King's Fund Primary Care Group

WORKING WITH GPs

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EXECUTIVE SUMMARY

FEEDBACK

General Practice in London

* London GPs are aware of inadequate and often deteriorating health (primary and secondary) care and social care for their patients.

* They are demoralised by the increase in workload and loss of control of their professional lives.

* The Tomlinson proposals are seen as leading to further inadequacy of hospital admissions and GPs feel they are being asked to shoulder the responsibilities without adequate resources.

The Investment Fund

* GPs would like to see the Investment Fund used for projects directed towards providing care for vulnerable populations (elderly, mentally ill, substance abusers) and which address their own needs as providers (alternative models of 24 hour cover, involvement in purchasing).

The King's Fund

* GPs see the King's Fund as independent and having strengths in cross-professional working, and user involvement. It is seen by some as right-wing and by others as politically neutral. It is seen to be working with change rather than to be an ally in resisting change, particularly the transition from a professional to a managerial model.

RECOMMENDATIONS

* The King's Fund should consult with Representatives of GP organisations as well as interested individuals, and include in the mailing for the next consultation on the Investment Fund all those listed in Appendix 1.

* The steering committee of the Investment Fund should include a representative of users (eg from GLACHC or Patient's Association) AND a representative of General Practice. The most appropriate GP representative would be a nominee of the LIZ LMCs Tomlinson Task Force (secretary Dr. Tony Stanton).

* The King's Fund is well placed to facilitate the debate about the content and values of core General Practice as well as extended General Practice and alternatives.

* The King's Fund could usefully begin to work directly with Primary Health Care Teams, perhaps in one FHSA area to identify the organisational development required to respond to the health needs of the area and the support mechanisms that would enable change to occur.

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1. The Brief

The written brief, clarified in conversation in May, may be summarised as follows:

1. GP Networks.

To extend existing King's Fund contacts by opening up a series of networks of GP organisations in London.

2. The Investment Fund.

To consult with GP networks about the Investment Fund in order

(a) to discover what GPs perceive to be an appropriate use of the Investment Fund, including not only subject areas and criteria but the ways of launching and managing the Fund.

(b) to make GP networks aware of the way in which the Fund will be launched in the autumn to enable them better to engage with the funding process.

3. Ideas from General Practice.

To clarify what the King's Fund might expect back from the Investment Fund Launch.

4. Improving working with GPs.

To receive feedback and recommendations to improve the way in which the Primary Care Group works with GPs.

The feedback elements of these 4 areas are reported in 3.1 to 3.4. The recommendation elements are reported in 4.1 to 4.4.

2. Method

Contacts were made with individual GPs known to have participated in previous meetings at the King's Fund (individual approach).

Contacts were also made with GP organisations at national, London, Regional and FHSA levels with an attempt to ensure complete coverage across London (representative approach).

I discussed the questions contained in the brief, in person or by phone, in an unstructured format with around 50 GPs in London, as well as individuals from other backgrounds and GPs in Sheffield. I also attended meetings at the RCGP and LIZ LMCs' Task Force.

3. A View from General Practice

3.1 General Practice in London in 1993.

Many GPs, asked about the use to which an Investment Fund could be put, begin by identifying positive areas in which a better service could be delivered to Londoners. There are plenty of ideas and much enthusiasm out there in General Practice. Even the enthusiasts however come round to listing the current problems that are at the top of the agenda for the majority of GPs. The picture that emerges, summarised by one GP as "infectious awfulness", is consistent with the low morale found in a survey by the RCGP and the dissatisfaction found in a survey by the GMSC.

The 1990 contract redistributed resources within General Practice towards prevention and promotion of health, away from curative and supportive services. Taken in combination with the pressures to increase list size, GPs have had less time to spend with patients - particularly on the problems that patients have chosen to bring. Many GPs have felt increasingly dissatisfied as the core values of traditional General Practice have been eroded. There has been an increase in formal complaints to FHSAs which contributes directly to the stress of GPs and indirectly to their sense of being less valued by their patients. The most extreme pressure exerted by patients is physical violence. The threat of violence is at the top of the agenda of the London Division of the Overseas Doctors Association, and many GPs find themselves in situations where their physical security is threatened. Minority Ethnic doctors appear to be under the greatest pressures in many different ways and yet to have the least

support, particularly from FHSAs.

Probably even more important is the feeling amongst many non-fundholding GPs that they are no longer shaping the services their patients receive. The purchaser/provider split and the favourable treatment of fundholders has empowered fundholders but disempowered non-fundholders, who are no longer "at cause" in their professional lives but "at effect". This has been partly mitigated in areas where GPs have become involved with commissioning fora, though this positive influence may decline as purchasers ignore the wishes of participating GPs.

There are longstanding problems in London about the quality of premises and the level of remuneration. Premises require major investment and this problem is receiving some attention. Many workers in London receive a London weighting to take account of the higher cost of living in London but GPs do not.

Against this background it might be expected that the Tomlinson proposals for redistributing resources in the capital from secondary to primary care would be seen in a positive light. GPs are in general unenthusiastic about the proposals for a number of reasons.

Primary care is difficult when secondary care is inadequate and particularly when it is not possible to arrange emergency admissions. Bed closures are perceived as threatening to exacerbate the current situation.

One of the determinants of the need for admission is the level of social care provision. The deficit in this provision is so great that it is difficult to imagine enough investment in this area to permit substantial changes in the need for admission.

In many situations care at home will provide a higher quality of care than care in hospital, but it may be more rather than less expensive. There is a concern that this issue has not been addressed.

While some GPs may see predominantly the advantages of the proposed redistribution many feel that new tasks and increased workload are being "dumped on" them as a cost-cutting exercise.

3.2 The Investment Fund

There was a variable degree of awareness of the nature of the so-called "Challenge Fund". This name has led to confusion with the "Inner City Challenge". There was a general feeling that the first year LIZ money had been allocated in such a rush that it had not been possible to put together sensible bids and some concern that FHSAs will be unable to monitor and evaluate the projects. Once the hostility that remains from this experience has been vented there was appreciation that the King's Fund was consulting and informing on a realistic timescale and a hope that this could be a model for the LIZ funds in future.

3.3 Projects for the Investment Fund

Some of the suggested uses of the Investment Fund seemed to be examples of services that should be provided by mainstream funding - such as funding full PHCTs, interpreters, and PHCT facilitators.

Most of the suggestions for projects for the Investment Fund were focused on groups of Londoners whose needs were inadequately met. Most frequently mentioned were

Frail elderly people

This is one of the groups in which deficiencies in social care lead to particular problems in providing adequate health care. These arise around admission and discharge from hospital; the availability of residential care and "low-dependency" (ie. low medical dependency) beds for convalescence and respite and for treating acute illness; the purchase of bathing, home care, day care, social work and advice work.

People with mental illness

There is a need for a radical review of appropriate purchasing for Mental Health that is based in need and probably involving practice-attached mental health teams.

Substance Abuse

There is a particular opportunity to improve services for opiate users. At a time when the views of prescribing to opiate users has focused on harm reduction, GPs have been reluctant to take on the prescription of maintenance Methadone. To bring about an appropriate service requires a lot of support and backup for GPs considering undertaking this role. There also is a need for funding for the rehabilitation of substance abusers.

Child Protection

Some of the other suggestions related to areas where there are clear deficiencies or problems with service delivery at present. Most frequently mentioned were

24 hour cover / A&E

This is an area of concern for Londoners and A&E departments as well as being close to the top of the agenda of many GPs. It includes the dimensions of the unregistered and commuting populations, place of care at night, telephone answering, and the benefits of continuing vs episodic care. A&E departments are thought by some GPs to have a confused agenda of wanting to see rational care but needing attendances to avoid closure or loss of contracts.

Purchasing

GPs with an involvement in purchasing secondary care, particularly fundholders and those with an involvement in GP fora, have had a greater sense of shaping the service. One major problem for non-fundholders is that DHAs purchase services on the basis of the home address of the patient not the address of the practice. Since patients have choice of GP this can mean PHCTs relating to a number of secondary care teams for each speciality which is destructive to establishing good working relationships.

There is now a particular need to look at commissioning across the NHS/social services boundary. A trial project of devolving budgets for joint commissioning

of social care could include residential and low-dependency beds and working at a practice level the practice attachment of Community Care Managers. This could relate to services for the elderly, mentally ill or substance abusers or to the provision of temporary accommodation for the ill homeless (eg TB sanatorium).

Rationing

The process by which health care is rationed is at present unclear. There is a place for pilot projects to bring the rationing process into the public domain and for the involvement of GPs and users.

3.4 The King's Fund

The most frequently mentioned attributes of the King's Fund are its independence and its reputation for quality ("benchmark", "gold standard", "seal of approval"). When more detail was sought the first examples were usually politically neutral (eg quality of practice premises). The King's Fund is seen to have strengths in cross-professional working, user involvement and to be removed from the vested interests of the GMSC and the RCGP.

There are also some problems with the image of the King's Fund from the GP perspective. These should be interpreted with reference to the dissatisfaction GPs feel with many organisations at present. For example the GMSC is widely thought to have failed to resist the introduction of the 1990 contract and the RCGP is considered to have promoted the "ideal" at the expense of the "good-enough" general practice.

No GP identified the King's Fund as left-wing. The small number who volunteered a political dimension usually identified it as right-wing while those asked directly felt it to be politically neutral. While recognising that health-care expenditure is finite GPs feel from their day-to-day experience that the level of funding of the NHS is inadequate. The King's Fund is not seen as championing the underfunding argument as strongly as it might and this may account for the political perceptions.

The King's Fund is seen to be working with change while GPs may be seeking allies in resisting change. This is probably most significant in the move from a professional to a managerial model of health care delivery. The leaflet sent out for the Investment Fund consultation for example was seen by some to be

couched in the language of management and remote from the approach of practising GPs.

4. Working more closely with GPs

4.1 Networking with Representatives

The King,s Fund works very effectively by networking with interested enthusiastic individuals. Several GPs expressed the view that if there is a desire to consult (rather than seek out or try out new ideas) it would be most appropriate to consult with representatives of organisations rather than individuals. This approach not only confers more credibility but ensures access to a wider range of views and may have been a reason for seeing some "new faces" at the consultation meetings.

GP Networks.

In general the GP fora that relate to DHA boundaries seem to be one of the areas of greatest dynamism at present, especially in City & East London and in Lambeth Southwark & Lewisham. GP commissioning groups led by FHSAs seem to be worth cultivating, and two medical directors asked for their commissioning groups to be included in our mailing to give them food for thought.

The faculties of the RCGP give access to a different, enthusiastic subset of GPs. They sought out further meetings, intend to co-ordinate a bid for Investment Fund money, and are interested in other ways of working with the King's Fund.

LMCs in some areas (Enfield & Haringey) have become directly involved in the commissioning process while in other areas they have been happy to see this function taken on by GP fora. As the only elected representatives of London GPs it seems essential to include them in any consultation process.

Medical Advisers and particularly Medical Directors of FHSAs are in a powerful position particularly in relation to service development and substitution.
They have a particular concern for practices that are struggling to cope and whom we may be unable to contact through any other network.

Academic Departments of General Practice not only provide a source for

projects and developments but have reflected on the current state of General Practice and in particular on the difficulties of ensuring that research findings are incorporated into policy.

Other organisations such as the Overseas Doctors Association, National Association of Fundholding Practices and the Medical Practitioners Union contribute perspectives easily missed if their interests are not consulted.

When the bids are invited for the Investment Fund I suggest that in addition to contacting the list of representatives a copy is sent to each GP and each practice manager through the FHSA bag.

Database of King's Fund Contacts

I understand that there is an intention to integrate the various mailing lists held by the Primary Care Group into a single database. My experience of compiling a contact list may be of relevance.

Any contact list will need to contain both individuals and representatives of organisations. Since many of the key individuals are also representatives I have found it most convenient to identify representatives by name to avoid duplication.

It seems useful to be able to pull together all the contacts in one FHSA area and possibly each region.

A field could usefully be included to include any special areas of clinical or organisational interest which would be useful when organising events such "Purchasing Palliative Care".

A personal Contact List

The next stage in the consultation about the Investment Fund will involve sending a revised version of the leaflet to interested parties for comment. I suggest that a copy be sent to all those included in Appendix 1. This list includes individual GPs whom I have consulted; GPs who have expressed an interest in the Investment Fund meetings; and representatives of GP networks. Where one person represents more than one organisation their name appears more than once. Even though this leads to Tony Stanton appearing six times

as the secretary of the London LMCs I feel it is worthwhile to send him six copies so that one reaches each organisation.

4.2 The Investment Fund

The Focus and Criteria of the Investment Fund should ideally be felt by GPs to be part of the solution not part of the problem. It would be disappointing if it did not include reference to models of 24 hour cover and to GP involvement in purchasing.

4.3 Ideas from General Practice

Most of the suggestions I have heard from General Practice have been included above. I have been particularly excited by two ideas that do not readily fit into this classification.

* Clarifying Core General Practice

Many GPs pointed to the urgent need to redefine what is understood as the core of General Practice. This includes not only core content (24 hour responsibility, GP/Consultant boundary, needs assessment etc.) but also core values (sharing and interpreting the experience of life , empowering patients, living with uncertainty, ongoing rather than episodic care etc.)

I understand that the RCGP and the Nuffield are encouraging writing in this area but I have not followed this up. I am also aware that Paul Hodgkin and Marshall Marinker recently organised a meeting in Sheffield on this topic and want to take it on further.

It seems that the core values of General Practice will have completely altered in another year or perhaps two. While the profession is looking from the inside, it might be appropriate to bring GPs together with FHSAs, users and hospital consultants.

* A Simulation Game

The Purchaser/Provider split and GP fundholding have increased the number of players in the NHS, which seems bear some resemblance to a complex version of the game Prisoners' Dilemma. In this game players perform best by

pursuing their own ends regardless of the welfare of others UNLESS a general climate of cooperation is reached, in which case cooperation becomes the best strategy for each player. Cooperation develops if there is communication between the players about the nature of the game and the players underlying aims as well as if there is a history of cooperation.

One way of improving understanding, communication and cooperation across boundaries is to play a simulation game. Two or more players, for example an FHSA and a group of Primary Health Care workers, could play to improve their understanding of their own and their "opponent's" position and the implications for both of their range of potential strategies. One starting place could be a series of anonymised real-life problems to which players are asked to respond and draw out the underlying aims and principles.

Dr. Ben Essex has experience of creating games for teaching (eg Village Midwives and Immunisation strategies for the WHO) and for promoting debate and understanding (Medical Dilemmas for GPs in the UK). He has given some thought to devising a simulation game of the NHS for use by a variable number of players to promote local understanding. This seems to me to be an excellent way of tackling many of the "process" issues highlighted in the Investment Fund consultations.

4.4 Specific Suggestions

* An Independent Opinion

There is a place for bringing together the experience of a wide range of approaches to primary care and its boundaries in the form of "consensus conferences" which could identify fruitful approaches. Publication of the conclusions of the conferences would provide a summary of the "state of the art". The proposed topics for the "Capital Conferences" could be followed by exploration of the nature of core General Practice, core Primary Care, the Consultant role and models for GP and user involvement in purchasing. These publications would be of greatest value if they included additional review material or if the conferences were more extended.

Several people suggested that the King's Fund could maintain an ongoing "clearing house" for ideas, developments and existing good practice in primary

care in London with a fairly high profile.

* Presentation & Image

GPs would view The King's Fund more positively if the message about underfunding of the NHS were heard more consistently.

Material, such as the Investment Fund consultation leaflet, would be more accessible to GPs if couched in language with which they are more familiar.

* Working with RCGP

The RCGP (Mollie McBride and the London Faculties) would like to work more closely with the King's Fund. They suggested a joint meeting, perhaps around training needs for GPs in purchasing.

* GP development

With the increasing emphasis on the role of primary care it might be opportune for the King's Fund to become more involved directly with General Practice. There was a lot of discussion about alternative ways of supporting GPs to change and the need to look at the full range of different types of practices with their potentials and problems - patch mentors, educational networks, respected practitioners, external "task forces", facilitation etc. There is a great deal to be done in bridge-building between GPs and FHSAs. One possibility would be a fairly major project in a single FHSA area, looking at the organisational development and learning needs of the practices in order to meet the population needs. This could include facilitating existing networks, seeking new ways of supporting GPs who are isolated or underperforming and building bridges and trust.

Appendix 1 GP network list (by FHSA)

In classifying the networks of GPs it is natural to group these by FHSA where possible. LMCs, MAAGs and many commissioning groups function at the level of FHSA and these natural boundaries are reinforced by the development of Joint Commissioning Agencies. GP commissioning groups usually relate to all or part of an FHSA area. These organisations as well as some individual interested GPs and practices are included in Section 3 of this appendix.

Section 2 includes networks that relate to more than one London FHSA. Some of these are Regional and the others could if necessary be accommodated within Regional subdivisions. Section 1 includes national networks.

1 Networks at National Level

* RCGP
* BMA
* MPU

2 Networks at London Level

* Academic Departments of General Practice
* RCGP Faculties
* GMSC Task Force
* Regional Advisers in General Practice
* National Association of Fundholding Practices

3 Networks at FHSA level

* Barking & Havering
* Brent & Harrow
* Camden & Islington
* City & East London
* Croydon
* Ealing Hammersmith & Hounslow
* Enfield & Haringey
* Greenwich & Bexley
* Kensington Chelsea & Westminster
* Lambeth Southwark & Lewisham
* Merton Sutton & Wandsworth
* Redbridge & Waltham Forest
    * GP (as individual or practice)
    * Medical Director/Medical Adviser
    * GP forum/ purchasing group/ commissioning group
    * LMC
    * MAAG