station Approach, Hayes, Kent BR2 7EH Tel: 0181 462 2211

4.	Systematic involvement of wide range of stakeholders: East Sussex Conference and consultation methods with a wider range of stakeholders were used before, during (they chose the chapter headings in the strategy) and after the project to establish and publish the join DHA/FHSA strategy. Contact: Dr Peter Brambleby (address above)
5.	Detailed referencing of evidence underpinning strategic intentions: East Sussex As an example of evidence-based strategy writing, the East Sussex paper (identified above) provides extensive references to the relevant scientific literature. Contact: Dr Peter Brambleby (address above)
6.	Bridge building between DHA and FHSA: East Sussex The project to develop a joint primary care strategy, itself involving secondment of a Consultant in Public Health to the FHSA to act as project leader, was important preparation for establishing the new East Sussex Health Authority over the coming year. Contact: Dr Peter Brambleby (address above) or Derek Hoddinott, Director of Commissioning and Development at East Sussex FHSA, Springman House, 8 North Street, Lewes, East Sussex BN7 2PB Tel: 01273 485300
7.	Detailed discussions with the Commission's many partners: Lambeth, Southwark and Lewisham Discussions were held with local practitioners, local people, acute, mental health and community trusts, representative groups, local authority and voluntary sector (including through a major conference). We expect this form of discussion to continue throughout the implementation process and into the future. It is essential to maintain these relationships and continue to build upon them. Contact: Hemantha Perera (address above)

8. Futures group to shape priorities: Lambeth, Southwark and Lewisham

The futures group drew together key stakeholders from a variety of professional backgrounds. It provided the opportunity to exchange, debate and challenge ideas about priorities for improvement and models of development. It met nine times, including one very successful away day.

Contact: Hemantha Perera (address above)

9. Premises audit: Kent FHSA

Baseline information has been assembled on all GP premises through a study conducted by a professional surveyor with architect direction, providing a starting point for a long term process of improvement.

Contact: Jacqui Stewart
East Kent Health Authorities
7-9 Cambridge Terrace
Dover
Kent CT16 1JT Tel: 01304 227227

10. Processes for locality commissioning: East Kent DHA

Progress so far in relation to commissioning of secondary care services.

Contact: Richard Osmolski
Director of Contracting
East Kent Health Authority
7-9 Cambridge Terrace
Dover
Kent CT16 1JY Tel: 01304 227227

11. GP purchasing groups: West Kent DHA

West Kent has been promoting different kinds of alliances among local groups of GPs, and supporting the best developed of these in evolving their own purchasing plans

Contact: Dr Richard Swann (address above)

Lessons for achieving positive change

The second part of this review invited commentary on how progress was (or was not) made in 1994/5 and the lessons which could be drawn from different local experiences. The first meeting of the learning network had identified fourteen elements which seemed likely to be important in achieving strategic change in primary care. Respondents were asked to indicate the extent to which each element had been established in their agency during 1994/5, using a 1-5 performance scale (where 1 means the element is absent or poorly established and 5 means the element is very well established). Modal scores on each element, listed in the order of high to low performance, are recorded in the table below.

	ELEMENTS	Performance 1-5
1	FHSA support for primary care as major focus for strategic development	5
2	DHA/FHSA agreement on primary care as major focus for strategic development	4
3	Primary health care providers involvement in reviewing existing services and shaping primary care development priorities	4
4	Clear priorities for medium-term change and benchmarks for reviewing progress	4
5	Informed 'stock-taking' of strengths and weaknesses in existing provision	4
6	Development of the partnership between commissioners and providers (general practice, community health services etc.) required to deliver the change agenda.	3
7	DHA support for primary care as major focus for strategic development	3
8	Common views among key stakeholders about how primary care is to be understood	3
9	Arrangements to review and learn from progress	3
10	Appropriate managerial resources invested in developing and implementing primary care strategy	3
11	Identification of the sequence of steps required to link these and other elements together over time to implement the primary care strategy	3
12	Shared vision among key stakeholders about future patterns of primary care provision	2
13	Financial investment strategies required to implement proposed changes in primary care	2
14	Public involvement in reviewing existing services and shaping primary care development priorities	2

Asked about which of these fourteen elements had been most important to achieving progress, nearly all received some mention, with 1 being most mentioned, followed by 4 and 5, i.e. first, Authority commitment to making primary care a major focus for strategic development, and second, systematic work on the strengths and weaknesses in existing provision leading to clear priorities for medium-term change.

When asked about other important factors, the one most emphasised was the need to work closely with primary care providers, particularly GPs. There was also clear recognition that getting to grips with primary care strategy required significant managerial investment and an evolutionary approach which addresses wider changes in the structure of Health Authorities, as captured in this comment:

> 'Following the development of a joint agency, the first year led to disorganised ways of working as we grappled to understand each other's contributions. We are now beginning to work together on primary care issues, gradually developing a matrix management approach to include people from across the agency. Progress is slow but beginning to be made as we all get clearer about the part we can play.'

Asked about the most significant barriers to making progress, many of the same issues reappear. It was reported that the preparation for mergers between DHAs and FHSAs could lead to delay and distraction from difficult challenges like this. Paradoxically the new emphasis in national policies on 'a primary care led NHS', because of its lack of clear definition, risked displacing attention from the development of primary care provision. Inevitably too, DHAs brought other priorities to the new partnerships, with acute services rationalisation tending to preoccupy the most senior managers (notwithstanding the connections to primary care development).

Commonly there was also important work left to do in building shared visions of the future and measures of success. Progress was likely to be slow where Authorities lacked resources for investment, lacked the numbers of able staff required to establish and mobilise dispersed development programmes and found key partners like GPs lacking the time and incentives to make a full contribution.

What advice then would respondents offer themselves and managers in other Joint Commissioning Authorities about how best to make progress in improving primary health care in 1995/6? This review suggested eight lessons as particularly important:

i. Seek to make primary care development a corporate priority with responsibility at Board level and identified Executive and Non-Executive Director leadership.
ii. While recognising useful connections, be clear about the difference between improving primary care provision and developing primary care led purchasing.
iii. Organise and recruit to ensure good, credible staff are available 'on the ground' to work with primary care providers and other local interests.

iv. Establish a realistic work programme which builds a sound information base, starts from relatively simple developments which GPs and others want and recognises that significant changes are likely to require time, effort and skills in persuasion and performance management.
v. Establish a financial framework linked to Authority priorities which makes funds available to pump-prime development.
vi. Work to develop 'ownership' for the emerging strategy among all relevant 'stakeholders'.
vii. Recognise existing pressures on GPs in their roles as providers and seek to focus any extra contributions from them on specific priorities, recognising also that their willingness and ability will vary.
viii. Look more widely than the NHS increasingly to work with the Local Authorities in their development of related community services, notably for 'community care'

1995/6 Priorities

Finally, looking forward to 1995/6, respondents were asked what they anticipated would be the most important foci for their Authorities in developing primary care. Key themes are identified in the following list:

* Development of primary care practitioners: this will focus on the need for increased clinical manpower in general practice. Bromley

* Service developments which better meet the needs of local practice populations. (A small pilot to develop practice based needs assessment is being carried out) This will include practice agreements with local providers for the provision of services. Bromley

* Movement of some traditionally hospital based service to more easily accessible and local surroundings. Bromley

* Developing competencies of primary care practitioners, especially GPs, Practice Managers and Fund managers (management development). East Sussex

* Developing primary care technical medical skills for enhanced 'provider' role. East Sussex

* Developing greater involvement of primary care teams in commissioning (not necessarily as fund holders). East Sussex

* Aligning the primary care development programme with the strategy to ensure that the commissioning of current and future developments are in line with the strategic priorities. Lambeth, Southwark & Lewisham

* Maintaining the dialogue between all people involved in health care to ensure that services are equally accessible to local people. Lambeth, Southwark & Lewisham

* Developing primary care within the national context, as the focus of health service delivery. Lambeth, Southwark & Lewisham

* Analysis of roles, responsibilities and relationships for practice and practice-attached staff. East Kent

* Ensuring planned development in practice premises to meet needs of patients and staff in collaboration with providers. East Kent

* Increased sensitivity to selected GP and public perceptions of health needs . Really making this work in terms of diabetes and asthma where both existing authorities have considerable stake. West Kent

* Rationalisation of overlap eg child health surveillance, family planning etc. The development of an overall health strategy. West Kent

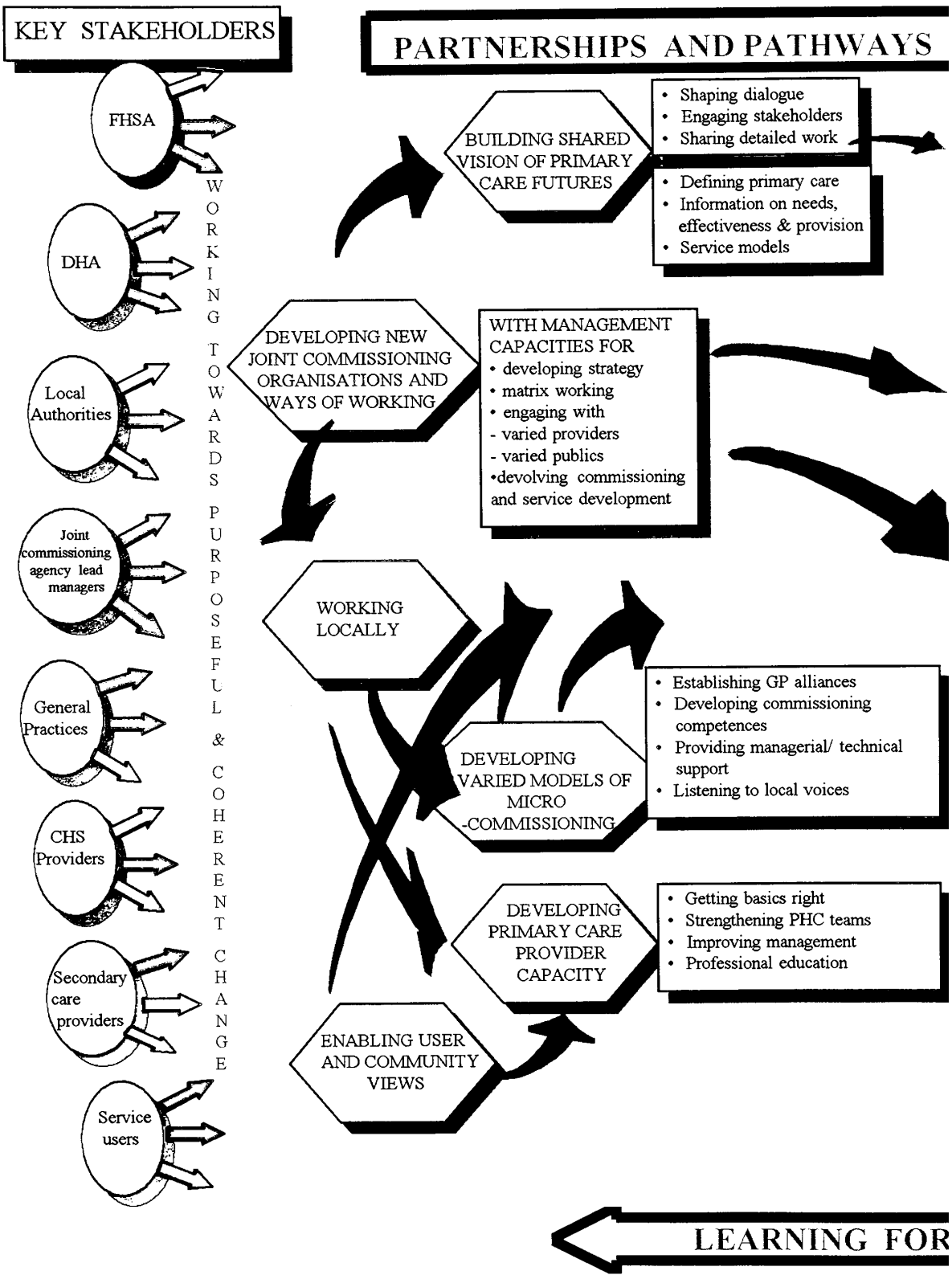
* Getting commissioning at GP subcommittees with fundholders and non-fundholders to work. West Kent

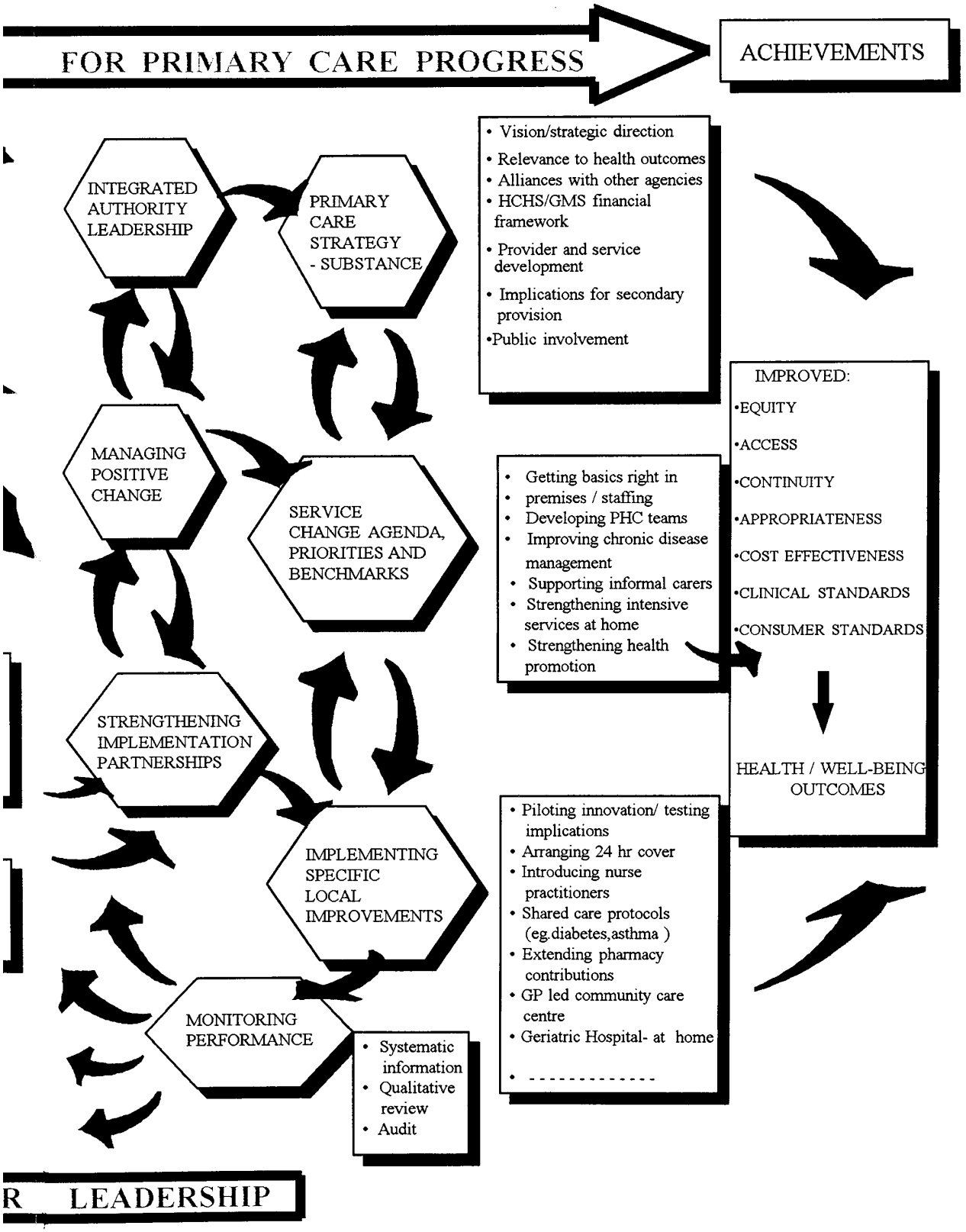
III PARTNERS AND PATHWAYS FOR PROGRESS - OUR MAP OF THE TERRAIN

PLEASE SEE OVER:

- OUR EXPLANATION OF THE LANDMARKS FOLLOWS IN PART IV

'LANDMARKS'




FOR PRIMARY CARE PROGRESS
ACHIEVEMENTS
INTEGRATED AUTHORITY LEADERSHIP
PRIMARY CARE STRATEGY - SUBSTANCE
MANAGING POSITIVE CHANGE
SERVICE CHANGE AGENDA, PRIORITIES AND BENCHMARKS
STRENGTHENING IMPLEMENTATION PARTNERSHIPS
IMPLEMENTING SPECIFIC LOCAL IMPROVEMENTS
MONITORING PERFORMANCE
• Vision/strategic direction
• Relevance to health outcomes
• Alliances with other agencies
• HCHS/GMS financial framework
• Provider and service development
• Implications for secondary provision
•Public involvement
• Getting basics right in premises / staffing
• Developing PHC teams
• Improving chronic disease management
• Supporting informal carers
• Strengthening intensive services at home
• Strengthening health promotion
• Piloting innovation/ testing implications
• Arranging 24 hr cover
• Introducing nurse practitioners
• Shared care protocols (eg.diabetes,asthma)
• Extending pharmacy contributions
• GP led community care centre
• Geriatric Hospital- at home
• ----------
• Systematic information
• Qualitative review
• Audit
IMPROVED:
•EQUITY
•ACCESS
•CONTINUITY
•APPROPRIATENESS
•COST EFFECTIVENESS
•CLINICAL STANDARDS
•CONSUMER STANDARDS
HEALTH / WELL-BEING OUTCOMES
R LEADERSHIP

IV SOME ORIENTEERING LANDMARKS

The preceding *map of the terrain* which the Learning Network generated as our discussions continued over the year, like any map, simplifies the complex aspirations and processes through which people in our Districts have begun to make the progress identified in Part II. It is stronger on landmarks than on possible hazards along the journey. It does however draw attention to what we have learnt are two critical features in successfully developing and implementing strategies for improving primary health care.

The first of these is the wide range of 'stakeholders' who need to become *partners* in working towards positive and coherent change. In the *map*, we have identified eight sets of stakeholders who vary considerably in their organisational base, interests, perspectives, influence on service provision and links with each other. They are partners then, not in the sense necessarily of 'playing on the same side' but rather of all needing each other's contribution if progress towards better health care is to be optimised.

At one pole are the Health Authorities themselves, coming together at Board level as single Joint Commissioning Authorities charged with strategic leadership on behalf of the local population. Within these Authorities are the relevant managers: some leading work on primary care commissioning and/or service development; others offering expert contributions, for example in public health medicine and NHS finance; themselves with different experiences in the NHS (notably, of working previously in DHAs or FHSAs) and with different perspectives on primary care, but responsible over time for deploying these differences in ways which maximise the Commissioning Authorities' positive impact.

Outside the Health Authorities there are provider Trusts, in the case of community health services managing a dispersed work-force to provide part of a network of primary and community services. There are also likely to be 2-300 general practitioners working as independent contractors and a smaller, but still large number of practice organisations which for most people form the core of primary care provision - and are increasingly looked to as the key influence in the decentralised commissioning of health services.

At the opposite pole, there is the local population - typically 600-800,000 people - who as citizens and taxpayers are the ultimate commissioners of health services and as users of services are the NHS's most important partners in the co-production of health.

Clearly, the way each of these (and other) sets of partners engage in developing primary care needs to be shaped to their distinctive characteristics. Our experience as managers confirms however that all must be taken seriously as partners in this enterprise.

The second critical feature of primary care strategies suggested by the *map* is the importance of these partners in various combinations making progress through pursuing

different but potentially complementary pathways which over time add up to **concerted action**. The two dimensional *map* presents these pathways in terms of movement from left-to-right, making connections from top-to-bottom, but of course this should be a guide to continuing action in which the various pathways are trod and retrod while themselves changing as new relationships are established and new ways of organising emerge.

For the more 'rational planners' among us, this sort of metaphor felt initially unfamiliar, but we were encouraged to learn that in other fields of organisational life there is increasing interest, first in the idea that benefits are typically co-produced by users and various service agencies working together in dynamic partnerships; and second, in the view that anything as complex as the arrangements for shaping and delivering primary care needs to be understood as having some of the properties of organic systems in which adaptation to a changing environment relies on shared purpose, dispersed action and various forms of feedback rather then bureaucratic controls.

Thus conceived our map becomes an instrument for potential partners locally to explore and develop their sense of shared (or complementary) purposes. It should also help to identify particular foci for action and find promising connections within the total system of relevance.

Key points from our experience on each of fourteen elements in this picture are summarised in what follows.

1. BUILDING SHARED VISION OF PRIMARY CARE FUTURES

Fundamental to the work in all our Authorities has been the need to engage a wide variety of people in giving direction to primary care development: clarifying what we mean by primary care and why this is important; promoting debate on the opportunities and priorities for improvements; and generating a vision (always subject to revision in the light of experience) about the pattern of services we should be helping to establish into the 21st century.

Why is better primary care important?

From the creation of the NHS, a well-developed primary care system with a generalist physician as a first point of contact has been seen as the backbone of a rational health service and the foundation for appropriate use of secondary care. The importance of primary care has increased, and is set to increase further as life expectancy has grown and people are surviving longer but with more chronic ill health.

The trends suggest that the NHS in future

- will have to regard chronic ill health as seriously as acute disease events;
- develop patterns of care which co-ordinate multiple inputs into people's support;
- manage acute events within long-term conditions often outside hospitals (as currently conceived);
- meet many of the care needs of people who have received short stay and intensive acute treatment in, or near their own homes.

Hence the strategic significance of strengthening the primary care sector.

In all our Authorities, the strategic challenge is to further develop a primary care system, made up of appropriate and accountable provider organisations which form a network of services, both coherent in themselves and sufficiently diverse to respond to the variations within our local communities. There is much on which to build in current services, but also considerable unevenness in standards of care, the organisational competence to take on new functions and the capacity of providers to work with other parts of the health and welfare system.

Future development needs to recognise and utilise the important but different strengths of general medical practice:

- almost universal coverage of the population and the 24 hours;
- expert generalists leading the primary care team and basing practice on biographical medicine;
- rights of referral to hospitals and more specialist practitioners;

and community health services:

- also expert generalists (mostly nurses);
- experience of caring for people with complex needs arising from disability and illness;
- providing population focused preventive programmes;
- expanding community based specialists.

What is primary care?

Paradoxically, while we found wide agreement on the importance of strengthening primary care, we also found it necessary to discuss and debate locally what we mean by primary care. Clearly at its most general primary care is a network of services which covers the whole spectrum of health and social care provision delivered by general practitioners, community health services, local authority social services, independent agencies and unpaid carers, in turn embracing a wide range of professional contributions. We typically found it useful to identify the key characteristics of an effective primary care system, for example, in the East Sussex strategy, as including:

- it is first contact care;
- it is readily accessible by self-referral;
- it is provided in a home or community setting;
- it is comprehensive and holistic, from cradle (or even earlier) to grave, and grounded in a family and social context;
- it is led by professionals who have trained for a generalist role;
- it is continuing and personal care and the fixed point for those tapping into wider networks of social or hospital care;
- it is increasingly capable of providing acute care, high-technology care and specialist care, and referrals between primary care professionals are an increasing trend;
- it has at its core a large number of independent contractors, working in teams with directly employed practice staff and employees of NHS Trusts, with links into the voluntary, statutory and private sectors;
- above all, it is deeply entrenched in the culture and tradition of health care in this country, cherished by those who use it.

In understanding and defining the development agenda for primary care we also found helpful the idea of 'care domains' and the map of a changing service landscape shown in the two figures (overleaf).

Looked at in this way, we became increasingly sure why our Authorities need primary care strategies (not just health strategies and client group strategies, although of course these are related) so as to develop the capacity of this system to address many different kinds of health need. We also had a basis for identifying the outcomes which are relevant to primary care, mobilising appropriate epidemiological contributions and reviewing the scientific literature relevant to assessing effectiveness and establishing clinical standards. We were increasingly able therefore to give more substance to the

list of achievements sought through better primary health care (summarised at the right-hand side of the map in Part III).

Sharing the vision

From these starting points, it also became clear why a multiplicity of different stakeholders need to be engaged in shaping the vision of future patterns of health care - and also acting on this vision. In each of the emerging Joint Commissioning Authorities this has required significant efforts to pool different kinds of expertise and experience, linked to major initiatives to involve - and indeed develop a stronger partnership with relevant providers and community interests. We have set up task groups on key issues, organised workshops and conferences and consulted widely, supporting these efforts with detailed preparatory and analytic work. We have also been changing the ways we work to make this kind of participation and networking a continuing feature of strategy implementation. There are many challenges inherent in this process. Within primary care itself, a new synthesis is being sought which better manages the tensions between:

a focus on personal care	⟷	an orientation to population need
demand led services (patient choice)	⟷	needs led services (evidence on effectiveness)
professional development as key to change	⟷	organisational development as key to change
primary care providers exclusively as generalists	⟷	new partnerships with community-based specialists

We are learning as we go along how best to meet these challenges together.

2. ENABLING USER AND COMMUNITY VIEWS

As users and funders of the NHS, and of course as 'co-producers' of health with NHS professionals, local people have a vital role in shaping NHS provision and reviewing its quality. This is particularly important in primary care, partly because these services provide the great majority of interactions with users but also more subtly because many of the outcomes sought through primary care - the maintenance of ordinary life in the face of disability or chronic illness, reduction in anxiety or discomfort, sustaining the confidence of unpaid carers, dying in the manner of one's own choosing - can best be judged from the patients' (and potential patients') perspectives.

We have recognised that mobilising and taking seriously the views of users and other community members is integral to the development and implementation of primary care strategies. It is important in building the vision, in defining priorities, in assessing innovations, in reviewing local services and of course in shaping individual 'packages of care'.

Partly encouraged by the Government's 'Local Voices' Initiative, our Authorities have been establishing a wide variety - and admittedly sometimes uncoordinated - set of activities to address this agenda, some of which , including:

- community organisation input into locality commissioning;
- practice population surveys followed by focus groups on local priorities;
- consultation with particular interests (e.g. ethnic minority communities) and particular sorts of users (e.g. mental health 'survivors');
- direct involvement of user representatives (e.g. older people and their carers) in micro-commissioning teams;

are particularly relevant to primary care.

(The 'User as Commissioner' project in East Sussex - further information from Andrew Partington, Director of Communications, East Sussex DHA - provides more detailed analysis and guidance on these issues.)

3. INTEGRATED AUTHORITY LEADERSHIP

As they move towards becoming Joint Commissioning Authorities, all our Authorities either have, or are aiming formally to agree primary care strategies. Beyond this, we recognise that Authority level priority to primary care is essential because:

- this is a high profile national priority;
- better primary care is essential to achieving 'Health of the Nation' targets, better value for money and the shift in balance between secondary and primary care;
- the key reason for creating Joint Commissioning Authorities is to promote a primary care led NHS;

It is also essential because as Authorities move from purchasing to commissioning in partnership with primary care providers, their main function becomes to create and nurture local capacities for appropriate service development. For primary care, real change will require sustained efforts through many channels over several years, not just with primary health care providers but also with secondary providers and related local

authority services. With increasingly 'lean' managerial resources, Board level leadership will be required to give authority, coherence and impact to these efforts.

In terms of the complex ways action is achieved through Health Authorities, giving priority to primary care means:

- Publishing and regularly reviewing progress in the primary care strategy with key partners;
- Identifying board level 'champions' for primary care;
- Carefully drawing out all the implications of the primary care strategy for all other strategies (and vice versa);
- Establishing a financial framework for change which links HCHS and GMS funding;
- Ensuring that annual purchasing intentions, contracting and contract monitoring processes properly represent this strategic agenda;
- Promoting, empowering and recognising the 'near the ground' managerial initiatives and partnerships required to implement real improvements in services.

4. PRIMARY CARE STRATEGY - SUBSTANCE

The strategies our Authorities have been adopting provide a way of bringing together this and other work in an explicit form, and providing the framework for a specific agenda for service change (5) and the implementation of local improvements (6) which really make a difference.

Our published strategies set the direction for:

- improving care, particularly for people with chronic ill health and disabilities;
- enhancing the population focus of primary care;
- further developing expert generalists (nurses and doctors);
- developing specialties in the community to support generalists;

They also need to tie together the different strands of work required to achieve these substantive changes, including:

- establishing the financial framework for investment and disinvestment;
- making alliances with other agencies;
- sustaining public involvement;
- investing in provider and service development;
- developing and redefining the criteria for assessing success;

as well as addressing how the Joint Commissioning Authorities can develop their capacity to promote this agenda.

5. THE SERVICE CHANGE AGENDA, PRIORITIES AND BENCHMARKS

Within this framework, the medium term development challenge in primary care is three-fold:

- improving all local services to the levels of good practice established elsewhere;
- establishing more flexible forms of primary care to meet the needs of people not well served by mainstream family-based practice;
- developing an extended role for primary care which shifts the balance and relationship between hospital and community-based services.

In all our Authorities this is potentially an enormous agenda. We are having to establish criteria for prioritising investment, including, for example, do proposed developments:

- contribute to positive health outcomes;
- reflect broad definitions of quality including dimensions valued by users and unpaid carers;
- embody standards/protocols for which there is good evidence;
- demonstrate a new relationship between people and professionals as 'co-producers of health';
- encourage systematic and safe diffusion of clinical expertise;
- make appropriate use of new technology;
- establish appropriate arrangements for co-ordinating different services around individuals and/or for people to move smoothly through different aspects of provision;
- ensure that new ways of working are built into these dispersed systems (and not therefore dependent on 'heroic' individuals);
- achieve a real transfer of responsibility and finance from hospital to community-based providers.

6 IMPLEMENTING SPECIFIC LOCAL IMPROVEMENTS

The real test of all this work on vision, strategy and priorities is of course the gradual implementation of an expanding range of specific local improvements in primary care which contribute both to better outcomes and an increasingly coherent pattern of services. As the substantive highlights listed in Part Two show, all our Authorities are mobilising positive action of this kind and shaping an increasingly well-formulated programme of future work to implement desirable changes over the next year or two.

Common to our agendas are efforts to:

- get the basics right in primary care premises and staffing;
- develop effective multi-professional working ('primary care teams') and the capacity of such teams to respond better to the needs of practice lists/local populations;
- improve the management of chronic illness and the support available to people and their unpaid carers;
- strengthen intensive services at home and develop alternative 'intermediate' services which reduce unnecessary use of acute hospital facilities;
- establish better co-ordination and partnership between hospitals and primary care practitioners which both share expertise and provide more integrated services from the perspective of individual patients;
- strengthen prevention and health promotion through the work of primary care practitioners, including opticians, pharmacists and dentists, as well as health promotion staff and 'healthy alliances' with other agencies;

The current list of specific improvements is correspondingly diverse and includes:

- establishing practice development plans focused on achieving agreed standards for premises, the practice environment, staff skills and practice management;
- improving arrangements for 24 hour access to primary care;
- introducing nurse practitioners;
- developing pharmacy contributions;
- establishing shared care protocols and monitoring practice (e.g. in relation to the management of diabetes and asthma);
- introducing and testing different kinds of 'hospital-at-home';
- establishing intermediate care centres etc.

In many of these examples, one or more of our Authorities is evaluating innovative forms of service provision and we are all seeking to understand the implications of replicating particular innovations on a larger scale for other elements in local NHS provision.

7. DEVELOPING NEW JOINT COMMISSIONING ORGANISATIONS AND WAYS OF WORKING

The preceding elements have focused on establishing and delivering an informed agenda for developing primary care through widespread participation and action at many 'levels' from individual general practices to the new Health Authorities as a whole. This is taking place while major change in the structure of these Authorities - with creation of Joint Commissioning Authorities and a future single Local Health Authority - is being implemented. The nature of commissioning is also being transformed through the devolution of purchasing (another side of the 'primary care led' NHS) - requiring these new Authorities to provide strategic leadership through working with a significant number of other parties.

All this implies a major challenge to the new Joint Commissioning Authorities themselves to develop forms of organisation, management and ways of working appropriate to these functions and relationships. As the 'BODS' story at the start of this paper illustrates, all our new Agencies are having to invest in organisation and management development designed to:

- redefine the strategic role to fit this changing context;
- develop matrix working to pool different kinds of expertise around important challenges, promote concerted approaches to service development and ensure consistency in relationships with other parties;
- devolve authority and develop the capacity of the Agency at its periphery so as to be able to work effectively with small commissioners (See Section 9) and contribute to primary care service development 'near the ground' (See Section 10);
- establish new relationships and new ways of engaging with both the variety of professionals and their organisations, and the variety of relevant public voices.

Beyond establishing new structures this is requiring:

- agency-wide efforts to redefine the purpose and ethos of the new authorities;
- carefully designed processes (new forums, relevant agendas, skilled facilitation) which enable staff with different histories, loyalties and perspectives to come to terms with change, understand what each brings to these new challenges, establish a common language (e.g. on what is meant by 'service development') and build shared commitment;
- creating new teams able to represent the Authority at its periphery;
- renegotiating centre (headquarters) - periphery (locality teams) relationships so as to combine strategic leadership with devolved action.

In turn, these new ways of working are requiring us to learn new approaches and skills, notably in:

- working through networks to achieve change and accepting the need for diversity and the reality of differential rates of progress;
- taking action based on a common sense of purpose, available opportunities and specific tasks rather than formal position in the new organisational structures;
- developing new relationships with primary care clinicians as micro-commissioners;
- understanding better the needs of the small organisations at the heart of primary care provision;
- getting better at coming out from our offices to engage directly with the public.

8. WORKING LOCALLY

The thrust of recent structural changes in the NHS has been to establish much larger Health Authorities in relation to the population served: partly to provide the basis for a better strategic overview; partly to increase leverage with large provider agencies; and partly to reduce management costs. Almost all our new Joint Commissioning Authorities (Bromley being the exception) now serve populations which only a few years ago required two or three District Health Authorities, i.e. from 400-800 thousand people. The development of a 'primary care led' NHS now requires however that these new Authorities develop ways of working locally:

- with local people to shape health services to meet local need;
- with GPs and other primary care staff in commissioning;
- with the variety of local providers in promoting service development.

Moreover, with the pressure to reduce management costs in the new Authorities, there is a particular challenge in getting close enough to these local partners to make a reality of the new relationships required. From the perspective of primary care providers, local may mean neighbourhood populations of 6-10,000. From the strategic perspective it is easy to think areas with 100-200,000 people are quite small.

In strengthening primary care there are two main dimensions to local working, concerned respectively with developing varied models of micro-commissioning (9) and developing the capacity of primary care providers (10).

9. DEVELOPING VARIED MODELS OF MICRO-COMMISSIONING

Current Government policies to promote a 'primary care led' NHS are giving particular emphasis to the dispersal of commissioning power, initially through extension of GP fundholding, but now involving a variety of approaches, including coalitions to create multi-funds and total fundholding, all of which involve a shift in accountability for using public funds. More evolutionary approaches are strengthening practice-sensitive purchasing and building new kinds of alliance with primary care providers. Typically in our Authorities we are having to find good ways of working with a plurality of these models of micro-commissioning.

We are seeing potentially strong benefits in the impetus these developments give to:

- ensuring commissioning is sensitive to the needs of small populations and influenced by clinical experience;
- encouraging strategic/local partnerships;
- fostering greater emphasis on accountability;
- promoting attention to the capacities required for effective commissioning and the need for accreditation processes.

At the same time we are having to address the potential problems with this variety of dispersed commissioning, including the

- continued ambiguity about responsibility for commissioning primary care;
- emphasis on GP involvement to the relative exclusion of other primary care providers and the public;
- possible damage to community health services (e.g. through reduced attention to community-based specialist contributions, broad quality-of-life issues and consumer choice);
- possible damage to secondary services through uncoordinated purchasing;
- increased diversion of funds into transaction and management costs in order to make the new arrangements work effectively.

In seeking to maximise the benefits and tackle the problems, we are working on two fronts:

- investing in developing the capacities for the new micro-commissioners to undertake or influence very local commissioning;
- changing the way our Authorities work so as to support these efforts and establish partnerships which articulate strategic and local considerations.

In the former category, we have been:

- trying to reduce other administrative demands on primary care providers so as to make space for commissioning work;

- encouraging initiatives which improve the capacity, particularly of practice organisations, to establish development plans, review expenditure on the practice population, systematise information on patient need, etc.;
- investing in educational activities (e.g. the Community Oriented Primary Care training programme) which help primary care teams and local provider coalitions develop a population focus in commissioning, use information on epidemiology and effectiveness, and set priorities informed by clinical experience.

In the latter category, we are having to organise ourselves so that the Authority presents a personal face to each team and coalition, backing these new relationships with expert support from public health, finance and contract managers. We are also encouraging new ways of listening to local voices (see Section 2) which are relevant to these commissioning partnerships.

10. DEVELOPING THE CAPACITY OF PRIMARY CARE PROVIDERS

Overlapping with 9, but conceptually separate is the need to strengthen the capacity of provider organisations to develop and deliver improved primary care. The existing legal and resource framework for general medical services, still grounded in the deal struck at the inception of the NHS, lags considerably behind what is needed to achieve current aspirations. Nevertheless all our Authorities have been looking for means of going beyond the traditional investment in professional education - important though this is - to address a wider agenda for improving the organisation of primary care suggested in the figure, below.

In particular, we have been working with providers to:

- address problems of low morale, particularly in general practice, by recognising current pressures, working with the grain of local priorities, and directly assisting in problem-solving;
- get the basics of premises, staffing and organisation of primary care delivery right;
- encourage more effective ways of working within primary care teams;
- promoting better management for both practice organisation and community services networks;
- ensure close links between professional education and the service development agenda.

11. MANAGING POSITIVE CHANGE

All the preceding Sections are of course about managing change consistent with the emerging vision, using approaches and methods which fit with the nature of primary care as a dispersed network of different kinds of agency. To summarise, positive change in this system requires managerial activities which promote increasing convergence between:

- shared ideas for a better future;
- commitment to primary care in all the Authorities main strands of decision-taking;
- new ways of working which foster a strategic overview while devolving commissioning and service development and which promote the resulting agenda for service change through a range of levers including:
  - agreements with providers on what will be delivered for specific resources allocated to primary care.
  - professional education and mutual professional influence focused on local priorities.
  - assistance to providers in developing the capacity of their own organisations (management, staffing, information systems) as partners in service development.
  - a range of agreed methods for monitoring progress.

12 STRENGTHENING IMPLEMENTATION PARTNERSHIPS

Similarly, the importance of partnership has been a common theme of the preceding Sections but it is also an essential characteristic of the process of implementing specific improvements. There are three particular challenges here:

- engaging the active interest of autonomous general practitioners, through the variety of methods discussed above;
- strengthening partnership within general practice through improved practice management and team building;
- developing collaboration between general practice, community health services and relevant social services, for example through:
  - jointly commissioning community health and social care;
  - developing new provider agencies which combine primary care and other community services;

- jointly specifying local requirements for community and practice-based nursing;
- promoting meaningful attachment of community staff to practices.

13 MONITORING PERFORMANCE

The design and implementation of strategies for primary care development is a continuing process. All our Authorities are committed to reviewing progress and up-dating formal strategies in the light of experience. Our published strategies (see Part II) suggest a range of markers for success, focused initially on new processes and activities (e.g. evidence of public dialogue; utilisation of relevant professional training programmes; expansion in specific services; introduction of new forms of more integrated provision; greater satisfaction with how the new Authorities are working with others to secure these changes) but increasingly aiming to complement these intermediate measures with evidence on standards and outcomes drawn from epidemiological data, clinical audit, patient feedback and specific studies.

With particular attention to general practice, there are significant opportunities for review based on practice development plans, prescribing budgets and other utilisation data, patient's charter standards and the medical audit requirements.

We are all at an early stage in establishing ways of reviewing performance in the various forms of micro-commissioning, taking account of the accountability framework for GP fundholding being established by Government. With increasing comparative experience however, we are beginning to identify some of the necessary characteristics of the different models of micro-commissioning (Section 9) for joint review with the practices and coalitions involved.

V LEARNING FOR LEADERSHIP

This Working Paper has been based on the experience of Joint Commissioning Authority managers with lead roles in primary care development. We have no doubt that our biases show, not least in the language we have used to order insights from the last year's work.

Our most important conclusion however is that substantial progress in developing primary care is only possible through partnerships in which there are many co-leaders - and therefore co-followers, all of whom need to learn from reflecting on experience to establish effective ways of working together.

For ourselves, we have learnt the need to develop confidence in our own capacities to work 'outwards' across the boundaries of our organisations to engage positively with external partners while working 'inwards' i.e. with colleagues in other roles, to ensure our Authorities maintain a purposeful and coherent approach to promoting change. In turn, we have seen this requires managers to be clear about their own values and roles as they operate at the junction of competing pressures, able to accept uncertainty, take sensible risks and cope with diversity.

Similarly we have appreciated the importance of our Authorities engaging in sustained programmes of organisation development designed to increase our 'fitness for purpose' in the latter half of the 1990s and to invest in the development of our partners, particularly, of course, primary care providers.

Much of this learning needs to be undertaken locally and involves mixed groups of stakeholders in producing their own 'map of the (changing) terrain' as a guide to finding the most promising 'pathways'.

We believe there is also scope for further learning across the new Authorities, of which our Learning Network was one example and, we hope, this Paper a further stimulus.

Certainly, we still have a long way to go!

Appendix: The South Thames (East) Learning Network Explorers, 1994/5

John de Bene	Service Development Director, East Sussex FHSA
Peter Brambleby	Consultant in Public Health Medicine, East Sussex DHA
Angela Dawe	Service Development Manager, NHS Executive, South Thames
Janet Dickson	Locality Health Commissioner, East Sussex DHA
Sheila Falconer	Primary Care Commissioning Manager, Greenwich and Bexley Health Commissioning Agency
Jackie Goodchild	Primary Care Commissioning Manager, Greenwich and Bexley Health Commissioning Agency
Derek Hoddinott	Director of Commissioning and Development, East Sussex FHSA
Richard Lewis	Director of Operational Commissioning, Merton, Sutton and Wandsworth FHSA
Robin Lorimer	Director, Primary and Community Care Commissioning, Bromley Health
Nick Lowen	Divisional Manager, Service Development, Greenwich and Bexley Health Commissioning Agency
Helen Medlock	Business Director, Kent FHSA
Brendan O'Connor	Director of Public Health, East Sussex DHA
Hemantha Perera	Primary Care Strategy Development Officer, Lambeth, Southwark and Lewisham Health Commission
Stephanie Stanwick	Principal Contracts Manager, West Kent DHA
Richard Swann	Consultant in Public Health Medicine, West Kent DHA

Facilitators:

Diane Plamping	Fellow, King's Fund Management College
David Towell	Fellow, King's Fund Management College
	11-13 Cavendish Square, London W1M 0AN
	Tel: 0171 307 2400

setrha.doc