PLANNING PRIMARY CARE

Forging Links Between Family Practitioner Committees and District Health Authorities

Edited by Linda Marks

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Preface

Family practitioner committees (FPCs) and district health authorities (DHAs) need to work and plan together to create a coherent primary care service. Joint working for primary care has been high on the agenda since FPC independence in 1985, its importance further emphasised in the 1987 White Paper, Promoting Better Health.[1] This publication reflects lessons learned from three years' involvement in this important area of primary care planning. There were two strands to this work. First, in 1985, the DHSS funded two development workers, for a period of two years, to further collaboration in selected FPCs and DHAs. A project co-ordinator, part of the primary health care group at the King's Fund Centre for Health Services Development, monitored and supported this work. These projects yielded important lessons about how to get collaboration off the ground. A national conference, held in May 1988, provided further information on local initiatives and a selection of 'views from the field' constitutes part two of this report. A second strand was a national survey of FPCs carried out in the summer of 1987 along with a study of FPC annual programmes and of collaboration more generally. This provided a context for assessing the achievements of the two collaboration projects and indicated progress in the field. This forms the basis of part one.

Joint planning does not occur in a vacuum. After a long period of policy torpor, primary care policy is undergoing rapid change. This is due partly to changes in the context of primary care, notably the changing boundaries between primary and community care, and primary care and health promotion and partly to management changes. Part three focusses on these changing boundaries, highlighting a number of initiatives.

As an introduction to this report, the rationale and development of joint working in primary care is charted. While FPC/DHA collaboration is not synonymous with primary care planning it is difficult to imagine strategic development, or effective and efficient delivery of services, in its absence.

INTRODUCTION

Primary health care can be defined in a number of different ways. A common conception is that reflected in the introduction to the Green Paper on primary health care:

> *all those services provided outside hospital by family doctors, dentists, retail pharmacists and opticians — the family practitioner services — and by community nurses, midwives, health visitors and other professions allied to medicine — the community health services.* [2]

In other words, primary care is first contact care provided by a range of professionals in a community setting.

At the other end of the spectrum is the public health approach to primary care espoused by the World Health Organisation and documented in the Declaration of Alma-Ata. [3] This emphasises community participation and health promotion. It is based on a broad definition of health and of primary health care which includes many other sectors with an influence on health.

The WHO approach is an inspiring one. However, some of the basic building blocks of joint working have yet to be put in place. Problems of co-ordination and teamwork amongst professionals remain endemic in the provision of primary care. Since 1985, and the independence of FPCs, increased attention has also been addressed to collaboration between FPCs and DHAs and, in particular, to the role of FPCs in planning and managing family practitioner services. This emphasis is clear in both the Green and White Papers on primary care. FPCs are expected to participate in setting local targets for (and monitoring the uptake of) certain preventive services, to monitor practice premises more rigorously, to provide better information on family practitioner services, and identify the views of the public on the quality of services provided . The 1989 White Paper, Working for Patients further strengthens the monitoring role of new and streamlined FPCs. [4] They are to monitor the expenditure of GPs choosing to work within practice budgets; promote better information links between DHAs and GPs; set up local medical audit advisory committees and small units to support and monitor the medical audit procedures of local practices. FPCs will also set and monitor indicative drug budgets for each practice in consultation with the GPs concerned. Despite a welcome emphasis on the importance of collaboration between FPCs and DHAs, there is little analysis in these documents of the nature of the hurdles to be overcome if successful joint working is to be achieved. Collaboration is clearly not easy in a primary care service provided by managed and salaried staff on the one hand, and independent contractors on the other. Despite an extension of their planning and monitoring powers, FPCs are not in a position to predict nor plan the services provided by independent contractors.

Yet joint planning in primary care is essential for professional reasons and for reasons of efficiency as well as to ensure a planned and co-ordinated service. More specifically, FPCs and DHAs need to work together for the following reasons:

both are providers of primary care services, which can be neither efficiently nor effectively delivered unless both agencies work together. Examples of such services include cervical cytology, child health, contraceptive services, dentistry and antenatal care. The 1987 White Paper clearly indicates that GPs are to play an increased role in child health, health promotion and caring for elderly people. These shifts in the balance of services need to be planned and the quality of care monitored;

The boundaries between primary and secondary care, and primary and community care are shifting. More day care and increased throughput in the hospital sector affects GPs and members of primary health care teams. Likewise, the gradual closure of long-stay institutions raises questions over the balance between hospital outreach services and extended primary health care. It also means that primary care teams will be increasingly involved in the care of groups with which they are not necessarily familiar;

GPs act as gatekeepers for the expensive resources of secondary care. In a time of financial restraint, there is concern to maximise appropriate referrals (and, by the same token, appropriate prescribing). Many DHAs are keen to limit care provided in out patient departments and prescribing by the hospital pharmacy where GPs and community pharmacists could provide the same service. Changes of this kind require protocol development, clear lines of communication and co-ordination;

there is increasing concern over the quality of care and a new awareness of the potential for reducing avoidable deaths and illnesses. In many cases quality assessment involves feedback across primary and secondary sectors. GPs need feedback over referral and diagnosis and hospital clinical staff should be aware of health outcomes for discharged patients;

organisational changes within DHAs, among them neighbourhood nursing and locality planning and management, require the participation of GPs (and GP data) in order to be fully effective. This has provided a spur to collaboration in some instances.

Such issues have long been recognised as important in planning primary care. The Report of the Joint Working Group on Collaboration between Family Practitioner Committees and District Health Authorities , promoted a comprehensive collaboration agenda. [5] Established in 1983, the group made 29 recommendations. These included the strengthening of planning in FPCs and local representative committees (LRCs); the production of FPC profile and strategy statements every five years, and annual programmes; closer links between DHA professionals, FPCs and LRCs; monitoring the balance of shared services, such as dentistry; developing arrangements for the interchange of staff; extending the role

of community physicians, computerisation and data exchange.

The report was published to coincide with the third reading of the Health and Social Security Bill (1984). The ensuing Act places a statutory duty on FPCs, DHAs and local authorities to collaborate to secure and advance the health and welfare of the people they serve.

The rationale and the potential for collaboration are clear. Making it a reality however is a more complex matter. Itemising some of the problems encountered also serves to highlight processes involved in planning primary care.

PART ONE: PLANNING PRIMARY CARE

Planning primary care is complicated in at least two ways. First is the nature of the two authorities involved — FPCs and DHAs — and the problem of joint planning between such different organisations. The second concerns specific problems to do with planning primary care, both within DHAs and across FPCs and DHAs.

Separate spheres

FPCs and DHAs are organisations with separate structures, cultures and ways of working. FPCs traditionally carried out 'pay and rations' duties, administering the contracts of the four groups of independent contractors — doctors, dentists, pharmacists and opticians — and advised by the corresponding professional committees (the local representative committees). In contrast, DHAs directly employ staff who are managerially accountable. Their management and planning structures reflect long-standing obligations to plan both for particular services and particular client groups. Unlike FPCs, health authorities have traditionally provided services for defined populations and have therefore been concerned, for example, with population needs, and uptake of preventive services. Independent contractors are not managerially accountable, but undertake to act within professional codes of conduct. **Major differences in accountability, information-gathering skills and in planning traditions means that the gulf between DHAs and FPCs as organisations, is much greater than between DHAs and local authorities, despite the apparent similarity in goals and despite both forming part of the NHS.**

In contrast to FPCs and DHAs, problems of joint planning between health and local authorities have been amply documented. In their account of joint planning between health and personal social services, Wright and Sheldon document six factors considered crucial to effective decision-making. [6] These are (in summary):

- the importance of personalities who can work well together and who carry authority within their own services
- a small group with consistency of membership
- clear, agreed operational guidelines and agreement on tasks to be set and goals to be achieved
- provision of an adequate data base from which to operate
- adequate links with other planning levels including direct reporting to major decision-making bodies
- time to allow relationships to develop to such a point where personnel are no longer defensive about their own services

While the first two of these are as easy (or as difficult) to achieve for FPCs and DHAs as for any other organisations, agreements on goals, the creation of an adequate data base and forging links with other planning levels prove rather more elusive.

Data are not routinely shared between FPCs and DHAs. Indeed, each authority may remain largely unaware of the data-gathering methods of the other, or of the potential of their data bases. Typically, data systems for FPCs and DHAs have been developed in isolation from each other. Thus, the Korner review of community health services was specifically directed to exclude FPCs.[7] Likewise, the FPC computer system was largely designed for administrative rather than planning purposes. Despite the fact that DHAs remain responsible for population-based preventive services, the best available population register, the FPC patient data base, has not been routinely available to them. The publication, in 1987, of a consultation document concerned with access by DHAs to FPC patient registers may clarify data exchange in this area.

While the management structure of DHAs allows senior managers to implement decisions affecting their staff, such is not the case for the senior executive of FPCs. 'Direct reporting to decision-making bodies' has quite a different flavour for FPC administrators, who have to work through local representative committees and independent contractors.

Primary care planning has long represented a policy void, partly as a result of this fragmentation of services, and partly due to the independent contractor status of those providing family practitioner services. There are few clear goals and objectives. For example, in their review of the management of FPCs, the National Audit Office emphasised the need for 'a strategic planning process for the FPS which ensures full integration within NHS planning. To this end, there is an urgent need for guidance to FPCs, both on policy priorities and planning procedures. This would also provide a spur to collaboration. In this review which included a detailed study of five FPCs chosen to provide a reasonably varied cross-section of local progress and problems, they also noted a number of barriers to fully effective collaboration.[8] These included the large numbers of agencies with which FPCs had to relate; government delays in issuing guidance on planning procedures and policy priorities; limitations on middle management resources of FPCs and FPCs' limited powers to direct practitioners. **Recognising the different nature of these two authorities represents a first step towards recognising — and overcoming — hurdles to primary care planning.**

Planning within FPCs and DHAs

Before planning across the FPC and DHA is considered, primary care planning within those authorities is discussed. It is optimistic to assume that authorities which fail to plan effectively within their organisations will succeed in joint planning.

The role of district health authorities

Much of the blame for difficulties in planning and co-ordinating primary care services has been levelled at independent contractors. Such contractors largely operate outside a framework of managerial or public accountability; they are not required to provide information relevant to FPCs or DHAs for planning or monitoring services, or to ensure adequate uptake of services (although many do so, and with the incentives proposed in the 1987 White Paper, more are likely to follow suit). Less attention has been focussed on problems in planning DHA-provided primary care (included as part of locally available 'core services' in the 1989 White Paper) and these difficulties persist despite the existence of formalised planning structures. While each health authority may have separate health care (or care group) planning teams for acute services and for mentally ill, mentally handicapped and elderly people, primary care cuts across each of these areas. Relevant to each, it becomes the focus of none. Since the first Griffiths report in 1983, and the creation of management teams for acute, community and priority services, community unit management teams have become a major focus for the discussion of primary care. This serves to cloud the importance of the implications of acute services for GPs, or of the potential contribution of primary care teams to 'care in the community'. Indeed such aspects have often been rather conveniently ignored, with local GPs often quite unaware of district policies on deinstitutionalisation or on the development of day care services.

The history of primary care as a fragmented service, provided by independent contractors on the one hand and salaried and accountable staff on the other, has ensured the lack of a coherent organisational and policy framework for developing high quality primary care services. In addition, this division, combined with the lack of information about current activities or future plans of family practitioners, has not encouraged the development of clear policies within DHAs for specific shared services. Child surveillance, school health, dental screening of school aged children, contraceptive services, cervical cytology, antenatal care, shared care for chronic conditions, are all areas where effective policy development has been slow.

Therefore, despite a tradition of planning within DHAs, consideration of primary care services is partial. The newly independent FPCs, often eager to exercise their planning and management functions in collaboration with DHAs, may find it difficult to locate a suitable organisational focus for dealing with the breadth of primary care issues.

Within this context old habits die hard. In particular, DHAs may choose to negotiate directly with the local medical committee or with individual practitioners, effectively by-passing the FPC. The relationship between

the FPC and GP representatives on district planning and management teams may remain distant, and arrangements for briefing and reporting back, obscure. The distinction between providing professional advice and representing FPC plans and priorities often remains blurred.

The role of FPCs

Planning within and for family practitioner services takes place in at least four different ways. First there are plans made for their own practices by those providing family practitioner services. For example, many GPs have age sex registers (ASRs) enabling them to plan and monitor patient care and provide a range of preventive services. Not all GPs have such registers, however, and variable use is made of them. For example, a survey of GPs in the Brighton health district carried out by Brighton Health Authority showed that 32 practices used ASRs for cervical cytology, and this was the most common service for which ASRs were used. Only one or two practices used registers for audit, paediatric screening, tagging certain diseases or as a disease index. In addition, only two practices allowed the ASR to be used by health visitors. The information base within general practice is of limited use for FPCs in planning services, although item of service payments provide FPCs with a picture of certain services rendered (such as cervical smears, immunisation and vaccination). In order to get a fuller picture of the activities of general practitioners, FPCs (and DHAs) have employed a number of devices, including questionnaires, practice visits and the use of GP facilitators. In City and East London FPC, for example, a survey of general dental practitioners (GDPs) was carried out in order to identify information about the FPC and the community dental services needed by GDPs, as well as information needed from GDPs by consumers, other primary care workers and the FPC. This was carried out in conjunction with the local dental committee. **Arguably, little progress can be made in planning primary care or in promoting joint working between the FPC and DHA until doctors and dentists can provide profiles of current activities and future plans.**

Second is the role of local representative committees. The members of these committees are elected by local practitioners and they are recognised by law as advisers to FPCs on the services practitioners provide. Half of the 30 FPC members are drawn from professional members of the four LRCs (medical, dental, optical, pharmaceutical).

The 1989 White Paper envisages a streamlined FPC consisting of eleven members in total of whom four are professional members, appointed by the RHA, and serving in a personal, not a representative capacity, and five are lay members, also appointed by the RHA. The FPCs would be headed by a new chief executive, appointed by the chairman and lay members.

Although elected by local practitioners, LRC members do not currently maintain close contact with each practitioner whose professional interest they uphold. They are not repositories of information on the provision of family practitioner services nor are they guardians of their quality. As FPCs take on new management and planning functions this inevitably implies changes in the traditional role of LRCs and in their relationship to

the FPC. Some LRCs have already tried to develop and change their role. For example, in Newcastle upon Tyne the LMC developed a ten year 'progressive plan' towards the provision of a package of primary care services. This would entail practices (rather than individual practitioners) providing a package of guaranteed minimum services.

They also envisaged that the LMC would have the major role of advising the FPC on appropriate annual targets for the care of specified chronic conditions and for various preventive measures. They argued that their plan would help solve some of the major difficulties that beset general practice namely *'lack of direction, relative lack of accountability, poor measurement of outcome, inconsistency of service provision, and difficulty of marrying the salaried community health service with the entrepreneurial and independent general practitioner service'.* [9]

Left unresolved in such initiatives and more generally in the relationship between the FPC and LRC is the question of which body becomes the lead agency — and shoulders the major responsibility — for attempting to plan family practitioner services. **The conflict between managerial and professional priorities has been documented within health authorities and is likely to achieve greater prominence within FPCs, once they expand their management task.**

In a study carried out soon after FPCs became independent, Sandra Williams pointed out that *'while FPCs were increasingly becoming involved in meetings at community unit level, they were rarely represented directly at meetings of the district management team, where the GP member, elected by the LMC, was viewed as providing the FPS element. Districts sometimes found it difficult to disentangle who the GP member represented, particularly where the GP was a member of both the LMC and the FPC'.* [10]

Where there is a strong LMC the FPC may be bypassed altogether. In addition, LMCs may appoint as representatives GPs who are not LMC members, thus making arrangements for briefing and report back even more difficult. The distinction between FPC representatives and professional advisers needs to be kept clear for LRC representatives on planning and management forums; likewise the two roles of the FPC — persuader of professionals and regulator of contracts — need to be clarified.

The third planning resource within FPCs are its members. In addition to their existing sub committees (allocation, deputising, dispensing, hours of service) many FPCs have appointed planning sub committees. Membership may include LRC representatives, lay members, FPC chairmen, and, more rarely, representatives from DHAs, such as community unit general managers. In Liverpool, and partly as a result of a DHSS-funded demonstration project, the FPC planning sub group now includes the community unit general manager, district nursing officers and director of planning. Joint service reviews have been started. Extended membership of FPC planning groups has also been a feature of other FPCs.

The extensive involvement of members by FPCs is an inevitable consequence of the lack of resources for management and planning within FPCs. This was noted soon after FPC independence:

> *New initiatives for involving members were also in part a response to a perceived lack of staff to match the expansion in collaboration and planning activities.* [11]

It is not clear how far FPC members themselves wish to extend their planning role. While DHA members often play an active part in planning groups they are always provided with extensive officer support — and the distinction between membership and officer roles remains clear. This distinction risks becoming blurred in FPCs if members represent the FPC at meetings largely composed of officers.

It remains the case that many planning sub committees are unclear about aims and objectives of primary health care, operating with a degree of uncertainty in a policy vacuum. Neither do they have access to detailed information on contractors with which to inform their decision-making. Clearly this inhibits their ability to represent the FPC — or local contractors — in their dealings with the DHA and other bodies.

Last but not least, there are senior FPC staff. Some FPCs have appointed a member of staff with a specific remit for planning and collaboration, but many largely rely on the administrator and deputy administrator to carry out the whole range of planning and management tasks. The lack of sufficient staff to carry out additional duties is a common complaint among FPCs. The proposals in the White Papers will serve to add to an already increased workload. For example, FPCs will be involved in setting targets, monitoring referrals and prescribing patterns (as well as more rigorous monitoring of premises) and gathering information from local practitioners and from consumers.

A study funded by the NHS Training Authority on the management development needs of FPCs was carried out during the second year of independence. It suggested a number of barriers to organisational achievement:

> *There was a lack of coherent vision, with a consequent lack of a clear strategy for pursuing purpose. Even when senior managers felt they were clear about purpose, this was not conveyed adequately throughout the organisation, with negative consequences for staff motivation.* [12]

Even where FPCs have grasped the management challenge, the wide range of activities implied by a joint agenda for collaboration has meant that the task has been approached piecemeal with particular initiatives often reflecting the interests of individuals involved. The complexities of planning primary care within each organisation are therefore substantial, and this is reflected in the nature and extent of joint working.

Planning across the FPC and DHA

The organisational context

The detailed mechanisms of collaboration between the FPC and DHA take place within a broader organisational context. Hudson outlines three models of organisational co-existence which has implications for joint working : independence, interdependence and conflict.[13] Arguably the relationship between FPCs and DHAs exhibits aspects of all three.

FPCs are currently formally independent of DHAs and RHAs, and are directly accountable to the Secretary of State for Health. Family practitioners are independent contractors who set their own goals and ways of working and do not require the support of the DHA to carry out their role. Yet FPCs and DHAs are also interdependent in the sense that in order to achieve their shared goal of providing comprehensive health services, co-operation is essential. FPCs and DHAs have to work together to ensure the provision of accessible and efficient primary care, the monitoring of preventive services and efficient discharge arrangements. But, they are also organisations in conflict. While all may agree with the 'banner goal' of good primary care, operationalising this goal may result in disagreements. For example, the expansion of GPs into child development and contraceptive services encroaches on the territory (and job security) of clinical medical officers and others. Likewise, the community dental service may be loath to give up its traditional function of screening school aged children. Changes in the location of services are not always prompted by concern over the quality of services provided; they derive more from concerns of co-ordination and efficiency. As Hudson points out:

> *There are many cases where a transfer of resources from one organisation to another may be desirable from the viewpoint of a co-ordinated system, but may be beneficial to only one party.*[14]

This is clearly the case in the provision of certain preventive services. A related issue is that of which organisation takes the lead in planning and monitoring primary care services. While the bulk of primary care has been carried out within FPCs, DHAs have always taken the lead in identifying the need for health services — and in planning services accordingly. Thus, in the many parts of the country where GPs provide a small proportion of population-based preventive services, DHAs have 'filled the gap' left by general practice. The 1989 White Paper makes clear the government's intention to make FPCs accountable to RHAs. This may enable a more strategic approach to be adopted in primary health care.

The 1987 White Paper proposes financial inducements for GPs to undertake preventive services; yet FPCs do not exert direct managerial control over their practitioners, and cannot directly promote improved uptake. It is unclear how DHAs can continue to maintain responsibility for services largely provided outside their control; conversely if FPCs are to undertake responsibility for this, they will need to develop information and monitoring systems to suit.

The question of 'lead agency' in planning remains ambiguous. For example, government guidance under HC(FP)86 2 asks FPCs to identify in their 1986/7 annual programmes strategic proposals of health authorities which affect the family practitioner services. In order to fulfill their new role — and respond to the changes proposed in the White Papers — FPCs clearly have to go beyond this reactive mode.

Getting collaboration off the ground

Since 1985, all FPCs and DHAs have attempted to foster collaboration. The Joint Consultative Committee order (HC(FP)(85)8) formalised such relationships between FPCs and DHAs. Priorities for collaboration have been identified and FPCs were asked to meet the target date of March 1988 for the implementation of a cervical cytology service, and plans for breast cancer screening. Uptake levels for immunisation and vaccination have been indicated, and all FPCs asked to provide information on *'implications for the FPS of local residential and nursing home developments'*. Finally, they have been asked to co-operate in reducing hospital waiting lists and waiting times and to develop with DHAs policies for the care of AIDS patients (HC(FP)(87)3).

The publication of the White Paper in November 1987, gave a further impetus to joint working in encouraging general medical and general dental practitioners to undertake preventive work in child health and in promoting joint setting of targets by FPCs and DHAs. Not surprisingly all FPCs have now established some processes for working jointly with DHAs.

There are three main types of organisational procedures for collaboration between FPCs and DHAs: representation of FPC officers and/or members on established DHA and joint committees (and vice versa); regular exchange of information and the setting up of groups with membership from both the FPC and DHA with the specific task of fostering joint working.

Working through existing committees

There is generally FPC representation on Joint Consultative Committees and Joint Care Planning Teams, and to varying degrees, there is FPC representation on DHA planning teams. The extent to which this occurs is partly determined by the number of DHAs to which one FPC may relate, and partly by the complexity of planning structures within those districts. Cross membership can make collaboration easier. For example, FPCs are advised to include a nurse with community experience amongst their members, and there is extensive sharing of duties between members of diverse committees. The importance of cross membership rests on the extent to which it enhances joint working without specific joint planning structures also being created. On a more negative note, the same few people may enjoy membership of a wide range of committees resulting in a concentration of power.

In addition to arrangements for formal membership, observer status at FPC meetings may be granted to a wide range of people including CHC members,medical and dental advisors and chairmen of health authorities.

Likewise local medical committee (LMC) meetings may be attended by the FPC administrator. Less easy to document is collaboration beyond the formal FPC committee, i.e. within its sub committees and the local representative committees. As recommended in the report of the joint working group on collaboration many FPCs have set up planning sub committees and in some cases senior planning officers from DHAs have been allowed to attend as observers on a regular basis. For example, Northumberland FPC's medical, dental and pharmaceutical committees are attended by the district medical, dental and pharmaceutical officers, respectively.

Exchanging information

While exchange of FPC and DHA minutes is commonplace, there is wide variation in the nature and extent of other information exchanged between FPC administrators and DHA staff. In some districts, information from both unit and district-level management meetings is provided for FPCs. On a topic basis, FPCs may provide information to DHAs on practice areas, changes in medical practice, list sizes (to facilitate nursing attachments) and on GP involvement in shared services such as contraception or immunisation and vaccination. DHAs may provide information on waiting times for outpatients' appointments and admission and on changes in consultant staffing. For example, Northern RHA intends to provide GPs with posters showing a monthly breakdown of waiting times in different specialties, clinic locations and procedures for urgent appointments. Information on immunisation and vaccination and cervical cytology take-up is often shared as a matter of course. The recent consultation document on exchange of information between DHAs and FPCs should help clarify arrangements. [15] Beyond formal exchanges however, much depends on the quality of informal networks and the range of opportunities presented for joint discussion.

Setting up new committees and posts

Committees specifically established to reflect or promote joint working take a number of different forms. The major distinction, however, is between those focussed on a single topic (such as child abuse, immunisation and vaccination, breast screening, cervical cytology, data provision, AIDS, drug dependency) and those where a range of issues may be discussed. In the latter category, committees typically involve the FPC administrator and unit general manager(s). As a maximum they may include secretaries of the local representative committees, directors of planning, nurse managers, district dental officers, district medical officers, district pharmaceutical officers and various consultants. There may be both officer and member groups, or one group to represent both. In Leicestershire, for example, the 'DHA/FPC Officers' Collaborative Forum' involves FPC officers, community unit general managers, the district nursing officer and a community physician specialising in information and primary care.

Barking and Havering established a 'Collaboration Group' early in 1985. It consists of the district medical and district dental officers, the specialist in community medicine, the director of nursing services, the district pharmaceutical officer, a community unit administrator, district planning

administrator, consultant paediatrician, GPs, a dentist and FPC administrator.

Such special groups are in addition to formal requirements for annual meetings between DHA and FPC chairmen and members, and for regular meetings between the CHC and FPC. Some FPCs too have established special posts to aid joint working and many planning/information officers have FPC/DHA collaboration as part of their task.

The existence of arrangements outlined above does not guarantee success and the potential for mechanistic — as opposed to purposive — collaboration is clear. However, it is also the case that establishing even such basic processes may meet with particular difficulties. The first of these is the lack of geographical and organisational coterminosity between FPCs and DHAs. Of the 90 FPCs in England, for example, while 60 refer to one or two DHAs, seven relate to four and six relate to five or more.[16] Each of the DHAs may have established quite separate planning structures to which the limited numbers of senior staff in FPCs will need to relate.

Clearly the need to establish a specific joint planning group with an FPC-wide remit becomes more urgent where the FPC has to relate to a large number of diverse DHAs.

In the case of Surrey FPC, for example, a small staff relates to seven DHAs of which four relate solely to Surrey FPC and three are divided between Surrey and other FPCs. There are eleven District Councils, seven CHCs, seven JCCs, two RHAs and patch based social services arrangements which do not relate to the DHAs. Lancaster FPC relates to seven DHAs and fourteen District Councils; Essex relates to six DHAs and seven JCCs. Clearly, setting up mechanisms for collaboration is in itself a major task given such structures.

A second difficulty, also well recognised, is the disjunction between FPC and DHA planning structures. Without a clear planning tradition, and with few senior staff, FPCs are nevertheless having to undertake a wide range of planning tasks. DHAs, in contrast, have well established planning and management systems, with the staff to match.

It is clearly not possible for FPCs to fit in with — or mirror — DHA structures. While members of FPCs are being encouraged to become involved in planning, they cannot realistically be expected to match the activities of the planning departments of DHAs. In addition, in the first 18 months of FPC autonomy, one third of members were newly appointed.

Finally, and most importantly, FPCs themselves need to establish a planning partnership with their local representative committees — who have to do likewise with the contractors they represent. Traditionally, LRCs have acted in a professional advisory capacity for the FPC; now that they are expected to represent the FPC in its new planning and management capacity, a major reconsideration of their role is required. Some of the basic 'common ground' for collaboration in terms of information exchange may not exist. Thus, LRC minutes may not go to

the FPC, the FPC administrator may not attend LRC meetings; even less likely is the involvement (as observers) of DHA officers at FPC meetings.

Despite these difficulties, progress is being made in collaboration and examples of successful joint working are described in part two.

PART TWO: VIEWS FROM THE FIELD

This section consists of four examples of new and imaginative ways of joint working. The first outlines the potential of including FPCs in regional reviews of DHAs, as a way of promoting strategic planning. This is drawn from a lecture and workshop presented at a national conference on FPC/DHA collaboration held at the King's Fund Centre in May 1988. The second and third examples are drawn from the experiences of two DHSS-funded FPC/DHA collaboration projects. In each of these projects a development worker was appointed for a period of two years. Jointly appointed by the FPC administrator and district general manager(s), the workers were located within the FPC, but by definition, the development workers fell outside existing management structures and hierarchies. Able to move between each authority, and between layers of the same authority, they enjoyed great flexibility and had access to information from professionals, consumers and managers. The East London example outlines the range of initiatives undertaken in one area of primary care — dental services. The Liverpool example focusses in some depth on the success of one particular initiative — the setting up of a local primary care forum concerned with the needs of elderly people. Each case illustrates issues of more general concern to primary care planning. Full reports of each of these projects are available. [17,18]

Finally, with FPCs increasingly expected to undertake a wide range of planning tasks, the fourth example outlines the potential contribution of community medicine and describes the activities of one community physician seconded to one inner-London FPC. Both the report of the joint working group (1984) and the Acheson Inquiry (1988) exphasised the importance of community medicine for FPCs in relation to planning, monitoring and evaluation. [19,20]

Each of the examples represents a model which could be of value for FPCs and DHAs seeking to enhance joint working: secondment, the creation of new 'development worker' posts to reflect changing circumstances, and the importance of a strategic, supradistrict view of primary care services.

Regional review of primary care — objectives of a voluntary initiative

Michael J.Rigby

Probably the greatest paradox in the NHS is the total separation in management and structure between family practitioner services on the one hand, and community and hospital services on the other. Firstly, there is the difference in accountability whereby hospital and community services management units are accountable through district health authorities and regional health authorities to the NHS Management Board and through it to the Secretary of State, whilst family practitioner services are accountable through family practitioner committees to a division of the Department of Health and so to the Secretary of State.

The managerial channels therefore do not converge until ministerial and permanent secretary levels. Secondly, there is the totally different style of provision, with community and hospital services being provided by directly employed staff in a planned service with equality of provision and access being important objectives, whereas primary care services are provided by independent contractors over which FPCs have registration and administrative powers but only limited organisational direction. Thirdly, whereas community and hospital service activity is systematically recorded in some detail (albeit hitherto with some significant gaps, though these are largely being redressed following the work of the Steering Group on Health Services Information), activities within family practitioner services are only very poorly recorded and then usually for financial reasons or as parts of wider studies.

Recently, political and managerial changes of philosophy have had some effect in reducing the differences but not necessarily bringing the two halves of the service closer together. In the light of the recent government Green Paper and White Paper on primary health care, many family practitioner committees have started to take a more positive and managerial approach within existing regulations. In secondary care, drives for greater efficiency have resulted in some district health authorities taking a more contractual approach to service provision, through the internal market within the NHS and through arrangements with the private sector. Undertaken separately by the two branches of the NHS these changes will have only a neutral, or even a disadvantageous effect, on service co-ordination and management.

The Mersey and Cheshire initiative

Given this incongruous situation in the management of health care, in 1987 a pilot initiative was agreed within Mersey Region, whereby Cheshire FPC would participate voluntarily in the review process in conjunction with the district health authorities. This paper describes the objectives and scope of the process, but predates the completion of the first formal review process and therefore does not consider outcomes.

The motivation for such a proposal is fundamental and powerful. In a supposedly single national health service, patients should be the focal point if the service is to achieve its purpose. The individual member of the public, whether ill and seeking treatment, or seeking advice and prevention, wishes to benefit from a complete and comprehensive service drawing as appropriate upon all branches and services of the NHS. So far as the patient is concerned, good care must be seen as seamless care, and therefore any reduction of the barriers and tensions between separate parts of the service must be beneficial. Increased efficiency in the use of resources is a further benefit.

This pilot was undertaken in the slightly complex setting of one family practitioner committee relating to five district health authorities and one town of a sixth district health authority in a region of ten districts. By contrast the remaining four FPCs relate to only one or two districts each. The benefit of the setting was the commitment of the respective chairmen and senior officers.

Potential tensions

Because of the 40 year old separatist traditions of the two branches of the service, any managerial collaboration clearly must overcome certain attitudinal hurdles. In particular, the practitioner professions view any managerial overview of organisation or performance as a potential threat to their autonomy. There is also the background thought that should discussions identify mis-matches between approaches to service delivery, clinical practice itself in either branch of the service might become open to questioning. District health authorities, though properly geared to a review process, feared a double scrutiny if two other NHS agencies were involved, whilst FPC management is already tightly stretched to meet extended current tasks without undertaking a significant additional one. Early results would be necessary if the process were to maintain credibility, whilst further bureaucracy was to be avoided. Finally, though the principal concern was about local service delivery, recognition had to be given to the fact that the accountability line of the family practitioner committee is to the Department of Health.

Principles for progress

The first stage in the Mersey and Cheshire setting was therefore to undertake a feasibility study to ensure that the objectives of improved care could be achieved. This required establishing a process acceptable to all parties and capable of being achieved within existing timetables and resources. An initial study put forward the following agreed principles:

- the focus of the review should be at the operational level of service provision — the DHA level rather than the county-wide FPC level;

- topics in the DHA review to be jointly addressed with the FPC should be specifically identified;

- these identified topics should be jointly addressed by the DHA and FPC, with the RHA reviewing the joint response;

there are clear benefits to be obtained from establishing the direct dialogue which would allow practitioners and FPC to discuss with the DHA and RHA service-specific anxieties more openly than before;

primary care services could benefit from the strength of the channel of communication from RHA to Department of Health and Secretary of State regarding organisational or resource mis-matches or service innovations;

the RHA would involve the Department of Health in the overview review of the FPC contribution;

all parties were committed to the fundamental objective of better and more efficient services to the public.

Inauguration

The Mersey and Cheshire pilot of a voluntary review process for primary care was introduced half way through the RHA/DHA review year. It thus had to limit its scope, and therefore its potential for immediate significant success, by being constrained to what could realistically be achieved in a short time-scale. One pre-existing review task of each district health authority, concerning a number of aspects of its hospital and primary care interface, was made a joint task, and one other specific task per district was added. Because of realistic assessment of what could be achieved in a part year, in most cases these were tasks related to analysing services to identify potential improvements rather than attempting to inaugurate totally new services or changed patterns of service delivery within the timescale. In addition, the new channel for communication and collaboration ensured that emerging management issues could be tackled in a more comprehensive yet more radical way. Throughout this inaugural period operational managers recognised that while early results in terms of additional or changed services would be highly desirable, the building of better information bases and mutual understanding of the scope for innovation were more realistic for a six-month period.

The full-term potential

In a full year much more fundamental approaches can be undertaken, looking in particular at means of ensuring closer harmony between services and better use of resources. The agenda in any particular setting must necessarily be appropriate to local issues, and the theoretical list is endless. However, the kinds of areas for study can be broadly categorised into the five groupings below, within which examples are given.

Health promotion and screening	Interface with community health services and continuing care	Interface with hospital care	Service support	Management and planning
Immunisation — locality and practice specific data	Co-ordination of family planning services	Improved referral and discharge communications	Co-ordination between community nurse and practice nurse provision and duties	Locality management
Cervical cytology — local data	Common strategy for pre-school developmental surveillance	Agreed approaches to open access for diagnostic and paramedical services	Availability of supply services	Information and database exchange
Screening of the elderly	Co-ordination of school health services	Shared maternity care	Appraisal of ambulance service utilisation	Publicity and promotion for service initiatives
Support for health promotion	Complementary objectives for dental services	GP minor surgery	Sharing of training expertise	Exchange of waiting list information
	Co-ordination of care in the community	Clinical policies for shared care		
	Support to nursing homes and residential homes	Complementary services for terminal care		

Conclusion

Ample material is therefore available from which specific local agendas can be drawn. To the public it would seem obvious that the NHS should have close co-ordination in these areas. Indeed, any argument to the contrary would seem untenable. On the other hand, all these areas will need careful handling if anxieties of professionals about district autonomy, and concerns of statutory bodies about potential unloading of responsibility, are to be avoided. This would seem to be a challenge which cannot be avoided in the light of current policy and resource scrutinies by the government. It is also an area which has major intrinsic value in terms of improving services, though the outcome in performance review terms may be difficult to quantify. Overall, it would seem much more desirable to move forward voluntarily than wait for public or political pressures.

Working together to improve dental services in East London

Penny McVeigh

The East London collaboration project was established in 1986 by the DHSS and the King's Fund to look at communication and collaboration in planning primary health care between City and East London Family Practitioner Committee and the three district health authorities within the area: Tower Hamlets, City and Hackney and Newham. A development worker, funded for two years, was jointly appointed by the FPC and DHAs. The project was based at the FPC offices and a steering group was established to support the worker and to forge links between the project and the four authorities.

The practical focus of the project was primary dental services. Dentistry was chosen for a number of reasons:

the Joint Working Party on Collaboration between FPCs and DHAs had made particular mention of dentistry; [21]

all four authorities had expressed an interest in the provision of dental services appropriate to the needs of the community;

primary dental services are the responsibility of both independent contractors (general dental practitioners) and health authority staff (the community dental service). Therefore assessing current provision and planning for the future would reflect many of the issues to be addressed by DHA/FPC collaboration in general. It could therefore serve as a model for primary care planning.

Specific collaborative issues in dental services include: the supposed duplication of services by general dentists (GDPs) and the community services (CDS), particularly in relation to services for school children who may use the community service, even though they are eligible for free dental treatment from GDPs; referral between the services; ensuring that dental services are adequately available for priority and special needs groups; and that dental provision is an integral part of the planning processes of both FPCs and DHAs.

Good information is a cornerstone of successful joint planning. This paper looks at attempts to gather and share information about dental services and to agree ways to effect improvements.

Dental information in East London

In the early stages, the project undertook an investigation of dental information with a view to mapping services provided by the FPC and DHAs.

The first weeks were spent trying to establish this baseline information. It had been anticipated that basic 'mapping' would be relatively straight forward and that from this the epidemiological, demographic and planning issues would emerge. The project would then work to establish joint discussions within existing planning structures on how to develop services to under fives and/or the elderly, for example. In particular, as the CDS changed its role, reducing its services to those groups who could use the GDS, they could concentrate on epidemiology, information, advice to planners and health promotion services to priority groups.

The community dental service

The amount of available data varied from authority to authority. Only Newham had a district dental officer (three sessions a week). In Tower Hamlets there was a senior administrative dental officer with agreed dental responsibilities; City and Hackney for most of the 1986-88 period had no administrative dental officer. In none of the DHAs were dental officers an integral part of care group planning.

All authorities had to collect data for the DHSS and it was straightforward to obtain lists of clinic hours, services provided and staff numbers. However, in no district was information on cross-service referrals available. It was not possible to know if children identified during school inspections as needing treatment did in fact get it.

Further, none of the DHAs had a dental strategy in 1986; links with the GDS were poor; little had been done to identify the needs of the community or to ensure that the CDS provided a service for the priority groups identified in DHA policies.

The general dental service

The FPC's information on contractors was held on manually updated cards which were often confused and inaccurate. It was not possible to map specialist services or to relate dental provision to demography. There was no way of monitoring if services such as home visits were undertaken by GDPs who had indicated that they were willing so to do. The FPC had no overview of services provided and no up-to-date dental list.

The project was able to produce a map of East London marking information as far as it was available. However this was not sufficiently detailed to show levels of service available by each clinic or practice. The initial assumption that gathering information would indicate gaps, overlaps and an area of dentistry in which to develop collaborative working had been shown to be misguided.

Attempts to gather information had demonstrated that there was no FPC-wide dental information and no clear structure for planning dental services. Dentistry was not an integral part of the post-Griffiths planning structures and two of the three DHAs had no clear dental strategy. Unclear primary care decision-making processes made it difficult to discover how contractors could have any major input into primary care planning.

Neither was it possible to assess the quality of dental care for priority groups. DHAs had made no overtures to the FPC on what they needed to know of the GDS to ensure that the CDS provided a complementary service either district-wide or on a patch basis.

Creating an FPC-wide strategic dental forum

In order to develop a strategic approach towards dental services, a mechanism had to be found to bring together all branches of dentistry with the FPC and community unit managers. With this in view the project organised two dental seminars to explore how services might be improved. It was anticipated that special attention would be given to services for under-fives and that some time-scale for strategic planning would be drawn up.

The first seminar, held at the King's Fund Centre in February 1987, raised familiar but pressing questions of how to develop dental strategies. How was responsibility for determining both levels of service and levels of need to be achieved across the FPC area? What vision was shared by FPCs and DHAs over the shape of dental services, the balance between independent contractor activities and those of the community dental services, the particular needs of priority groups, or the promotion of dental health? However, the seminar failed to focus discussion on any particular aspect of dental services and it became apparent that across the FPC area, even with all those properly concerned gathered together, it remained impossible to describe services, needs or demands. The responsibility for planning dentistry remained uncertain within wider primary care planning; it simply was not clear where decisions were taken. No individual could be identified who had the role of co-ordinating information, carrying out surveys or providing epidemiological information.

The seminar agreed the need to:

establish primary care strategies of which dentistry would form a part;

improve access to care group planning for practitioners;

appoint a lead officer to initiate and co-ordinate dental services.

A second seminar, held at The London Hospital Dental Institute in June 1987, attempted to look further at how dental information could be improved and whether the Joint District Dental Advisory Committee (JDDAC) was in a position to perform the necessary co-ordinating role.

Senior dental officers and the FPC administrator discussed what information they held and what was needed to assist them to plan. It was emphasised again that methods for obtaining FPC-wide information remained unclear as general DHA/FPC protocols for information exchange on primary care had not been established. Information gathered or shared remained activity-based and was not collected to assist in the planning of agreed strategic goals.

Although the seminar members were in agreement over what should happen (i.e better information) the variety of structures within DHAs, the

lack of an FPC-wide district dental officer and the uncertainty of overall primary care priorities and strategies were identified as obstacles to primary dental services.

It was agreed however that with input from the project, the FPC and the local dental committee, a survey of GDPs should go ahead to provide information on current activities and future plans.

The seminar demonstrated that the JDDAC was a suitable forum for discussing collaborative issues, but progress was tardy. This was partly due to initial lack of recognition of the status of the JDDAC by some of the districts. Despite the fact that it was constituted as a professional advisory group only, with no executive status, there was agreement that its members should produce a paper on its role and on possible collaborative issues. This was produced, with assistance from the project: the reassessment of the role of the JDDAC can thus be seen as a positive outcome of the second seminar.

Information for professionals and the public

The project had identified that residents of East London found it difficult to obtain clear information about local dental services. As primary health care workers could be a valuable source of information on this issue, a survey of district nurses and health visitors was carried out in conjunction with the directors of nursing services. This survey showed that:

seventy five per cent were asked about dental services by clients;

less than thirty per cent had dental lists;

less than five per cent had details of services, hours, or access to practice premises;

patients were concerned about the cost of dental treatment.

In order to try and fill this information gap the development worker organised nine '*Meet the Dentists*' seminars for primary care staff. Three meetings were held for each DHA, in different health centres and almost 200 staff attended. [22,23] These sessions proved helpful in enabling primary care workers to meet local dentists, share information and discuss gaps in services. More importantly the role of the FPC vis-a-vis dental services was explained. The FPC increasingly became aware of the need for up-to-date dental lists, which would assist not only consumers but also primary care staff.

'Meet the Dentists' had shown how, at little cost, information could be provided for primary care staff. Better information for the public was also a priority. Conversations with the CHCs and with groups such as Age Concern centred not only on the lack of an FPC dental list but on consumers' ignorance about rights, costs and access to services.

In Newham the district dental officer had produced leaflets, in conjunction with the district health promotion officer, but this was not a priority across the FPC area.

Over six months, a small group aimed to produce a *consumer leaflet* containing basic information on dental services. This initiative demonstrated the willingness of a diverse group to work together, and the need for the FPC, LDC and the CDS, with advice from CHCs, to contribute to such a project.

The follow up to the *'Meet the Dentists'* took the form of a questionnaire to the 187 primary care workers who had attended all the meetings. Generally, responses indicated that the meetings had been helpful and that similar sessions should be held annually. These surveys also indicated the sort of detail they felt should be available about dental services across the FPC (in particular access to premises, domiciliary visits, services on the NHS and whether dentures were available on the NHS).

Furthermore, 100 per cent requested more information on the role of the FPC and on how a system could be developed for staff to pass back to the FPC (and DHA officers) details of gaps in services, or of information they required.

The project thus organised three *'Meet the FPC '* meetings (one per DHA). These concentrated on the information the FPC could make available to primary care staff (or could collect from them), including details on how to change GPs, chemists open at night, calling out the GP, etc. It may well be that further sessions would open direct communication between the FPC and primary care staff and indicate the sort of detail on contractors' roles and services the FPC (in collaboration with the DHA) should ensure is made available to primary care staff.

A survey of GDPs

The dental seminar held in June 1987 and the *'Meet the Dentists'* sessions had indicated that little up-to-date information on the GDS was available. The project set up a sub group to identify services provided by contractors and their plans for future developments.

It was decided, with LDC assistance and agreement, that a survey of GDPs could provide information for a number of different purposes.

> Planning*: in addition to the basic list, further information could be aggregated with CDS information for broad planning purposes;*
>
> Consumers: *an up-to-date dental list to be published by the FPC could include details on languages spoken by dentists, access to surgeries and services offered under the NHS;*
>
> Community dental service*: a survey of GDPs could provide the CDS with details on GDPs willing to take certain referrals or to undertake home visits;*

General dental service: *GDPs would be asked what they knew or needed to know about the CDS to assist them (e.g how to borrow mobile equipment, availability of health promotion material and DHA policies likely to affect them).*

The survey was drawn up by the sub group, and administered by the LDC. The difficulties attached to undertaking the survey illustrate many of the matters relevant to DHA/FPC collaboration generally: lack of FPC staff or funds; contractors are independent and do not wish to be 'monitored'; information is required for particular purposes and should not simply be activity-based; lack of agreed dental strategies meant a survey would be undertaken without any clear notion of what information would be helpful for planning; lack of overall primary care aims and strategies made it difficult to establish proper exchange of information; historically in East London there was a relatively poor relationship between the GDPs and FPC: the JDDAC was very uncertain of its role.

Dental services and primary care planning

This account of dental initiatives undertaken by the project shows that whilst certain simple initiatives such as *'Meet the Dentists'* could be easily organised on a collaborative basis, attempts at any strategic initiatives illustrated wider problems in primary care planning. These are briefly outlined below as barriers to successful joint working between DHAs and FPCs.

Planning mechanisms

Across London all four regional health authorities had different planning arrangements. It was often unclear with whom the FPC should collaborate. Planning mechanisms within DHAs related to care groups and it became apparent when seeking the route into planning for dentists that access to DHA care groups was not available for contractors. At the same time, contractors had little notion of DHA policies that might affect them.

The FPC had a planning sub committee but no planning officer. The lack of FPC contact with planning groups in the DHAs, however, meant that the FPC's role remained uncertain. There was a need to develop the representative role of FPC members, who should relate closely to the FPC planning group. At the first of the two dental seminars it had been shown that dental services were not planned as part of care group planning: there were no dental policies for the care groups identified by DHAs.

The DHAs' joint integrated planning groups addressed themselves to a part of primary health care only. Lack of senior staff prevented FPC officers attending all care groups. In none of the DHAs was there a forum where overall strategies for primary care were discussed. Lack of contractor access meant that care groups might well discuss details with local authority officers and assume that contractors would provide relevant services when required. Looking at dental services had illustrated that unless proper information on contractor services were available such assumptions could not be verified.

Primary care forum

There was no clear primary care policy across East London and no forum for discussing the relationships between primary and secondary care or primary and community care. An assumption made at the outset of the project was that primary care was on agendas and that collaborative improvements — in this case to dental services — could be effected. It was found that there was no such forum: across the FPC area there was no agreement on the nature or aims of primary health care. Thus anybody attempting to discuss dental services had no strategic background within which to work.

Issues that the FPC wished to see on a primary care agenda, and discussed jointly between the FPC and DHA, were identified. They included items such as:

how the FPC could ensure that its plans for filling practice vacancies would mesh with DHA objectives;

how to involve contractors more directly in service planning;

how to establish methods through which FPC information could be incorporated into 'patch profiles';

the identification of collaborative protocols (e.g discharge of patients from hospital);

initiatives on information exchange.

In particular, a primary care forum would allow the FPC to participate actively in developing primary care — a task virtually impossible for a multi-district FPC to undertake given the complexity of DHA planning structures.

After considerable negotiation, a meeting of the FPC administrator and the community unit general managers (or equivalent) was set up. Initially, long-standing negative views on the FPC's inability to plan were discussed but the group rapidly moved on to talk of the need for compatible aims in primary care planning. This group has continued to meet.

Information policy

As a first step, and in the absence of clear strategies, the project organised meetings to allow those who had direct 'hands on' computer experience to find out about the possibilities of the FPC's computerised register. Officers were able to discuss certain practicalities, as well as agree to collaborate over the development of a community index. In addition the meetings showed the need for a forum to recognise and deal with constraints to information sharing.

Continuing care nurses are available for the terminally ill, and a care attendant scheme can provide short-term relief for carers. Whilst health visitors are trained to work with the elderly, in practice the needs of young families in Speke result in their workload being mainly confined to this group.

Social services are very involved in the care of the elderly in Speke; there is an elderly team (covering an area wider than Speke) and a home help service. A social work liaison officer (SWLO) helps community organisations develop their activities in the area. In addition, there are numerous voluntary initiatives concerned with this group.

Whilst the provision of services in Speke for the elderly seemed no greater or lesser than in other parts of Liverpool, there did not appear to be any information on the level of use or demand for such services.

Formation of the SSEG

Preliminary discussions with PHCWs and residents in Speke highlighted the need for collaboration in three key areas:

a means of identifying the elderly at risk of acute or chronic health problems;

a greater awareness amongst PHCWs of the kinds of services available for the elderly;

a system of support and assistance to carers of the short term and long term sick.

This paper concentrates on the second of the three areas identified, the need for greater awareness amongst PHCWs of the kinds of services which exist for elderly people.

Some PHCWs had revealed that they were unsure of the existence or specific roles of other services. For example, one GP claimed that he did not know of the availability of continuing care nurses for the terminally ill; some GPs were unaware of a prominent Speke day centre for mental health.

The only multidisciplinary forum existing at the time was an 'Elderly Interest Group'. Liverpool Social Services Department had set up elderly interest groups covering all districts. The elderly interest group serving Speke also included two other areas, and took the format of a monthly lunch time forum for the exchange of information about changes in the provision of services, benefits, etc. Speke PHCWs rarely attended this group, not just because of the physical distance involved, but also because they felt the other two areas covered had very different needs from Speke.

Accordingly the development worker proposed to set up a multidisciplinary Speke Services for the Elderly Group to improve awareness of services, promote discussion about roles, and to elicit overlaps and gaps in service provision. Those invited to meetings, and sent minutes were:

GPs	All seven Speke GPs
DHA	District Nurse Nursing Officer (Speke), Health Visitor Nursing Officer (Speke), Nursing Health Promotion Officer (Elderly) Health Promotion Unit;
Social Services	Social Work Liaison Officer (for district covering Speke), Social Work Advisor for the Elderly;
Voluntary Organisation	Chairman of Speke Senior Citizens Welfare Committee

Project Development Worker

Activities of the SSEG

The SSEG began in October 1986 and met every month or six weeks until the summer of 1987. On average four or five members took part. In practice, only one of the seven Speke GPs consistently attended meetings, which were held in the District Nursing Centre in Speke. Due to industrial action and internal re-organisation, the SWLO found it difficult to attend meetings for a while. The development worker provided much of the organisation and administrative back-up for the group.

The meetings provided a vehicle whereby PHCWs could exchange information on the services each provided, or which were known to them. For example, the group discussed the implications of the local occupational therapist going on maternity leave, and made alternative arrangements in her absence. The Health Promotion Officer provided details of schemes operating elsewhere in Liverpool that Speke residents could take part in, such as the 'keep warm' schemes to reduce the risk of hypothermia.

Additionally, the group identified gaps in service provision. These included a lack of domiciliary physiotherapy, poor transport facilities to hospitals and clinics, long waiting lists for chiropody and poor access at the clinic, no nursing homes in Speke, no carers support group and Speke not being included at the time in the Age Concern 'Good Neighbourhood Scheme'.

Directory of services for the elderly

By the summer of 1987 the group had compiled a draft guide of services for elderly people in Speke. Through the compilation of the directory, the group had exchanged much information, had discussed each other's roles, and had elicited gaps in service provision in the area. Various avenues were being explored for funding the printing of the directory (suggestions included approaching the Health Promotion Unit of the DHA, a Speke community organisation, or a charity).

A second development worker took over the project in September, with the specific objectives of:

assisting the group to publish the directory;

assisting the group to determine a new focus once the directory had been published;

raising with primary health care staff, and with managers and planners of primary health care services, how such an informal group could feed into the formal structures of both authorities.

The directory was finally produced in the format of an A4 looseleaf ringbinder. It consisted of comprehensive information on each service, listed alphabetically (e.g. aids and adaptations, services for blind and partially sighted, continence advisor, diabetic association, fuel boards, gardening services, holidays, lunch clubs, pharmacists, respite care, shopping delivery scheme, transport). Services were indexed, and cross referenced. A list of useful addresses was appended. In addition, a plastic pocket at the back of the ringbinder contained copies of relevant literature and leaflets produced locally and nationally (e.g by Gas Board, Department of Transport, Age Concern, Health Education Authority, Liverpool City Council, Community Health Council).

The launch of the directory at a special meeting in Speke was well attended by local PHCWs from both statutory and voluntary sectors. The FPC was represented by its chairman. The community unit of the DHA was represented by the unit general manager and senior officers. Two Speke GPs were welcomed, especially since they had not regularly attended previous meetings of the group. All those who attended the launch received a copy of the directory, and their names and addresses were recorded in order that they could be mailed with updates when produced.

'Meet the FPC'

The development worker suggested that members of the SSEG meet together with the FPC chairman and officers for informal discussions, and this idea met with enthusiasm. The purpose of this meeting was twofold:

Primary care workers are often unsure about the role of the FPC, and how it functions;

The FPC needs to have a higher profile (given its additional roles and responsibilities, and the current debates around developing primary care).

Before the meeting, members of the SSEG were circulated with background information on the history of FPCs, how they fitted into the DHSS structure, and how they were constituted. The FPC chairman and officers were circulated with the names and designations of the PHCWs who would be attending.

The meeting was considered to have been useful, with wide ranging discussion on issues such as the purpose of the group, existing provision in Speke of services for elderly people, difficulties encountered by district nurses and health visitors in collaborating with individual GPs, possibilities for the planned new health centre, current composition of Liverpool FPC membership, the role of the FPC in planning primary care services, how the group could fit into existing formal structures, GPs' reaction to the idea of nurse prescribing. The meeting concluded with the SSEG inviting the FPC to the launch of the directory, and the FPC inviting the group to return to be shown films on FPCs and to look around the departments.

The Exhibition

The SSEG organised a day long exhibition of services available for the over 60s in the area. Whilst the directory itself was aimed at PHCWs in Speke, the exhibition was targeted at local elderly residents to increase their awareness of what was available for them in their neighbourhood.

The exhibition took place in early September 1988 after extensive publicity, at the local comprehensive school and on pension day when elderly people would be visiting the post office in the vicinity. Organisations providing services outlined in the directory were approached over their interest in participating in this venture, and the response was very favourable. There were over 30 separate stalls demonstrating the wide variety of services on offer, each stall staffed to provide information and help. The DHA had constructed a model of the new health centre and had staff on hand to answer queries about this long awaited provision.

Admission to the exhibition was free. Arrangements were made by the SSEG to make the exhibition accessible to all the elderly in Speke (including those who were isolated and housebound, and those resident in homes) through arranging a variety of transport facilities. Sixth-formers at the school were recruited to assist during the exhibition.

Representatives of the DHA, the FPC, and social services were invited to the exhibition, as were all Speke GPs. Local radio and TV celebrities were encouraged to attend and lend their support. Businesses in the neighbourhood were requested to donate goods which could be given as 'spot prizes' to the elderly.

Future plans

The SSEG continues to meet monthly, and meetings are well attended on a regular basis by the original members of the group. Membership has recently been widened to include representation from the Speke Women's Health Action Group and the local police. It has been agreed that open invitations can be sent out for organised events and special meetings.
The group is in the process of sending out updates on the information in the directory, made necessary by changes in social security. The remaining directories are being finalised and distributed to an agreed list of those working with the over 60s in Speke.

SPEKE SERVICES FOR THE ELDERLY GROUP

Will Be Presenting An

EXHIBITION

SPEKE SERVICES FOR THE ELDERLY GROUP

SPEKE SERVICES FOR THE ELDERLY

COMMUNITY CARE

SPEKE COMMUNITY SCHOOL

CENTRAL AVENUE

Thursday 1ST September 88

10.A.M TO 4.0.P.M

Come and see what facilities are available for the elderly in Speke.

FREE ADMISSION

REFRESHMENTS AVAILABLE

ALL RESIDENTS WELCOME

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B Smoje.

The directory has met with wide approval so far. The group intends to formulate a system of monitoring the use of the directory by PHCWs, and incorporating suggestions from PHCWs for improvements.

The SWLO is willing to chair meetings of the group pro tem and to provide administrative services. Headed notepaper has been designed and printed, and a constitution for the group is being considered.

Learning collaborative lessons

As well as achieving the production and circulation of the directory and organising the exhibition, the SSEG has served other functions.

- It has created a local forum for health care professionals in the statutory sector and local people in the voluntary and community sectors to meet and exchange information relevant to the immediate neighbourhood.

- The group does not fit into any formal structures. Its autonomy may well be its strength. Links have been created, though, with the DHA, the FPC and with social services. The unit general manager of the DHA community unit is supportive and encourages staff to attend meetings and maintain full involvement. The FPC has already discussed the group's initiatives at its planning sub committee, and has extended an open invitation to the group to raise issues with them in the future. The director of social services has conveyed his appreciation of the directory.

- The need for a 'bottom up' approach in primary health care planning has been demonstrated. The gaps in services elicited by the group have been relayed not only to the DHA and the FPC, but also to the Joint Care Planning Team sub group for the elderly. Many people living and working in Speke have observed the limitations of existing primary health care provision, and have assessed future needs. Yet there has been no forum in which their voices could be heard. When members of the group were shown a recently published DHA profile of services for the elderly, they immediately pointed out its inaccuracies. Centre/periphery communication is also poor between the FPC and fieldworkers: at the '*Meet the FPC*' event the chairman and officers were taken aback when asked by a health visitor if they were doctors.

- The importance of local GP involvement has been highlighted. It is regretted by the group that the majority of Speke GPs do not attend its meetings. A primary health care team requires the involvement of all GPs and commitment from all PHCWs. Notwithstanding the difficulties for GPs in attending meetings, the experience of the SSEG in involving GPs in collaborative exercises has been echoed in other areas of the project. As independent contractors, GPs are — at the same time — field staff, middle management, and their own planners. If GPs are content with the existing situation and see no reason for change, what then should be the response of the FPC, or indeed the DHA? One outcome of recommendations from the project has been joint meetings between the FPC planning sub committee and officers

from the DHA community unit, and this may well be a useful way forward.

- Whilst it has been advantageous to have a development worker acting as a facilitator in the initial stages of the formation of the SSEG, the growth and achievements of the group have demonstrated that issues relating to a specific sector of the population are of enough concern to a core of people locally for them to put time and energy into collaboration. What is needed in addition is support from managers, and for the mechanisms to be created so that relevant information can be exchanged between those working at field level, and managers and planners of primary health care services.

Conclusion

Concentrating on a specific geographical area such as Speke — whilst essential for the project — took precedence over promoting collaboration at DHA/FPC level. Focusing on the 'patch' was useful, however, given the move to neighbourhood and 'patch' planning. Also the experiences of the SSEG illustrated wider collaborative concerns.

- No-one had the responsibility to assess, evaluate and consider ways of improving services, either locally or centrally within the statutory sector.

- Whilst both the DHA and FPC had highlighted the need to look more closely at primary care, neither had indicated its priorities. Ideally, joint priorities are needed for developing effective collaboration, but no DHA/FPC planning forum existed.

- Local forums for discussion of primary care issues were undeveloped in Speke, and reflected a relatively low level of team working in primary care in Liverpool.

- GPs were often unaware of services provided by the DHA e.g. chiropody, psychiatry, physiotherapy, speech therapy, community dentistry. There is a lack of effective communication between the DHA and GPs over issues such as the discharge of patients from hospital, and the closing of long stay hospitals and establishment of care in the community schemes.

- The DHA and FPC have produced strategy documents and short and long term plans which reflect lack of collaboration at the drafting stage.

The wider collaborative concerns highlighted by the SSEG provide a challenge for both authorities, and an agenda for the future provision of effective and efficient primary health care for the people of Liverpool.

A foot in both camps — a community physician at the FPC

Rosemary Beardow

The re-establishment of family practitioner committees as independent statutory bodies in 1985 has served to clarify and extend their role, especially with respect to policy making and planning. FPCs are now expected to assume a greater responsibility for the planning and development of primary care services in response to the identified needs of the local community. This inevitably means closer working and collaboration with health authorities and their staff.

Community medicine with its particular skills and interests in epidemiology and statistical analysis, the assessment of needs in health care and planning and disease prevention would appear ideally suited to provide one such link between the DHA and FPC. This paper describes one attempt to forge this link.

An innovative proposal was made to second a senior registrar in community medicine (myself) to an FPC for two sessions a week. The main purpose of this attachment was to determine exactly what contribution could be made by a community physician and to identify the possible benefits that might result for both the FPC and DHA.

The attachment commenced in November 1987 and concerned a senior registrar from Paddington and North Kensington (PNK) Health Authority being seconded to Kensington, Chelsea and Westminster (KCW) FPC. PNK is an inner London health authority which ranks as one of the most deprived districts in the country. It has recently merged with Brent to form the new Parkside Health Authority. Kensington, Chelsea and Westminster FPC covers all of PNK and parts of Bloomsbury and Riverside Health Authorities. It has a large number of elderly single handed GP practices within it and a particularly high list inflation rate which reflects the high turnover of patients in this area. Computerisation of the registers at the FPC was only completed in January 1988. Links between the FPC and DHA have been good with the FPC administrator attending meetings of Community Management Board and sitting on the Primary Care Planning Advisory Group. The Local Medical Committee (LMC) agreed to the proposed secondment in principle but stressed the need to maintain a strict confidentiality. The original objectives were of necessity broad and ill defined. They were:

to explore the role of community medicine at the FPC;

to gain a better knowledge of primary care and of the contractor services and share this with the DHA;

to advise on the possible uses of the FPC computer data base and assist in their development;

to help identify the needs of the area and to encourage the appropriate development of practices in response to these;

to contribute to planning in the FPC;

to strengthen existing units and establish new ways of communicating between the FPC and DHA.

Initially, time was spent becoming familiar with FPC organisation at all levels and learning about available information. My background in general practice and continued local involvement proved an advantage, as I already had an elementary knowledge of the FPC and its delicate relationship with GPs. The complexities of general practice finance were also appreciated.

My role soon developed in three main spheres — planning, health promotion and 'facilitator' work. The publication of the government White Paper 'Promoting Better Health' also highlighted other areas requiring attention.

Planning

FPCs hold a large amount of information including details of GP practices, (GPs' age and sex, details of premises, staff employed, etc.), registration data and item of service claims. However, much of this information is not immediately accessible. For example, a great deal of time was spent grappling with the Exeter computer system in an attempt to extract information useful for planning. This proved a rather laborious and time consuming exercise as the computer system was sadly not designed with this purpose in mind. Others have also noted the missed potential of the registration system in this respect and the missed opportunity of recording full post codes. If easier manipulation of data were possible it would then be feasible to link the information with census data and mapping facilities. In this way, specific populations could be identified to include practice populations, those living in areas of high deprivation and those with particular characteristics. Health promotion programmes could be targeted and the uptake of different screening programmes for different areas monitored. The workload and uptake rates of individual practices could be related to the social class/deprivation indices for patients in those practices. There are many possibilities and other FPCs are also currently trying to develop schemes along these lines.

Using the Exeter system, I have managed to provide a breakdown of practice populations into age groupings (0-4, 5-14, 15-24, etc.) and into areas of residence using selected postal areas (W2, W9, W10 and W11) into which most of PNK neatly falls. Together with details of the individual practice and item of service claims, this information provides a profile of all the practices in Paddington and North Kensington. These have then been grouped (according to the site of the main surgery) into four areas corresponding to the postal districts. It is thus possible to obtain a picture of the individual practices and of general practice in the different areas and so compare them with one another and with health authority service provision. This had not previously been done. Certain interesting facts become immediately apparent including the following:

1 *Wide variations in the age distribution of patients registered with different practices*

This will have workload implications as it is generally recognised that the very young and the old have higher utilisation rates. Figure 1 shows variations between four practices in the same area with similar list sizes. Practice D has a much smaller proportion of patients in these categories. This could possibly indicate a restrictive practice by that GP.

Figure 1. Age distribution (%) by practice

Practice	0-4	5-14	15-24	25-44	45-64	65-74	75+
A	6.4	8.6	14.9	42.4	17.1	5.6	5.1
B	5.3	9.8	13.7	33.9	22.2	9.3	5.9
C	4.7	7.3	10.6	46.9	19.1	6.0	5.4
D	2.5	5.5	19.1	54.2	13.1	3.1	2.6

Similarly there are differences in the age distribution of patients between postal areas as shown below. Practices in W9 for example have a high proportion of elderly patients. This is the kind of inormation that could be useful in planning the development of community nursing staff in localities and to individual practices.

Figure 2. Age distribution (%) by postal district

Practices	0-4	5-14	15-24	25-44	45-64	65-74	75+
W2	3.8	6.9	13.2	45.4	19.8	6.0	4.7
W9	4.2	7.5	13.1	38.1	21.7	8.0	7.4
W10	5.9	11.1	14.9	36.3	20.2	7.0	4.6
W11	4.3	8.1	13.5	41.7	20.3	6.7	5.4

2 *Wide spread of patients registered with certain practices*

Although 80 per cent of patients on the lists of GPs in PNK are resident within PNK itself and 88 per cent of all patients are resident in KCW FPC area, half the practices have patients resident in four or more FPC areas. Four practices have patients resident in eight different FPC areas and only three practices have patients exclusively in the KCW area

3 *The high proportion of elderly single handed GPs in the W2 area with large lists.*

Any retirements here could cause significant problems (see discussion below on succession planning)

4 *The variation in the proportion of ancillary staff reimbursements claimed*

Whilst some practices are making full use of their entitlement others appear to use very little and only a minority of practices employ a nurse.

5 *The range of services provided*

This relates to the item of service claims only. In one area six out of 11 practices made claims for taking cervical smears in the course of one year and this number varied between two and 22 per thousand registered patients. Similarly, although all the practices in that area are providing contraceptive services the range was between one and 52 per thousand registered patients and only four practices made any claims related to the coil. Immunisation and vaccination claims ranged in the same area from 88 to 169 per thousand. Such information obviously has implications for health authority provision in the area.

Three planning issues have been identified for further attention:

Succession Planning

Twenty out of a total of 83 GPs in PNK will be aged over 65 in 1988. This represents approximately 20 per cent of the total list size. Sixteen of these GPs are single handed with a significant number in the W2 area. This will have major implications for the FPC and has highlighted the need for considerable forward planning rather than reacting to events as they occur.

Details of the actual age breakdown and distribution of patients will facilitate this process, and the information is going to be used by the FPC in negotiations with the Medical Practices Committee. An attempt can also be made to identify gaps in service provision and activity and try to rectify or improve this in the future.

Locality planning

This is at an early stage of development in PNK. Locality profiles based on the four postal areas are currently being prepared using information from the FPC. This is related to community services in terms of staffing levels and activity and both these are analysed in relation to the sociodemographic characteristics of the local population. It is hoped that a joint approach between the FPC and DHA will result in the development of a comprehensive and co-ordinated service. The possibility of more primary health care teams is raised as only two district nurses and one health visitor are currently attached to practices. Ways of encouraging the employment of a greater variety of ancillary staff are also being considered.

Developing primary care

As already noted information on item of service claims provides an indication of the range and level of services available within practices. This is particularly relevant in the light of the government White Paper 'Promoting Better Health' and to the FPC in its new enhanced role. It is evident that many practices in PNK do not provide facilities such as immunisation and vaccination, or cervical screening.

Many GPs make little use of employing ancillary staff and only a small proportion actually employ a practice nurse. It is hoped that in conjunction with the health authority some of these factors may be looked at and ways of encouraging practice development considered.

The provision of information per se is the first stage in the planning process. A report outlining these findings is being considered by the FPC who will decide what action to take.

Health promotion

The implementation of district cervical cytology call and recall schemes has posed particular problems in PNK because of the large transient population, the consequent high list inflation and the large numbers of women not registered with a GP. The health authority therefore decided to phase the introduction of call and recall, beginning the first stage in April 1988. As manager of the implementation programme, it has been beneficial both to the health authority and the FPC for me to be on the FPC premises during this time. Ease of communication has allowed problems to be solved quickly, and a better understanding of the system at the FPC has resulted in the development of a more appropriate operational policy, e.g. in defining result codings to be processed by the clerk. A more detailed evaluation programme can also be performed.

PNK has an apparently poor child immunisation take up rate. This may in part be exacerbated by poor information collection and exchange between GP, FPC and health authority. The accuracy of data on the child health computer system has been questioned after comparison with GPs' lists obtained at the FPC. The latter are considerably longer (not simply due to list inflation), there are many discrepancies in addresses, changes of GP are rarely recorded on the child health computer system and children entering the district may not be known to the health authority. The large numbers of homeless families who are temporary residents have to be listed on the child health system and this causes problems. Attempts are now being made to address these factors and to improve immunisation rates overall. More GPs are being encouraged to participate in the district scheme.

Acting as facilitator

The term 'facilitator' has tended to refer to either a nurse facilitator involved in the promotion of preventive health in general practice, or a GP, often retired, employed to facilitate communication between GPs and the FPC. Two other areas have developed in the course of my work, namely facilitation between FPC and DHA, and between GP and DHA.

As a direct result of my involvement at the FPC it has been possible to provide information for the community health service staff and managers and highlight areas of concern. Areas of potential collaboration have been identified and developed.

Good communication between health authority and general practice has not been evident in the past and a lot of ill feeling has existed on both sides. In an attempt to rectify or ease this I have been working with some of the local GP practices to look specifically at problems arising from the interface between primary and secondary care. Thirteen local GPs representing seven different practices now meet together on a regular basis to discuss particular health service issues. They are referred to as the 'Sentinel Practices'.

They provide a means not only of gaining GPs' views on topics of interest to the health authority but also of providing actual information on the use of services.

They are currently monitoring both the problems encountered in getting patients admitted as emergencies to the local hospitals, and are identifying patients that could benefit from a GP ward facility were it available. The health authority is to provide an open access physiotherapy facility for these GPs in an evaluation exercise prior to the possible extension of this service district wide. The LMC and FPC are kept up to date with developments and progress and information is fed back to the appropriate management group. This is eased by the fact that I attend meetings of the Community Management Board and the Primary Care Planning Advisory Team and can attempt to feed the information into the appropriate channels.

Promoting better health

The government White Paper has stressed the importance of collaboration between DHA and FPC and some of the areas mentioned have already been alluded to. Tasks where a community physician could make a major contribution include:

- the setting of screening targets;
- deciding the distribution of GPs in different areas;
- succession planning;
- provision of premises;
- the development of primary health care teams in response to the identified needs of the local community;
- computerisation,
- identifying good practice with respect to hospital referrals;
- the monitoring of practice activity and advising on improvements.

Many of the points I have raised have a bearing on these issues. The potential for a community physician based within the FPC and having the required knowledge of general practice is obvious.

The future

It is intended that the facilitator role should be continued and enlarged to enable more direct involvement with local practices. It is also intended that a nurse facilitator be employed by the FPC and that I become involved in advising and supporting her. Input into the strategic planning process and development of locality planning is still required.

It is perhaps early to evaluate the contribution made by a community physician at the FPC but my experience would suggest that this is an exciting and worthwhile development. A lot of necessary ground work has been done and important links established. This has taken time but with the foundations laid real building work can now take place.

PART THREE: WAYS FORWARD

The changing context of primary care

Parts one and two of this report have indicated some of the issues to be considered in making a reality of joint working, and provided examples of successful initiatives in this area. However, the collaboration agenda is constantly changing. This section looks firstly in more detail at the implications for joint working of the changing context of primary care, and in particular of the shifting boundaries between primary care and care for priority groups, acute services and health promotion. Secondly, and by way of conclusion, some major collaborative themes are highlighted.

The fragmentation of primary care and its separation from secondary care has meant that, in theory at least, collaboration between FPCs and DHAs has always been part and parcel of planning. In practice however, DHAs have had little access to information on services provided by GPs, or general dental practitioners, nor on how their activities might develop and change. Community health services have thus ensured, for example, that population-based preventive services are available for district populations. Just as the predominantly individualistic and reactive way of working in general practice — a mode reinforced by the current payment structure — has ensured an active role for community health services in preventive care, so too has it ensured that out-patient departments carry out the bulk of routine care for chronically ill people.

General practice is now changing. GPs, armed with age-sex registers, are playing an increasing — and in some areas a dominant — role in preventive services. Policies for care in the community, for each of the priority groups, have implications for the organisation of general practice, a point underlined by the recent Griffiths report on community care. [24] The need to rationalise shared services and expand the contribution of the primary care sector in 'acute' care, particularly in the context of the financial crises in many DHAs, reinforces trends towards an expanded primary care service. All this is taking place within the context of an increased planning and management role for FPCs and a White Paper on primary care which makes it clear that the role of GPs and dentists is to be extended in those services provided via FPCs and DHAs.

The relationships between primary, secondary and community care and associated changes in the balance of services between FPCs and DHAs (and in the location of care) thus provide a major focus for future joint working.

Promoting prevention

Changes in the balance and location of care are perhaps most clear in shared preventive medical services — immunisation and vaccination; child health surveillance; contraceptive services and cervical cytology. The White Paper proposes financial incentives to GPs who reach specified targets for vaccination and screening services and payment is also proposed for carrying out child surveillance. Already, and often without discussion with GPs, DHAs are cutting back on family planning services on the assumption that local GPs can provide acceptable contraceptive services at convenient times. [25] Likewise, the Health and Medicines Bill implies changes in the role of the community dental service, as screening of school age children becomes a discretionary, as opposed to a statutory function. The responsibility for the dental health of school age children will increasingly fall to general dental practitioners.

An increased commitment to prevention within general practice is clear — not least in the recent emergence of a new army of workers encouraging health promotion in general practice. Variously known as facilitators, preventive health officers, prevention nurses, prevention liaison officers, health promotion nurses, they are funded through a variety of mechanisms (joint finance; Department of Health; project-based; jointly funded by FPCs and DHAs). These facilitators may help GPs set up at-risk registers and provide training in screening procedures for members of the primary health care team. The Oxford facilitator project has provided the model for many of these schemes and there are now over 40 facilitators (in post or planned) helping to develop preventive activities in primary care.[26] In addition, many GPs have age-sex registers which enable them to monitor their practice populations.

While part of the agenda for joint working is to encourage the development of prevention in primary care, an equally important part of that agenda is to monitor the quality of services provided and the population coverage achieved. Facilitator schemes are often oriented towards risk factor identification for common 'killers' such as coronary heart disease (as in Derbyshire, Kirklees, Powys and other FPCs) and promote opportunistic screening of individuals presenting at a health centre. Effective provision of population based preventive services however, requires a more proactive approach coupled with efficient monitoring. Likewise, if dentists are to play a greater role in providing dental care for school children, FPCs and DHAs will need to develop ways of monitoring gaps in service provision and changes in dental health. While there have been a number of initiatives in outreach work using the age-sex register, as in the screening of over 75s by health visitors, in general GPs, local medical and dental committees and FPCs have not been involved in population monitoring of this kind. Changes in the provision of preventive services heralds a new public health role for FPCs, a matter of some urgency for the joint FPC/DHA agenda.

Family practitioner services and secondary care: changing the boundaries

Changing the boundaries between primary care and acute care is on the agenda for a number of reasons. The acute sector is increasingly concerned to maximise throughput, reduce costs and promote efficiency in the use of resources. In parallel with this, many GPs have been keen to maintain links with the acute sector (for education/training reasons) and in order to provide continuity of care for patients. From the point of view of users of the service — and reflected in the philosophy of primary care developed by the World Health Organisation — as far as possible, care should be provided in a community setting with the minimum of delay.

In practice, this is translated into initiatives in the following major areas: increasing the range of community-based DHA staff to whom GPs can directly refer and work with as part of the primary care team; increasing GP access to hospital diagnostic and therapeutic services; encouraging appropriate referral to secondary care and appropriate use of Accident and Emergency services and providing an increasing number of specialist services in a community setting.

The 1987 White Paper opened up new possibilities in the development of practice teams through its proposals to extend the categories of staff which may be reimbursed through the ancillary staff reimbursement scheme. The extent of change depends on the budget allocated to this initiative; it seems likely, however that attachment of DHA staff to general practice will be a major topic for a joint agenda for some time to come.

While attachment of community nursing staff is relatively commonplace, changing demands on primary care require an expansion of the primary care team. This derives from changes in the acute sector and from the implementation of policies for care in the community and raises questions over how 'outreach' work from both acute hospitals and institutions for mentally ill people and people with learning difficulties and the activities of expanded primary health care teams are to be co-ordinated.

Some DHAs have developed attachment schemes for community psychiatric nurses (CPNs), clinical psychologists, speech therapists and physiotherapists. In Mid-Staffordshire DHA for example 11 CPNs are attached to GP practices. Antenatal care shared by GP and community midwives is no longer rare.

In many districts, GPs enjoy direct access to over 20 hospital services such as radiology, bacteriology, dietetic services, speech therapy, psychology and chiropody. There is great variation in the extent to which services are made available (for example for physiotherapy, ultrasound and occupational therapy).[27] Dentists may use central anaesthetic facilities (as in Kirklees FPC area). Increasingly, too, DHAs provide specialised nursing services in the community: mastectomy care; stoma care; care of people who are dying; continence advice; geriatric visitors and specialist health visitors.

A major issue, particularly for inner-city areas is the use of Accident and Emergency Departments for 'general practice' cases. This has been well documented and in some studies up to 30 per cent of attendances were classified as more appropriate to a primary care setting. There have been various attempts to remedy this: health education; leaflets about registration with a GP and surveys to identify reasons for choosing the hospital over the GP surgery. A recent initiative from the Primary Care Development Project based at King's College Hospital in London is to locate a GP in the Accident and Emergency Department not just to provide appropriate care but also to provide education in the use of health services and to attempt to bridge the gap between health workers, the community and the hospital. Although FPCs have not been in the forefront of such initiatives, a number (Enfield and Haringey FPC for example) have expressed a commitment to provide advice and information on registration with GPs for those attending Accident and Emergency Departments.

Changing the location of services from hospital to community settings is an area where FPCs are taking an increased interest. For example, Cambridge FPC carried out a survey of GPs in order to identify which consultant services they would find of most value in a general practice setting. It was found that rheumatology was the preferred speciality, followed by dermatology and psychiatry. Annual Programmes demonstrate that FPCs are keen to expand the provision of specialist services, such as nail surgery, at selected centres.

Finally a number of FPCs have pre-empted the proposals in the White Paper to encourage GPs to carry out minor surgery. In Staffordshire FPC, for example, participating GPs are supplied with sterile minor surgery instrument packs designed by the LMC and paid for and distributed by the DHA. Over 60 GPs are already involved in the scheme, which is being evaluated through an analysis of attendances at accident and emergency and out patient departments. Over a 12 month period, 700 minor operations were carried out in North Staffordshire in 36 participating practices.

Many such changes are taking place. Yet these are often not charted within FPCs and DHAs and the national picture is difficult to gauge. One step in this direction is the intention of Kensington, Chelsea and Westminster FPC to develop a monitoring package with the DHA, local authority and community health councils, to identify those aspects of primary care most sensitive to changes in the pattern of acute services.

Primary and community care : monitoring changes

Policies for providing care in a community setting have implications for the organisation of general practice. This is true for each of the priority groups. For example, the expansion in residential and nursing homes for elderly people creates extra demands on GPs, particularly those practising in the 'retirement belts'. In Worthing, for example, there are over 140 nursing and residential homes. There is also evidence that many GPs are currently poorly equipped to meet the needs of physically disabled people and have little experience of people with learning disabilities.[28]

What balance is to be struck between DHA and GP-based care for mentally ill people? The effects of policies for care in the community are of clear concern for FPCs.

For example, as early as 1985, City and East London FPC established a working party to review GP and nursing care for elderly people living in residential homes in City and Hackney health authority. This followed concern over care of elderly people inappropriately referred to Accident and Emergency departments. In this case, a visiting medical officer was appointed. However many LMCs have argued that the nature of medical care required in nursing homes goes beyond primary medical services and that local authorities and FPCs should consult early in the planning process to ensure that adequate primary medical care is in place.

A number of FPCs are now attempting to monitor the implications for the FPC and its contractors of proposals for care in the community. In Lancashire FPC, for example, a worker was appointed through joint finance to interview GPs in order to identify their knowledge of policies for care in the community, and to help them develop appropriate services. The survey revealed GPs' lack of knowledge of policies, appropriate referral agencies (particularly in the voluntary sector) and of the numbers of people with learning disabilities or mental health problems on their lists. In response to this, the FPC has undertaken to provide GPs with updates on the closure of large mental handicap institutions, on the development of community-based facilities, and on regional and district strategic developments. GPs will also be encouraged to take part in and instigate multidisciplinary assessment meetings to monitor individuals' changing needs. The importance of appropriate referral — to paramedical, social service and counselling services — is emphasised, as is the need to keep records of incidence and types of mental handicap and maintain regular contact with individuals and families.

Such an approach is reflected in the recent Griffiths Report which advocates an enhanced role for GPs in ensuring that the social service needs of their practice populations are met.[29]

The trend towards creating local mental health resource centres as part of care in the community creates new opportunities for GPs to work closely with members of mental health teams. Typically, however, GP involvement in establishing these centres has been small.

Some progress has been made in meeting needs for eye and dental care of those being discharged into the community. For example, Brent and Harrow FPC has arranged for a local optician (paid by the DHA on a sessional basis) to provide a domiciliary optical service and Wirral FPC has identified contractors prepared to provide general optical services on a domiciliary basis.

Protocol development and audit

Changes in the pattern and location of services have to be matched with procedures for ensuring co-ordination and quality of care. This is true for preventive, 'acute' and continuing care within general medical practice (and, to a lesser extent, within general dental practice). Protocols are one such measure; they could be developed for clarifying management and referral for a wide range of disorders, including care of mentally ill people and of those with physical disabilities. In practice, however, attention has been focussed on those areas where GP (as opposed to out-patient) follow up of chronically ill people should be extended — asthma, diabetes and hypertension and in certain areas of preventive care. In Northumberland for example, a community paediatrician visited all GPs and discussed with all health visitors the 'minimum set' of procedures for child health surveillance. Each practice agreed to carry out the agreed tests (although the methods for doing this were left up to the practices concerned). [30]

There are also numerous initiatives to devise integrated systems of diabetic care. [31] In most cases the FPC is not directly involved. Arguably, if such initiatives are to become the rule rather than the exception, FPCs will need to play a more active role in enabling protocol development; such an intention is clear in a number of FPCs. Calderdale for example intends to:

identify and agree conditions for which shared care is desirable;

ensure there is an agreed procedure for sharing the care of each category of patients;

develop through the 'Age/Sex and Disease Register Group' the use of such registers for identifying patients with the selected conditions;

prepare a co-operation card to be held by patients on which to record visits to hospital or GP and the treatment given (or recommended);

establish a means of following up defaulters e.g through the hospital and FPC computers.

As shared care is increasingly adopted, FPCs are likely to have to play an increased monitoring role.

In Enfield and Haringey, a development worker (funded through the Primary Health Care Development Fund) will work with GPs, consultants and community health services personnel to develop guidelines in the care of patients with specified chronic conditions.

FPCs have also become involved with initiatives in pharmaceutical and optical services. For example, Cheshire FPC has suggested that practice formularies (an agreed list of drugs for prescribing and dispensing) be developed by the district pharmaceutical officers and the FPC, with information being disseminated to GP practices and pharmacies. [32] In addition, as health authorities increasingly establish prescribing policies

so that patients discharged from hospital receive drugs from the hospital pharmacy for a limited period only, FPCs will need to ensure that GPs and pharmacists are well-prepared.

In a number of FPCs and DHAs, initiatives related to child health, glaucoma and the identification of diabetic retinopathy have been set up. These require better liaison between opticians, GPs and hospital departments. In Calderdale, for example, a diabetic working group (including optometrists, GPs and consultants) set up such a scheme. Referral criteria were established and opticians circulated with details. Referral cards were printed and distributed to GPs and local optometrists. It is not clear whether the introduction of charges for eye tests will hamper such initiatives. In Staffordshire, attempts were made to set up a primary preventive ophthalmic service for pre-school children.

As such changes take place, the need for FPCs and GPs to monitor and audit the quality of care becomes increasingly urgent. Many FPCs now provide their contractors with performance indicators. In a study carried out in 1987, 15 FPCs were producing performance indicators for their GPs. These often form part of wider practice profiles and provide GPs with comparisons of their performance (as measured by item of service claims) with county or national averages. [33] Some FPCs, such as Nottingham, wish to extend the information provided to GPs and are encouraging DHAs to make available to GPs and FPCs statistical information on pathology tests undertaken and referral patterns, to enable each GP to audit performance. FPCs can play a role in developing mechanisms for feedback between primary and secondary care across a wide range of procedures. This will help assess the quality and cost effectiveness of primary care.

How far FPCs succeed in their intentions jointly to set and monitor targets with the DHA; monitor problems arising from the discharge of patients from long-stay institutions into the community or detail the effects of earlier discharge and increased day surgery depends on the effective exchange of information between contractors and the FPC. This is a notoriously time-consuming process; it is also the bedrock of primary care planning.

Many of the initiatives outlined in this section depend on resources being made available to FPCs — to carry out surveys, monitor quality, or promote shifts in the balance of service provision. It is worth emphasising that many of the respondents to the survey of FPCs carried out in 1987 complained of a lack of resources. As one put it *'FPC resources have not been increased since independence, despite a doubling of the management task'.*

Making progress on joint working

The two DHSS-funded demonstration projects, along with a host of other initiatives over the country, have shown that despite organisational constraints, progress can be made on joint working. By way of conclusion, some of the ingredients of successful collaborative initiatives are summarised.

Creating an FPC-wide planning forum

One of the major problems for FPCs keen to pursue their planning task is a lack of coterminosity with districts. FPCs may have to relate to a maximum of seven DHAs (but without the planning resources of any one of them).

As described earlier, primary care planning in districts is often fragmented, with no single primary care planning forum to which FPCs may relate. While representatives of FPCs are often invited to become members of planning and management forums, there is quite clearly a lack of sufficient staff in FPCs to carry out such duties effectively. There is some disagreement over the usefulness of a primary care forum within DHAs given the relevance of primary care to practically each area of DHA planning.

Whatever position is taken on this, it is clear that the totality of FPC concerns would be unlikely to fit into a single 'primary care planning group' but would need to encompass planning for acute and long-term care.

This question of an FPC-wide forum was approached in different ways by the two demonstration projects. In City and East London FPC, with its three DHAs, initial attempts to identify clear primary care forums within the three DHAs failed. Subsequently the three UGMs and the FPC met regularly to identify and prioritise an agenda for joint working, while recognising that progress on any specific issue would involve the participation of additional members. In Liverpool FPC and DHA, the FPC planning sub group was extended to encompass senior district staff. Other authorities have set up collaborative forums, with representatives from each authority. A major consideration is that such forums should have clear channels of accountability to decision-making bodies.

Topic-based forums

Specific topic-based forums may well be a necessary adjunct to an FPC-wide primary care planning forum. For example, the City and East London project brought together on two occasions the three branches of dentistry, along with health service managers, and the FPC administrator. The aim was to devise a strategy for dental services.

The creation of ad hoc groups for specific or urgent topics should not, however, override a need for a strategic FPC-wide group.

Local professional forums

Collaboration at management level forms only part of the picture. One of the hallmarks of successful collaboration is co-operation between primary care professionals. This question may be approached in a number of different ways, such as setting up specific forums where local fieldworkers can meet each other, discuss local services and identify gaps. The development of professional forums was a major emphasis in each of the demonstration projects.

In Liverpool, as described in part two, the development worker established the Speke Services for the Elderly Group after discovering that few primary care workers were aware of the range of local services provided (and therefore were unable to pass on this information to local people). The group produced a detailed directory of local services and carried on beyond the life of the project. Likewise, in City and East London, the development worker discovered that community nurses were regularly asked for information on dental services, yet did not possess detailed local information. A series of *'Meet the Dentists'* meetings was arranged. This enabled community nurses, general dental practitioners, community dentists and FPC and DHA senior managers to meet. It thus provided a dual function — bringing together DHA nursing staff with general dental practitioners and informing managers of the gaps in service delivery. This information subsequently fuelled a dental questionnaire sent out to all GDPs in the FPC area.

Clearly, collaboration in primary care without the committment of the primary care workers involved remains meaningless. Clear lines of communication need to be developed between local professional forums spanning both the FPC and DHA, and strategic management structures.

Gathering information from contractors

Information from independent contractors on their current activities and future plans forms the bedrock of primary care planning. As there is no direct management relationship between FPCs and their contractors, information on current activities and future projects has to be gleaned from surveys of contractors, personal visits, information from item of service payments, the Pharmaceutical Pricing Authority and the Dental Estimates Board (now renamed the Dental Practice Board).

While the premises visiting programme is regularly exploited to furnish information on contractors' needs, GP facilitators and specific surveys are increasingly being used. For example, Essex FPC carried out a survey of GPs willing to carry out home confinements; Powys FPC identified GPs carrying out screening for coronary heart disease; Leicestershire FPC identified GP services for women patients; Kensington, Chelsea and Westminster FPC carried out a survey to identify GPs prepared to accept homeless people on to their lists. Durham FPC surveyed all nursing staff employed by GPs. This information was made available to the DHAs so that they could rationalise their community nursing services.

Other FPCs (Northumberland and Durham) have carried out comprehensive surveys. This activity is not confined to FPCs. A number of DHAs (Wandsworth, for example) have carried out interviews of GPs to identify the range of their activities. In addition, there are a number of joint initiatives. For example, Haringey DHA and Enfield and Haringey FPC have set up a joint initiative to assess primary health care needs and review GP services in a particular locality.

Making use of such information may be hedged with problems of professional confidentiality; the responsibility for deciding whether to share information rests with the local professional committees. Indeed some FPCs have met with opposition from LRCs over proposals to carry out surveys, and have been unable to share information with DHAs for the same reason.

Surveys of dental practices have also been carried out. The demonstration project based in City and East London FPC devised a questionnaire in conjunction with the LDC, which included information needed by the FPC, consumers and the community dental services of the three DHAs to which City and East London FPC relates. Other FPCs have carried out surveys of GDPs' needs for a general anaesthetic facility (Kirklees FPC); their willingness to carry out domiciliary visits (Essex) and to provide treatment for handicapped and elderly patients.

A number of district dental officers, have carried out surveys of dentists (as in Enfield and Haringey) though in some cases such information remains confidential to the LDC.

While information of this kind helps build up a picture of the nature and extent of services provided by contractors, it is also argued that better quality information is gathered through direct contact with contractors. In some districts facilitators have been employed to identify GPs' needs through extensive visiting programmes. In some districts (e.g Gateshead), officers of the DHA meet individual practices to invite comments on proposed and future arrangements.

Whether, and how this information is used depends on whether a primary care agenda has been identified and prioritised and whether effective mechanisms for joint working have been established.

Locality planning

The account of a community physician at a FPC shows how the analysis of demographic variables, can assist in developing locally sensitive and collaborative approaches to primary care planning. As a consequence of the management reorganisation of the NHS prompted by the Griffiths inquiry over one half of the DHAs in England and Wales have decentralised their community health services. [34,35] A major recommendation of the review of community nursing services in England, chaired by Mrs. Julia Cumberlege reinforced this patch-based approach to community-based services provided by DHAs This opens up new possibilities for FPCs, GPs and community nursing staff to plan and monitor services on a locality basis. [36,37] Many FPCs have developed an interest in patch planning as a way of becoming more responsive to local

needs and as a way of deploying scarce resources where they are most needed. Some are experimenting with zoning of patients, to overcome the problems of too-dispersed GP populations. Clearly, patient choice needs to be protected, as well as local planning promoted.

Creating local forums — whether of professionals, consumers, managers or all three — is itself a time consuming task. However without some means of sharing local information with managers, effectiveness of such groups will be reduced.

In Liverpool, the development worker created links between the JCPT sub-group for the elderly and the Speke Services for the Elderly Group. In each of the projects *'Meet the FPC'* meetings were arranged. In City and East London community nurses met the FPC to discuss information such as how to change GPs, the location of women doctors, and which chemists opened at night. This highlighted the need for making FPC information on services provided by contractors more easily available. In Liverpool, too, a meeting was arranged between the FPC and the Speke Services for the Elderly Group.

Despite fundamental differences between the projects, each illustrated major themes relevant to joint working. They exposed the gaps in policy-making and planning for primary care services within DHAs and FPCs; they demonstrated how basic information on contractors and local services was needed before progress could be made, and showed how forums — at FPC, local and professional levels — could contribute to the planning process. By attempting to work through local representative committees and FPC planning sub committees, emerging tensions in FPC planning were identified.

Conclusions

Primary care planning within FPCs remains underdeveloped. The emphasis on acute services and internal markets in the 1989 White Paper does little to illuminate the problems for DHAs and FPCs in delivering shared services or of providing the wide range of locally accessible — and efficient — core services. Better information systems linking GPs, FPCs and DHAs will help, and more detailed information from contractors will provide a starting point for identifying gaps and overlaps in services. However, the short timetable for establishing GP practice budgets and better information on selected outpatient and inpatient services may yet again push persistent problems of planning primary care into the background. Relationships between FPCs and local representative committees need to be clarified (and this is to be addressed as a result of the 1989 White Paper). Yet the relationship between FPCs and their contractors largely remains one of providing information, monitoring services and persuading GPs to undertake improvements. Without the creation of a strong management framework for family practitioner services the goals of collaboration may be only slowly achieved.

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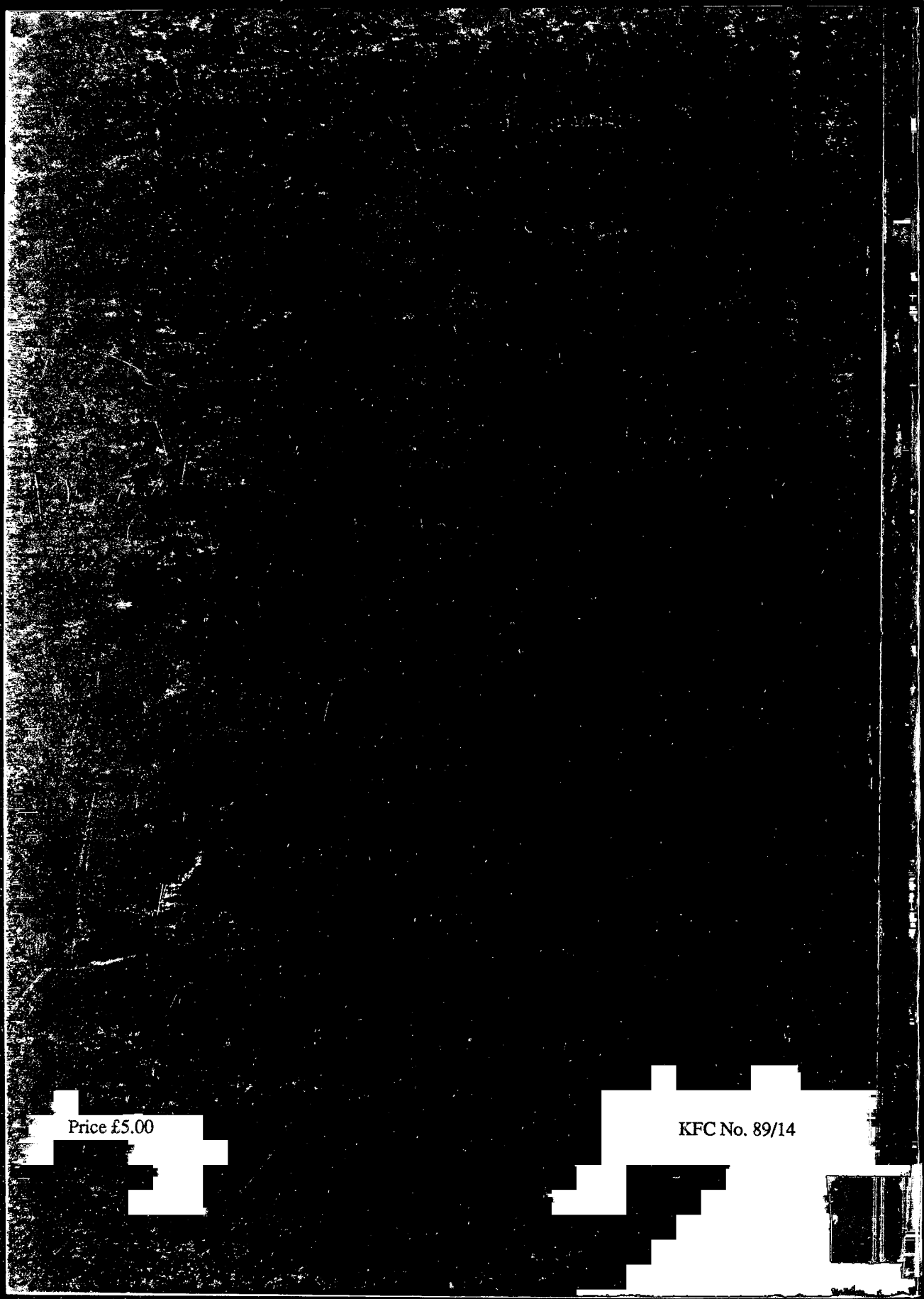
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