A Case Study in Developing Primary Care

The Camberwell Report

a case study IN DEVELOPING primary care

AUTHORS
Virginia Morley Tyrell Evans
Roger Higgs with Penny Lock
Commentary by Judith Allsop

KING's FUND CENTRE

A Case Study in Developing Primary Care

The Camberwell Report

Virginia Morley
Tyrrell Evans
Roger Higgs
with Penny Lock

Commentary by Judith Allsop

KING's FUND CENTRE

Primary Health Care Group
King's Fund Centre
126 Albert Street
London
NW1 7NF

Published by the King's Fund Centre
126 Albert Street
London
NW1 7NF

Tel: 071-267 6111

ISBN 1 85717 006 7

Distributed by Bailey Distribution Ltd
Dept KFP
Learoyd Road
Mountfield Industrial Estate
New Romney
Kent
TN28 8XU

The King's Fund Centre is a health services development agency which promotes improvements in health and social care. We do this by working with people in health services, in social services, in voluntary agencies, and with the users of their services. We encourage people to try out new ideas, provide financial or practical support to new developments, and enable experiences to be shared through workshops, conferences and publications. Our aim is to ensure that good developments in health and social care are widely taken up.

The King's Fund Centre is a part of the
King Edward's Hospital Fund for London.

CONTENTS

Notes on contributors v
List of tables and figures vi
Acknowledgements vii
Foreword viii

Introduction 1

1) *Setting The Scene: national policies and the local context* 3
● National policies for general practice ● Wasted skills? ● Standards of care ● The changing role of FPCs ● Where do nurses fit in? ● FPCs and DHAs working together ● Camberwell: an inner city population ● Health services in Camberwell ● The family practitioner committee for Camberwell ● GPs in Camberwell health district ● Camberwell District Health Authority ● The Department of General Practice and Primary Care

2) *The Origins of the Project* 17
● The need for the project emerges ● The concept and the King's Fund ● How to attract GPs ● The Camberwell Primary Care Development Project 1984

3) *Getting Started: interviewing GPs* 23
● Laying down the foundations ● Topics needing urgent action ● The chicken or the egg?

4) *Communication* 29
● Making GPs' voices heard ● GPs' links with community services and local authorities ● Communication between GPs and hospitals ● Delivery and collection ● The mysteries of outpatient timetables ● Communication between primary care and the public ● A handbook for users ● Chronology

5) *Clinical Waste* 41
● Danger to health ● Asking Camberwell GPs ● The DHA: talk but no progress ● Breaking the deadlock ● What next? ● Chronology

6) *GP Premises: room for improvement* 45
● The obstacles for GPs in Camberwell ● Where angels fear to tread ● The family practitioner committee ● Bewildered local authorities ● Health authorities ● Housing associations: a growing factor ● A helping hand ● The next steps in Camberwell ● Borough groups tackle specific problems ● Tailor-made support for GPs ● What has been achieved? ● Room for improvement ● Wider lessons ● Chronology

7) *Nurturing the Seeds of Teamwork* 59
● Teams in inner cities ● Selecting the professionals ● Why health visitors? ● Wariness among health visitors ● Ice-breaking

● Friend or foe? The study day ● Recommendations from the study day ● Face-to-face and local ● A team approach to child abuse; a study day ● What had the project achieved? ● Adverse side-effects ● Moving on: practice nurses ● How nurses are employed by GPs ● The view of practice nurses ● Breaking down the isolation ● Nurses develop their skills ● Opportunities for training ● Chronology: teamwork

8) Shared Care 73

● The views of Camberwell GPs ● Principles of shared care ● Delicate negotiations ● Diabetes ● Basic ground rules ● What kind of shared care card? ● Standards of care ● What do GPs think? ● Assessing the project's efforts ● Chronology ● Asthma ● The way ahead ● Chronology

9) Reflections – on a learning curve 83

● Before and after ● Selecting the objectives ● Underlying strategies ● Peer review ● Reaching out to all practices ● An honest broker is not enough ● Making innovation stick ● The strengths and weaknesses of the CPCDP ● The doctor's status: help or hindrance? ● Project workers' isolation ● A medical school base ● An advisory group ● Multiple sources of funding ● Camberwell limits ● How funding can distort the pace ● Political channels ● Expectations and achievements ● Key management issues

10) An Outside Assessment: a commentary by Judith Allsop 97

● Why a commentary? ● Stakeholders' interviewed ● The project's identity ● Uncertainty about roles ● Uncertainty about accountability ● Assessments of success ● Strategies for change ● Independence from a powerful base ● The project as a team ● Building coalitions ● Value for money ● A model for wider application? ● Lessons for whom?

Appendices 109

1. Funding the Camberwell Primary Care Development project.
2. Map – GP practices in Camberwell Health District 1989.
3. Advisory group for the project 1986-1989.
4. Abbreviations.
5. Diagram showing principal management team relationships in Camberwell Health Authority (1984).
6. Diagram showing principal management arrangements, Camberwell Health Authority (1988).
7. Lambeth, Southwark and Lewisham Family Practitioner Committee structure, pre 1985 and post 1986.
8. Structure of the CPCDP in relation to the Department of General Practice and Primary Care at King's College School of Medicine & Dentistry 1989.

References 121

Further Reading 125

NOTES ON CONTRIBUTORS

Virginia Morley was project director of the Camberwell Project and is now programme manager, primary care, South East Thames Regional Health Authority. Her background is in social administration and social research. She is a trained teacher and became involved in health while working for a national campaigning agency. Her current interests include organisational development in health, and training.

Tyrrell Evans is a general practitioner who has been working in Camberwell for 11 years. He is based at a health centre in the Dulwich/ West Norwood area. He has been extensively involved in local GP representation for the last seven years, and has been a research fellow and is now a senior lecturer in the department of general practice and primary care at King's College School of Medicine and Dentistry.

Roger Higgs is professor and head of the department of general practice and primary care at King's College School of Medicine and Dentistry. He also works as a general practitioner and course organiser in south London, and has been involved in the development of a new primary care facility locally, the Lambeth Community Care Centre. He has researched, written and broadcast on a number of issues including medical ethics, psychosocial care and aspects of adolescent and child medicine. He is co-author of 'In That Case', a book on medical ethics in British primary care.

Penny Lock is a freelance social researcher, writer and translator, and has worked extensively in Britain and Spain. She has an MSc in medical sociology and previously worked on a national project developing health promotion policies in the workplace.

Judith Allsop is reader in social policy at South Bank Polytechnic in London. She is author of Health policy and the National Health Service; The Emperor's new clothes a study of family practitioner committees (with Annabelle May), and Changing primary care: the role of facilitators (1990). Most recently, she has written a chapter on consumers and health care in Health policy for the 1990s. She is currently working on consumer grievances and professional regulation.

LIST OF TABLES AND FIGURES

Chapter 1	Figure 1	Map of Camberwell Health District	11
	Figure 2	Number of doctors per practice 1984 and 1989	13
	Figure 3	Age distribution of women GPs in Camberwell, 1985 and 1989	14
	Figure 4	Family practitioner services for England and Wales compared with Lambeth, Southwark and Lewisham	15
Chapter 3	Table I	Organisations approached prior to interviews	23
	Table II	Prompts to interviews	24
	Table III	Areas for immediate action	25
	Table IV	Issues raised by GPs	26
Chapter 4	Figure 1	Communication in the NHS	29
	Table I	CPCDP monthly bulletin topics since 1985	30
	Figure 2	Outpatient services leaflet	34
	Figure 3	Hospital referral information for GPs (King's College and Dulwich Hospitals)	36
	Figure 4	Handbook for users – sample pages	39
Chapter 6	Table I	Ownership of premises by practice 1984-7	46
	Figure 1	Age distribution of GPs in Camberwell 1985 and 1989	49
	Table II	Cost rent schemes 1985-8	56
Chapter 7	Table I	Topics discussed at joint GP/HV meetings, 1986 to 1989	65
	Table II	Practice nurses' skills or roles	69
Chapter 8	Figure 1	Diabetic record card	76
	Figure 2	Shared care schemes – the process	79
Chapter 9	Figure 1	Normal distribution curve of professional standards in general practice	85
	Figure 2	Strategy to bring about change	87
	Figure 3	Ownership – patterns of working with organisations	88
Chapter 10	Figure 1	Stakeholders interviewed	99

ACKNOWLEDGEMENTS

This report is about a project which was sustained for its first vital years by a grant from the King's Fund. We are grateful both to Jane Hughes and Pat Gordon of the King's Fund Centre London Programme for the confidence in us, and their inspiration and encouragement.

We also owe a considerable debt to Tony Ruffell of Lambeth, Southwark and Lewisham Family Practitioner Committee, and Susan Williams and Sue Osborn, joint unit general managers of the community and priority care unit, for their long-term commitment to and investment in the project, as well as to the many of their staff who have contributed to the project.

We would also like to acknowledge the financial assistance given for the development of the diabetes and asthma projects by Baring Bankers and South East Thames regional development fund for primary care.

Thanks are also due to members of our advisory group, who have guided the project and in recent months offered expert comment on this report, in particular John McEwan, Ros Corney and Nancy Dennis. Our thanks also go to all members of the department of general practice and primary care for their constant interest in our work.

Our warmest thanks must go to Penny Lock, whose return to London made the production of the report possible, and to Judith Allsop who undertook to assess the project overall, and also contributed to Chapter One. We should also like to thank Gill Davies for her analyses of the interview data. Considerable thanks, also, go to Janet Hadley for her careful and meticulous editing of the report.

We would like to thank all general practitioners and primary care workers in Camberwell who have played such an important part in the project. Finally, we are grateful to Georgie Robins for typing the numerous drafts of the report.

Virginia Morley
Tyrrell Evans
Roger Higgs

FOREWORD

Inner city primary care is often seen as an intractable problem with occasional flurries of excitement as a new policy or funding mechanism appears and is seen as the 'solution'. What the Camberwell Primary Care Development Project has demonstrated is that improvement is not impossible, nor is inner city primary care likely to be amenable to a 'quick fix'. To develop inner city primary care is a long, slow process requiring commitment and determination to overcome difficulties. This report, describing four years of the work of the Project, shows the real and lasting changes that can result.

The Project provides a great deal of learning for those of us who are struggling to bring about change. The team demonstrates how important it is to go and find out what are people's concerns, in this case by meeting almost all the GPs in the area. It is then essential to do something to respond to those concerns. The changes do not have to be dramatic, but the ability to deliver even small scale improvements is important for credibility. Small improvements can then be built on to develop a momentum for change. Too often development projects generate great expectations, only to disappear after a year or two as the champions leave.

As this report shows, the Project had a firm base in the Department of General Practice Studies at King's College Hospital Medical School, which meant that while the times and some of the people might change, the project would not just disappear. Most importantly team members, particularly the two GPs, had worked in Camberwell for many years and had a vision of what could be achieved to improve the quality of services. They acted as a development agency, a catalyst for change, at a time when few DHAs or FPCs (FHSAs) saw themselves in that role in relation to primary health care.

This is perhaps the most fundamental lesson for the NHS today, when the pace of change and the movement of staff has in many places brought long term service planning and its implementation to a standstill. We need to build incentives into the system to keep more managers and professionals in place for enough time, not just to develop the vision of how the service might improve, but to deliver on that. Improving health care, particularly inner city primary care, requires long term commitment and those involved need support and recognition from their colleagues and leaders in the NHS.

Barbara Stocking
Director
King's Fund Centre

The Primary Health Care Group at the King's Fund Centre was set up to improve primary and community health services, particularly in inner London, and to contribute to debates about primary health care policy. The group provides information and advice about primary care developments; works with NHS managers to establish and evaluate demonstration projects; organises workshops and conferences; and publishes papers and reports.

Related King's Fund Centre Publications

Changing Primary Care: The role of facilitators
Judith Allsop *£6.50*

Examines the rapid increase in the appointment of 'facilitators' in primary care, whose task is to build bridges between GPs and FPCs and DHAs. Based on a national study, this report looks at the experiences – good and bad – of GPs, nurses and others working as facilitators, the expectations of those who appoint them, their contribution to primary care and their likely future.

The Future of Community Health Services
Jane Hughes *£3.75*

Describes improvements and impetus for change in community health services and analyses current threats to continued progress. Of interest to all concerned with implementing policies for primary and community care.

Medical Audit in General Practice: A practical guide to the literature
Jane Hughes and Charlotte Humphrey *£7.50*

The authors explore the 'state of the art' of general practice audit. The main techniques currently in use are described and assessed, and case studies are given as illustration. This book is of practical use to all those with responsibilities for developing medical audit and quality assurance in primary care.

User Friendly Services: Guidelines for managers of community health services
Liz Winn and Alison Quick *£9.75*

Practical help on making services user friendly. Detailed case studies on 'getting started', common pitfalls and the particular problems of consumer surveys.

The Consumer's View: Elderly people and community health services
Jocelyn Cornwell *£5.00*

Looks at services from a consumer perspective. Discusses negative attitudes to old age and how these affect health care, and offers guidelines and resources for action. Of interest to managers and practitioners, and those who train them.

Enhancing the Quality of Community Nursing
Jane Hughes *£9.00*

Based on work presented at three national conferences on assessing quality in nursing care, this book describes impressive examples of good practice. Areas considered include ways of identifying patient needs; planning and reviewing services; staff performance; and management structures.

Who Calls the Shots? Public services and how they serve the people who use them
Ann Shearer *£7.50*

Public services are notoriously weak in terms of responsiveness to their users' needs. *Who Calls The Shots?* explores the balance of power and influence between providers and users of public services. By using examples from major institutions such as the BBC, British Rail and the NHS, Ann Shearer shows how sharing experiences can help both the managers and users of public services produce imaginative, effective solutions to this problem.

Available from: Bailey Distribution Limited, Dept KFP, Learoyd Road, Mountfield Industrial Estate, New Romney, Kent, TN28 8XU.

Cheques should be made payable to Bailey Limited, including 10 per cent for postage and packing.

INTRODUCTION

This report is an account of the Camberwell project, from 1985 to 1989. The project is based in a medical school department of general practice and is a team-based approach to the now widely used term 'facilitation' in primary care.

The report explores the project's role and function, in particular its relationship to the mainstream statutory organisations responsible for the planning of primary care. The use of case studies to illustrate the work of the project highlights the divisions in organisations which affect the provision of primary care services, and how the project brought together individuals and organisations in an effort to influence the development of good primary care services.

The project was initially funded in 1984 by the King's Fund London Project Executive Committee in order to explore the possibility of siting a broadly-aimed development project within an academic department of general practice. The Acheson Report [1] had clearly stated that academic departments in primary care should become more closely involved with general practitioners nearby, and the department was committed to doing this. At the same time, the grant provided an opportunity to explore an alternative model of facilitation to either Arnold Elliott's already published work in Islington [2] or to Nancy Dennis's initiatives already underway in Tower Hamlets [3]. Although at first the project was made up of general practitioners working part-time, it soon expanded to include a social scientist working full-time, and subsequently an administrator. They worked as a team, which in itself is a contrast to other projects.

Historically, primary care in the UK has been underfunded and underdeveloped compared to its acute service partner. The lack of effective cooperation between district health authorities and family practitioner committees in their joint responsibility for community health services was notorious. In 1985 the giving to FPCs of greater responsibilities, but little power to direct services, meant that the need for an effective and joint approach to primary care services is increasingly evident.

The report aims to be useful to anyone interested in developing primary health care, in particular family practitioner committees and those who run district health authority community health services. It is also intended to stimulate other medical school departments of general practice to take on the development of primary care with their local practitioners as a central part of their work. To make it a practical document, it concentrates on case studies to show how the work of the project has dealt with key issues. These broadly fall into three themes:

1. Communication: work on this highlights difficulties in many areas of primary care, for instance, ensuring services are provided and making the public aware of what is on offer, not only in primary care, but also in secondary care, and from the local authority and voluntary sector.

2. Premises and clinical waste: the problems here demonstrate how basic support services to professionals are often under-acknowledged, particularly when they fall across the responsibility of different organisations.

3. Teamwork and the development of particular services for those with chronic illness: work in these two areas involved efforts to bridge the gap between primary and secondary care.

During its lifetime, the project has changed too. It has moved from finding out what was happening through to developing services and getting in at the deep end in order to provoke action. The different types of activity, the changes in funding and staffing have each played a part in its development. Other factors which particularly influenced the project team included commitment to 'learning about ourselves', an attempt to be flexible and responsive, and a team dynamic which allowed for a variety of perspectives upon any particular course of action. Above all, the project's commitment was to action, development and 'getting our hands dirty'.

Some of the problems which have cropped up have been overcome, some remain unresolved. It is hoped that through wider discussion some lessons for others working in this field may be drawn out. Judith Allsop's commentary offers an outsider's view.

While every district has its own particular circumstances, many of the points made in the report reflect wider issues of relevance to primary care.

CHAPTER 1

SETTING THE SCENE: NATIONAL POLICIES AND THE LOCAL CONTEXT

The strategies and activities of the Camberwell Primary Care Development Project (CPCDP) were shaped by the direction of national policies for primary care, and by the particular circumstances of Camberwell itself. These external influences had an impact on the aims and objectives of CPCDP, as well as the values of the team and on GPs and others affected by or involved in the project. Policy shifts present opportunities and new ways of seeing old problems. The decade of the 1980s has been a period of unprecedented activity by central government policy makers in the area of primary health care. Primary care is defined as those first line services administered by two statutory authorities, the family practitioner committees and the district health authorities. The 1985 Health and Social Security Act established the family practitioner committees as free-standing health authorities. A 1986 Green Paper, *Primary Health Care: An agenda for discussion,* which opened a debate about improving primary care [4], was published at the same time as the Cumberlege review of community nursing [5]. In 1987, there was a Social Services Select Committee Report [6] on primary health care, which urged the government to take action on promoting change and to find the necessary resources. The 1987 White Paper, *Promoting Better Health* [7] made a large number of proposals which aimed to improve the standards and widen the scope of primary care. They are well summarised in Marks [8].

Since that time there have been a number of directives and circulars on particular aspects of primary care. In a few, such as community nursing, policies favour a flexible approach to delivering services on the basis of localities. However, most proposals in the 1987 White Paper depend upon negotiations with professional bodies.

The new contract for GPs marks a radical change from the past [9]. It outlines the details of procedures for health surveillance for a number of groups. It proposes financial incentives to reach particular targets in health screening and insists upon a flow of information from the GP practice to the FPC and vice versa to ensure that monitoring takes place. The Prime Minister's review of the NHS, *Working for Patients* [10], also outlines proposals which will radically alter the relationship between FPCs and GPs.

Essentially, GPs will contract with FPCs to provide a particular range of services for the practice population. The FPCs' powers to monitor services will also be strengthened. Since these issues relate to the future rather than to the past, what matters here are the primary care issues which have been debated during the 1980s because they set the context for CPCDP.

National policies for general practice

Outwardly, the responsibilities of GPs have changed little since the NHS was set up in 1948. There have, however, been major changes in structure and organisation of general practice. In 1966 the Doctors and Dentists Review Body encouraged a move towards group practice by enabling practices to reclaim 70 per cent of the costs of employed practice staff under the ancillary staff scheme. The change has been a result of financial incentives rather than government directive. By 1984, almost three-quarters of GPs practised in groups of more than three doctors [11].

In recent years there has been increasing discussion about GPs and the services they provide. There are more elderly people requiring care and treatment for chronic illness. The pattern of disease has also changed. There has been a relative increase in the incidence of illnesses caused by environmental or behavioural factors which are in theory preventable. There is strong evidence to suggest, for example, that the incidence of diseases of the circulatory system and the cancers could be reduced by a change in smoking behaviour [12]. General practice is seen to have a key role in promoting these changes.

Wasted skills?

The content of the general practitioner's work has changed already in several ways. Some argue that there has been a clinical drift towards hospital care in areas such as the care of diabetic patients and for minor surgery [13]. In 1983, the General Medical Services Committee argued that: 'too many medical skills and aptitudes are laid to rest when doctors enter general practice. If general practitioners are given opportunities and resources to use these wasted skills, it would lead to a redistribution of work within the NHS' [14]. On the basis of commissioned research, the committee also argued that minor surgery, hypertension screening and child health surveillance could be carried out more cost-effectively in general practice. These claims were well received by a government concerned to maximise value for money in public spending.

A second strand has been in the increasing emphasis on anticipatory care – the GP identifying groups 'at risk' of developing disease and attempting to reduce risk by changing behaviour. The Royal College of General Practitioners has supported this approach, arguing that, 'for the general practitioner, prevention has become a real option in certain contexts and is gaining in importance in relation to caring and curing' [15]. The 1987 White Paper, *Promoting Better Health*, identifies the issue as one of its main objectives and states, '... the next big challenge for the NHS, and one especially for primary care, is to shift the emphasis from an illness service to a health service offering help to prevent disease and disability' [7].

Family doctors and the primary health care team, suggests the White Paper, can contribute to promoting good health and preventing ill health by giving advice on lifestyle and by screening for early signs of disease. Because GPs provide continuous care they can play a key role in cervical and breast cancer

screening, screening for high blood pressure, improving the uptake of vaccination and immunisation, providing health surveillance for the under-fives and regular assessment of elderly patients, particularly those with special needs. Many practices already provide preventive services but this is difficult, if not impossible, in single, or two-handed practices and unless the GP is supported by a practice team [16]. The new GP contract carries forward the policy of GPs providing anticipatory care.

Standards of care

Group practice with an attached team of staff practising from reasonably adequate premises is the norm, but there are parts of the country where this is not the case. In some inner cities and towns, in particular, there are poor premises, small lists, a high proportion of GPs working alone, and a larger than average number of very elderly doctors. At best, these factors may inhibit change and at worst, offer inferior care to patients.

In 1981, the London Health Planning Consortium (LHPC) published the report of a study group chaired by Professor (now Sir) Donald Acheson, *Primary Health Care in Inner London* [1]. This demonstrated that general practice in many parts of London was poor, and that practices in London had not followed development in other parts of the country. The Acheson report made a large number of recommendations and called for urgent action. (Subsequent studies indicate that some, though by no means all, large cities in Britain had similar sorts of problem: Wilkin, Hallam, Leavey and Metcalfe [17] review the evidence.)

The government made no explicit response to the Acheson report, although resources were made available for some small-scale projects. Prashar, Rhodes and Young[18] conclude that the response was not adequate: 'They constitute a piecemeal, uncoordinated approach to the problems of primary care in inner cities (and) they represent a short-term approach, a temporary stimulus rather than a continuing commitment' (p.94).

The Royal College of General Practitioners launched its own initiative to improve the quality of general practice. This followed an attack on poor standards by the College's then Chairman, Dr Donald Irvine. He argued that, 'our foremost challenge is to show that we independent contractors are capable of establishing an effective system of self-regulation to provide primary and continuing medical care of a standard which will be regarded as not merely acceptable but highly desirable'[19] (p.521). The College published a consultation document in 1985, *Towards Quality in General Practice* [20]. A method of assessing performance had been developed in 1981 in *What sort of doctor?* [21] Working for patients [10] proposes a form of local medical audit as a method of improving performance.

The changing role of FPCs

GPs are independent practitioners under contract and until the 1980s the role of FPCs has been largely an administrative one: paying practitioners and providing advice and assistance when requested. Since the early 1980s, however, they have been required to take a more active stance.

In 1985, FPCs became health authorities in their own right. They were given a statutory duty to plan services to ensure that the population had access to appropriate primary care services. They also acquired increased responsibilities for monitoring and inspecting GP premises and the deputising services. The 1987 White Paper, *Promoting Better Health* [7], again stressed the importance of GPs working in a team with nurses and other primary health care staff. FPCs were urged to encourage GPs to employ staff under the ancillary staff scheme.

The 1987 White Paper, if taken together with *Working for Patients*, presents a new vision for primary care in the 1990s. The White Paper aimed to make GP services more responsive to consumers, to raise the standards of care, to promote health and prevent illness, and to extend patient choice.

It also set out to achieve better value for money and to make GPs and FPCs more accountable for their services. The government proposed a series of measures to invest further resources in primary care, to monitor performance more closely and to introduce mechanisms and incentives to improve performance and quality in general practice.

There is often a gap between national plans for policy changes and actual change at the local level. If change is to take place the authorities at local level must implement new government policies which, in the case of primary care, means seeking to change the behaviour of largely autonomous health professionals.

There are ways of assessing the scale of change during the 1980s, although these are limited. First, the share of resources going to primary health care has increased. For example, the proportion of public expenditure on health attributed to the family practitioner services has increased from 22 per cent in 1983 to 26 per cent in the planned out-turn for 1989 [22]. Secondly, between 1981 and 1987, the number of patients per doctor fell from one GP to every 2,150 patients to one to every 1,970. Thirdly, the trend towards group practice has continued: over the period 1971 to 1985, the proportion of GPs in England and Wales receiving the Group Practice Allowance rose from 58 per cent to nearly 80 per cent. There has been an increase in resources to improve practice premises and to pay for additional practice staff. Finally, the introduction of computer technology into FPCs and many GP surgeries has begun to lay the foundation for the assessment of how GPs perform. It has also made screening for disease or 'population medicine' possible [23]. Computerisation has been essential in enabling FPCs to fulfil their planning role.

On the other hand, there have been few extra resources available for changing FPCs into management rather than purely administrative bodies. Huntingdon's report for the National Health Service Training Authority outlines the training programme needed to '... fill the current managerial vacuum in primary care' [24].

In 1988, a National Audit Office (NAO) report [16] was critical of the lack of direction given by the DoH and expressed concern about the lack of improvement in general practice, particularly in inner cities. The NAO had been asked to examine two aspects of FPCs' management: first, whether the new family practitioner services were working satisfactorily and, second, whether these arrangements had had a practical impact on five areas relating to GP services: the use of deputising services, the employment of ancillary staff, the health care of the homeless, the promotion of group practice, and the improvement of practice premises. The report's conclusions were that the DoH had given insufficient guidance to FPCs in producing their planning strategies; that collaboration between health authorities had improved but there remained formidable obstacles; that lack of resources had prevented FPCs taking on the wider responsibilities intended for them, although good progress had been made with computerisation.

Most of the FPCs visited by the NAO had not reviewed their policies for monitoring staff employed under the ancillary staff scheme. Nor had they tried to increase the uptake of the scheme. The DoH had provided guidance neither on this issue, nor on planning the balance between group and single-handed practices. Despite the general trend towards group practice, the NAO said that in some inner city areas almost three-quarters of the GPs did not practice in groups. Furthermore, the standards of many GP premises in major cities remained unsatisfactory. In 1986, FPC returns had shown that 20 per cent of premises were unsatisfactory nationwide, but in inner cities this figure rose to 40 per cent.

The NAO noted a number of barriers to change, such as the large number of agencies with which the FPC had to liaise; the different priorities of DHAs and FPCs and the lack of guidance from the DoH on planning and priorities; the limitations in the middle management resources of FPCs; the lack of powers which FPCs have to direct practitioners; the high cost of improving premises in the inner city and the inadequate level of central government funding.

Where do nurses fit in?

Outside hospital there are two types of nurse caring for GPs' patients: community nurses and practice nurses. Community nurses are employed by the DHA. They may be district nurses, health visitors, or midwives. They are managed by a senior nurse within the DHA. In many areas, they are attached to particular practices and work as part of a primary care team. It has been estimated that 70 per cent of district nurses and health visitors are attached to GP surgeries rather than allocated to a geographical area [25]. This way of working has been supported in most government reports as the best way to develop good collegiate relationships. In the inner city, however, where GPs draw their patients from wide and overlapping catchment areas, attachment makes inefficient use of nurse time [26]. Many inner London DHAs have therefore organised community nurses within a geographical area covering a number of practices with which they liaise.

In 1986, the Cumberlege report on community nursing [5] made a number of radical proposals aimed at improving the autonomy and status of the community nurse. It was warmly welcomed by the nursing profession. A key recommendation was that nurses should be organised and managed on the basis of small neighbourhoods (population 10,000/25,000). It was argued that the pattern of services could then be planned from the needs of the population upwards and a partnership between the provider and user of services developed. Furthermore, the report recommended that all community nurses, including practice nurses, should be managed by the neighbourhood nurse manager. Individual agreements for nursing services would then be negotiated with each GP practice. These recommendations conflicted with those in the 1986 consultative document, *Primary Health Care: An agenda for discussion* [4] which proposed an expansion of practice-based nurses.

Few of the proposals from the Cumberlege review have been implemented. The DoH issued guidelines for locality-based nurse management but each district was left to develop its own policy. Nurses are now more likley to be grouped and managed on a locality basis but this development has been very uneven.

Practice nurses are employed directly by GPs. Their salary costs are frequently subsidised through the ancillary staff scheme. Research shows that practice nurses carry our a wide variety of tasks within general practice [27]. Some play a largely autonomous role in relation to clinical procedures and/or prevention as 'nurse practitioners'. At the other end of the spectrum some act as receptionists and general helpers in the surgery.

The number of practice nurses is relatively low compared to community nurses and there are considerable variations in the uptake of practice nurses in different parts of the country. Bowling estimated that the ratio of practice nurses to population varies from 1 nurse to 9,600 population in the East Anglian region to 1 to 54,000 in Mersey health region [25]. (District nurses, the most numerous group among community nurses, fall within the range of one district nurse to between 2,000 and 3,000 population.)

There is no FPC in the country which fully takes up the opportunity of employing up to two practice staff per GP offered by the ancillary staff scheme. The National Audit Office [16] estimated that only 15 per cent of practices in England and Wales were employing the full number of ancillary staff for whom they could claim reimbursement. Some practices are not organised in a way which can incorporate a practice nurse or may have unsuitable premises. Doctors may not know how to recruit and manage extra staff. It is clear that GPs' duties, as outlined in the new contract, will require an expansion in the role of the practice nurse and an increase in their numbers.

FPCs and DHAs working together

In 1984, the joint working group on collaboration between FPCs and DHAs [28] recommended that health authorities, FPCs and the committees representing each group of practitioners – GPs, dentists, opticians and

pharmacists – should work more closely together. This was considered to be especially important where they jointly provided services such as child health, family planning, and some aspects of screening. Furthermore, it was suggested that they should share information and data so that they could plan services together more readily.

FPCs have had an obligation to plan services jointly since 1985 but the difficulties of doing so across an organisational divide have frequently been demonstrated [29,30,31]. The barriers to joint working are great and are increased by a poor FPC database on general practice activity and an inadequate flow of information between FPCs and DHAs. In many areas, particularly London, DHAs and FPCs have different boundaries. Many FPCs have to relate to three or more health districts each with its own internal organisational structure and set of priorities. This makes collaboration yet more difficult.

Camberwell: an inner city population

In 1984 when the project began, Camberwell had a large number of single-handed GP practices and poor premises. For at least a decade its FPC had shown little or no interest in promoting change, and its district health authority was dominated by a teaching hospital as well as being faced with tight financial constraints.

The boundary of Camberwell health district encloses an area of two miles by three in south east London. Sixty per cent of the district lies within the London Borough of Southwark, and 40 per cent is in Lambeth. The social characteristics of the population vary from deprived areas in Brixton and Peckham to affluent Dulwich in the south of the district.

Young children and the very elderly are high users of primary care. In comparison to England and Wales and South East Thames Regional Health Authority, Camberwell has a greater proportion of its population in the younger age groups. At the same time the proportion of the population under 5 and over 85 shows substantial increases since 1981 [32].

Using Professor Jarman's indices of deprivation (based on GPs' assessment of deprivation factors which affect workload) [33], which include measures of the numbers of elderly people living alone, children, unemployment levels, overcrowding, and ethnic minority groups, Camberwell is the sixth most deprived health district in the country.

★ Unemployment – many of the electoral wards in Camberwell have high levels of unemployment reaching a maximum of 30 per cent in Liddle ward, North Peckham. Within wards there are pockets of even higher unemployment.

★ Housing – in Southwark 10 per cent of all households are living in crowded or very crowded conditions. Almost two-thirds of housing in Southwark is owned by the local authority.

★ Homelessness – in 1986 in Southwark over 1,500 households were accepted as being homeless, the majority with children. This is a three-fold increase over the previous ten years.

★ Ethnicity – Camberwell has a multi-ethnic population. In some wards up to 25 per cent of the population are black. In 1981, 21.6 per cent of the population were living in a household whose head was born in the New Commonwealth or Pakistan. This is likely to be an under-estimate of the black population as the census data are based on the birthplace of the head of household.

★ Fertility – on all measures of fertility, Camberwell has above average rates. Using information from 1987:

- the crude birthrate was 18.7 live births per 1,000 total population compared to 13.6 in England and Wales
- live births to women aged 15-19 were 50 per cent higher than national rates with 350 babies born to women under the age of 20
- abortion rates in Camberwell for women aged 15-44 were two and a half times the national rate.

★ Mortality – while there are major limitations in using mortality data to reflect the health of the population, they are used here to highlight the major causes of death. Many of these are considered to be 'avoidable'. In 1987:

- 30 per cent of all deaths were due to respiratory disease including chronic bronchitis, emphysema and pneumonia;
- 22 per cent were due to ischaemic heart disease;
- 8 per cent were due to lung cancer;
- 5 per cent were due to accidental or violent injury.

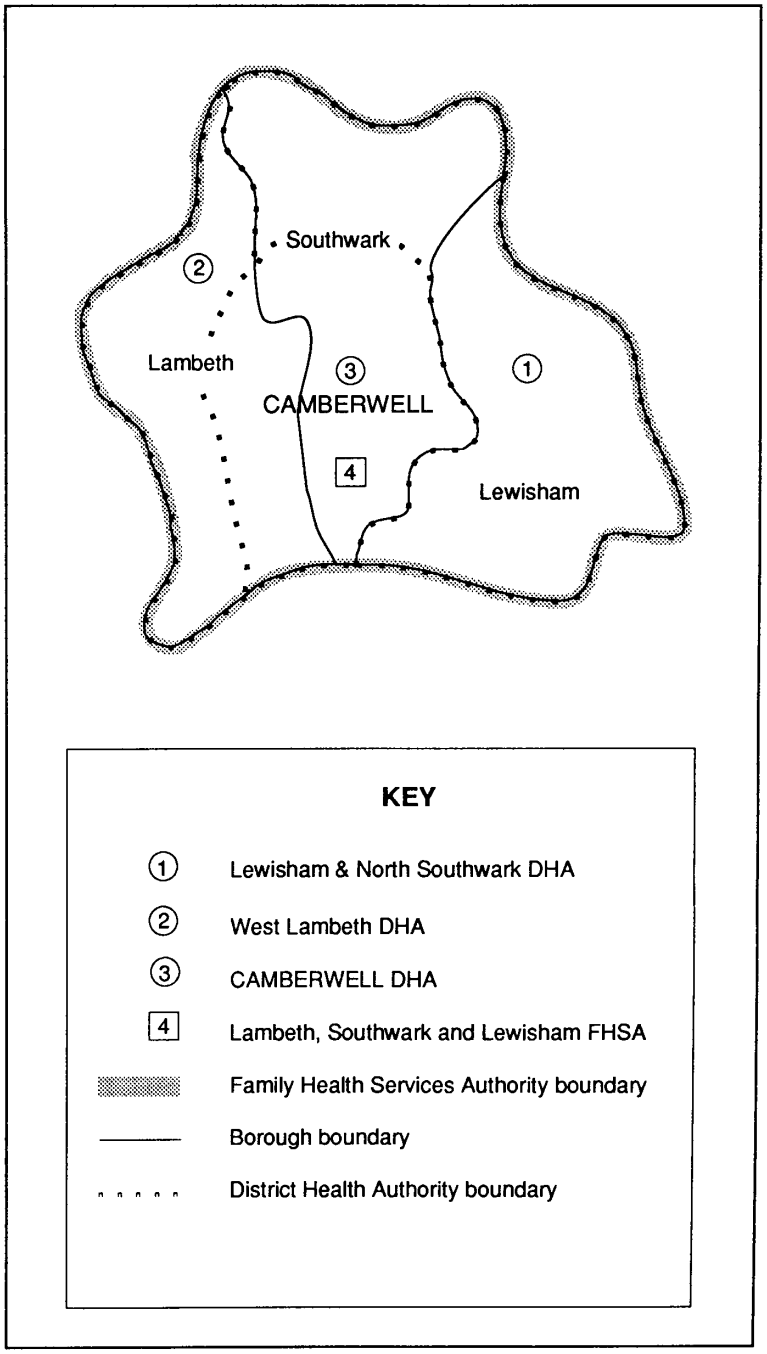
These rates are high compared to the national average.

Much of the data used here is reproduced courtesy of the authors of the Camberwell Public Health Report 1989 [34].

Health services in Camberwell

The organisation of integrated health care services is complex. Camberwell Health Authority incorporates parts of two London boroughs, Lambeth and Southwark, while the family practitioner committee which covers Camberwell has boundaries which take in the whole of these two boroughs and, in addition, the borough of Lewisham.

Figure 1: Map of health boundaries in and around Camberwell District Health Authority



The family practitioner committee for Camberwell

Until the legislation of 1985 which obliged FPCs to take on greater managerial powers and a proactive role in developing primary health care, Lambeth Southwark and Lewisham FPC was run along very traditional lines. Its management was characterised by its opposition to planning and collaboration with other agencies. Like other FPCs at that time, it had no middle management structure (see Appendix 7) and was therefore heavily dependent on the views of its administrator.

When the CPCDP was established, the FPC was undertaking no liaison or development work and it only responded to requests from general practitioners or other agencies on an individual basis. Its distance from the concerns of general practice was exacerbated by the location of its offices in north London. At the start of the project the committee offered its nominal support. Moreover, the most up-to-date list of GPs in 1985 was seven years old.

In 1986 a new administrator was appointed to the FPC. A year later, the committee's offices moved south of the river and the FPC developed a new management structure (see also Appendix 7). Commitment to develop services through a dialogue with GPs and other independent contractors also became evident and major changes were introduced, such as the introduction of a planning department and the setting up of computerised information in areas such as breast cancer and cervical cancer call and recall systems.

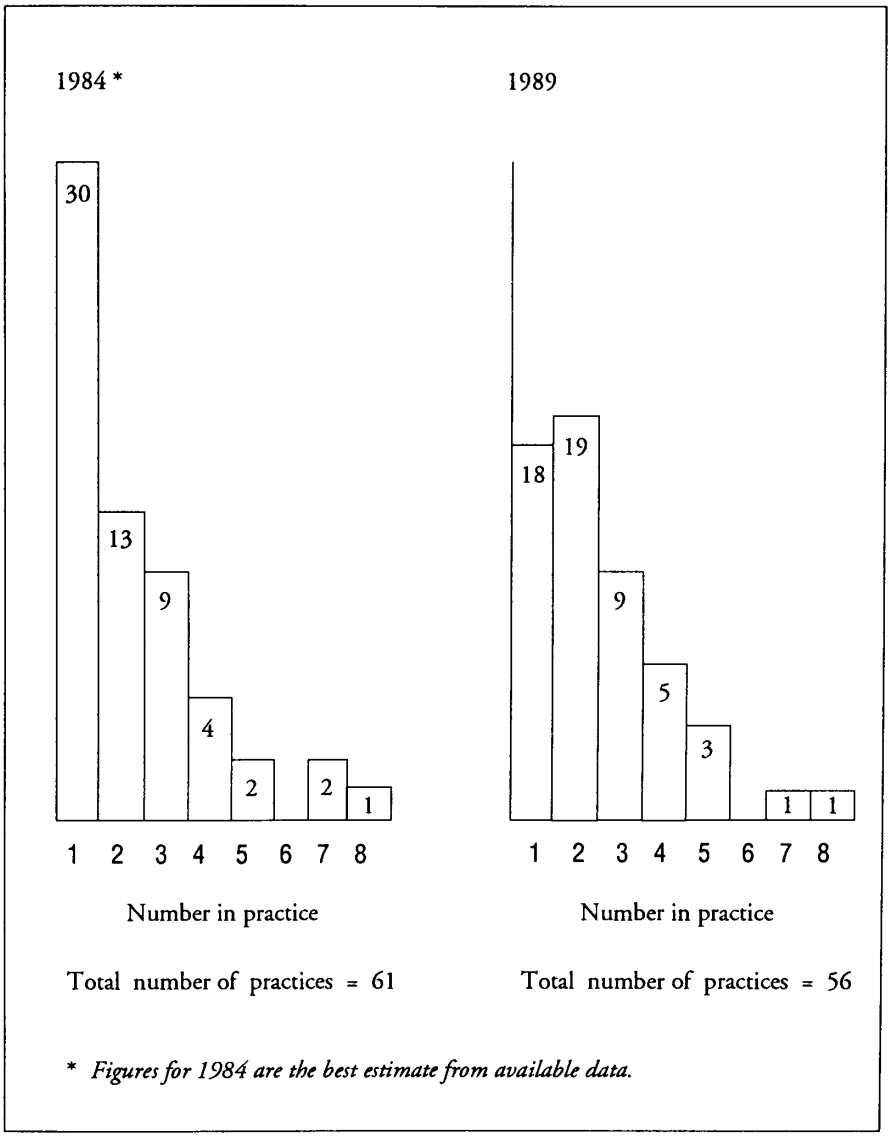
The project's relationship to the FPC also changed. The FPC began to show interest in the project's activities, especially on premises development and clinical waste. Increased collaboration between the project and the FPC gradually developed, although the project's involvement in areas which are the direct responsibility of the FPC, such as premises, has produced tensions where approaches have differed.

Through joint working on particular projects such as practice nurses, the project has welcomed the support and expertise developed within the FPC. The new emphasis of the FPC is clearly directed towards promoting change and stimulating development of primary care. It has now appointed GP facilitators for the other health districts, following the traditional model of choosing a senior GP. In other areas such as immunisation, vaccination and health promotion it has, jointly with the DHAs, appointed specialist, topic-based facilitators with nursing backgrounds across the three districts. The project has welcomed the opportunity to work together with the FPC on particular projects such as practice nurses.

GPs in Camberwell health district

In 1984 Camberwell reflected the situation of general practice in other parts of London which had been highlighted by the Acheson Report [1]. Almost half of all Camberwell practices were single-handed (see Figure 2).

Figure 2: Number of doctors per practice – 1984 and 1989



* *Figures for 1984 are the best estimate from available data.*

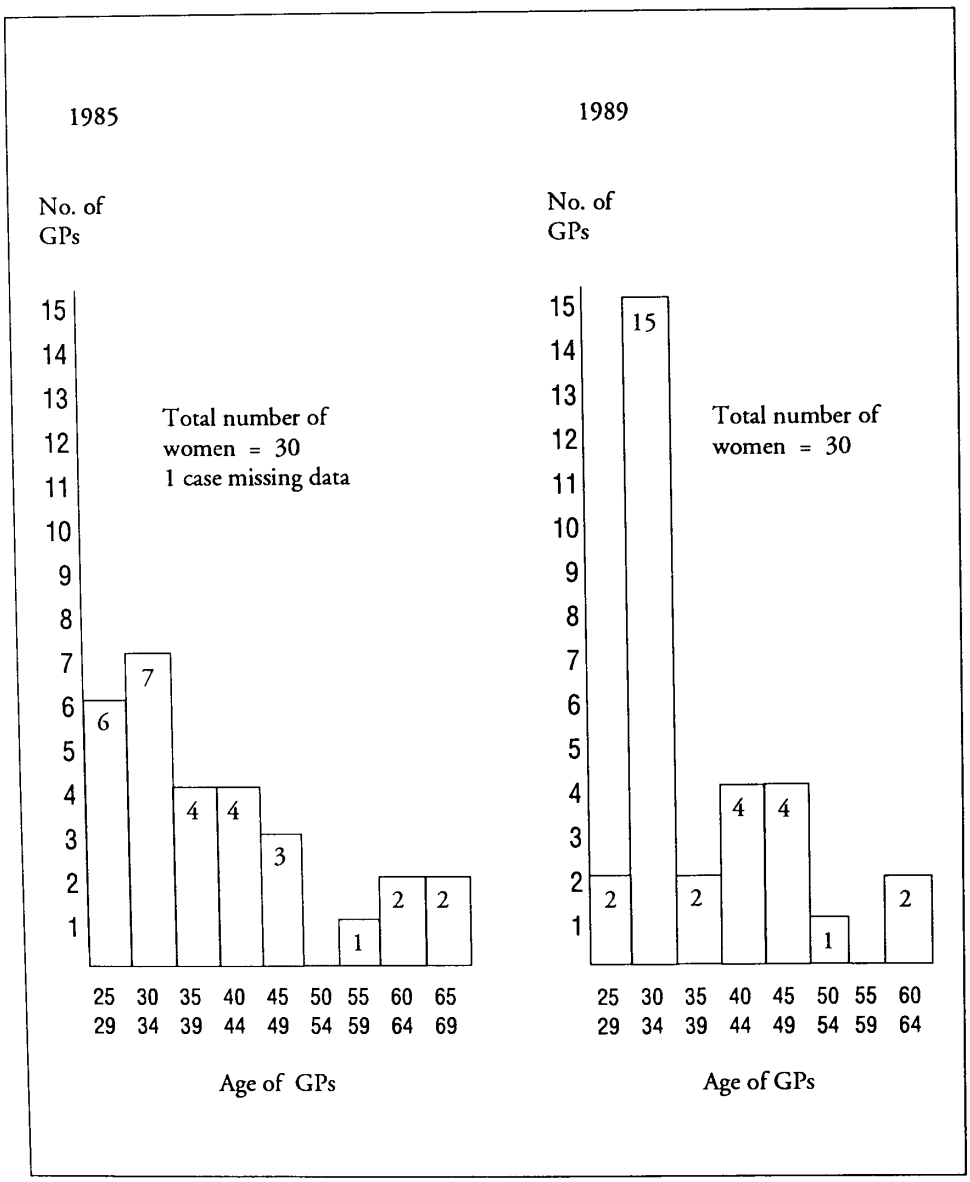
From CPCDP data shown in Figure 2, the number of single-handed GPs in Camberwell has fallen from 30 in 1984 to 18 out of 56 in 1989, although GPs have tended to move into partnerships rather than into group practices with two or three partners.

The Acheson Report highlighted the problems associated with developing GP premises, concentrating on the poor condition of many existing premises and the difficulties faced by GPs in acquiring, improving, running and disposing of premises in inner London [1].

Indications are that the standard of premises in Camberwell is improving albeit slowly. According to the FPC there were 28 cost-rent schemes in progress in 1989 compared to 17 in 1985. To be eligible for cost-rent reimbursement, practices must be in purpose-built or equivalent accommodation.

The number of women GPs – 30 – has not changed since 1984, but they are now more concentrated in the younger age groups (Figure 3).

Figure 3: Age distribution of women GPs in Camberwell 1985 and 1989



In 1984 the practice nurse was a virtually unknown member of the primary care team. In 1989 there are 16 practice nurses, none of whom are working with single-handed GPs.

Using the most recent performance indicators for Family Practitioner Services (1987/1988) Lambeth Southwark and Lewisham are compared with England and Wales on a number of criteria in Figure 4.

Figure 4: Family practitioner services for England and Wales compared with Lambeth, Southwark and Lewisham.

	England and Wales	Lambeth Southwark and Lewisham
% General medical practitioners < 65 years single-handed	9.27%	13.09%
% General medical practitioners 65 years +	4.37%	9.63%
% General medical practitioners with list size > 2,500	13.25%	24.20%
WTE equivalent ancillary staff per practice (inc. nurses)	1.25	0.94

Source: FPS Service Indicators 1987/88, May 1989, Department of Health

From the above table it is clear that Lambeth Southwark and Lewisham FPC has more than twice the national average of general practitioners aged 65 years and over and a higher than average number of single-handed practitioners aged less than 65. A significant number of practitioners, 24.2 per cent, have list sizes of over 2,500 patients, yet they employ fewer whole-time equivalent ancillary staff, including practice nurses. Although Camberwell is an area characterised by high levels of social and economic deprivation, these figures indicate that there are fewer primary health care resources available to meet the population's needs.

Camberwell District Health Authority

When the CPCDP began in 1984/5, health authorities were managed through a system often referred to as consensus management, which allowed for a representation of interests to be made before decision-making (see Appendix 5). As an inner London teaching district, the focus of attention in Camberwell was on the acute services based in Dulwich Hospital and King's College Hospital, rather than on services in the community.

The national initiative to introduce general management as outlined by the Griffiths Report [35] was introduced in Camberwell during 1986 and 1987. The old model of management was replaced by a model much closer to that used in industry, giving executive power to a district general manager, who is advised by other senior managers comprising the corporate advisory board. The subsequent structure of the organisation is shown in Appendix 6.

In the initial reorganisation, four functional units were created which included the King's Unit (King's College Hospital), the Dulwich Unit (Dulwich and St Francis Hospital), the Community and Priority Care Unit, and the Dental Health Unit (The Dental Hospital and School).

The project's main focus for liaison has been with the community and priority care services unit. For managerial purposes this is divided into five care groups, which are: primary and preventive care; learning disabilities (mental handicap); mental health; the elderly; and AIDS/HIV services.

The Department of General Practice and Primary Care

In the 1970s, at King's College School of Medicine and Dentistry, despite the fact that nearly half the undergraduate medical students eventually chose a career in general practice, clinical teaching was entirely hospital-based. The Department of General Practice Studies, now known as the Department of General Practice and Primary Care, was set up under honorary leadership in the late 1970s. It was formally established in 1981 with the appointment of a part-time senior lecturer. Its primary responsibility was to expand the teaching of general practice to undergraduate medical students.

In 1981 the department's input to the undergraduate curriculum was still small. A new curriculum was then developed, part of which required formal links with the departments of community medicine and psychological medicine. General practice studies also had responsibility for the post-graduate vocational training scheme and a broader, but less well defined brief to develop continuing education for local general practitioners.

The department was given no establishment for a core staff to teach undergraduates. A group of local practitioners was formed to examine the style and content of teaching. This became a network with the GPs acting as tutors for individual student placement and group leaders for a form of seminar teaching which had proved its worth in vocational training for general practice elsewhere. Group teaching builds on the experience and needs of the learner within the agreed structure. The realities of clinical practice and the self-defined aims of the learner are of paramount importance to aiding learning.

Furthermore, in order to learn good practice, students need to be exposed to quality practice so, as the teaching programme expanded, there was a concern to ensure standards in local general practices. Those involved with the department realised that it was necessary to address this question in a more systematic way.

CHAPTER 2

THE ORIGINS OF THE PROJECT

The need for the project emerges

As the department of general practice studies at the medical school developed it became increasingly clear that there was considerable distance between primary care staff and hospital staff in Camberwell. The lack of understanding, communication and constructive criticism that existed on both sides was unhelpful both for patient care and student education.

There was no post-graduate centre or other focus for meetings between primary and secondary care staff: even the social relationships which link members of the medical community outside London seemed surprisingly rare. In 1981 a programme of regular monthly meetings was established to fill this gap. These meetings, known as 'Meet the Department', enabled GPs and specialist teams regularly to discuss issues of common concern and attracted an average audience of 60-80. In this forum – which continues six years later – equal weight is given to the concerns of general practitioners and to the expertise of the hospital doctor. Patient groups, other members of the primary care team and specialist teams are invited.

Gradually occasional courses on issues of common concern, particularly in areas of women and child health, were set up. Both these initiatives were successful in forging links between GP and specialist teams and between GPs and other health care workers.

The research interests of the original departmental team in psychosocial issues, adolescents' health, and medical ethics, were firmly based in the realities of an inner urban client group. As local GPs, department members experienced at first hand inner city deprivation, as documented by Ruth Heller [36]; the low status of community care compared with nearby high technology curative services was compounded by relative isolation and the poor working conditions of those in primary care. Many general practitioners who started out enthusiastically, eager to undertake good practice, became dispirited by the scale of the task.

But it was not enough. There was a conviction among those involved at the department of general practice that student education and development of good general practice are implicitly linked. As well as wishing to see students on placement exposed to a higher standard of clinical practice, the department's original members were conscious of a desire to 'give something back' to Camberwell GPs who, on a voluntary basis, had given their time and energy to developing the student's curriculum and helping them develop their experience (see Chapter 1).

The report of the London Health Planning Consortium [1] on primary health care in inner London was also a spur to action: among its great many

recommendations for improving inner city primary care, it called for departments of general practice in medical schools to play a greater role in supporting local practitioners.

The concept and the King's Fund

The department concluded that a facilitation project under the umbrella of the department of general practice and primary care would be welcomed by GPs. Such a project, it was believed, needed to be sited outside the mainstream interest of any one organisation, whether FPC or DHA, if it was to be influential to both while at the same time combining education with service development.

At this stage the department's emphasis on the need to reach out to local practices coincided with the interest of the King's Fund Centre in supporting development work in primary health care in south London. The King's Fund had also funded short-term projects carried out elsewhere in London, such as in Tower Hamlets, where a worker was based in the community health services unit of the health authority and closely linked to the FPC.[3] Arnold Elliott's work in Islington was based on the premise that inner city GPs would respond best to advice and support from a respected GP from outside the district.[2]

The department's director approached the King's Fund. His original grant application to the King's Fund states the aims of the project thus:

- ★ to improve contact with all practitioners in the district in order to help practitioners describe their immediate and long-term service and educational needs, and to help them consider possible solutions
- ★ to improve contact with the administration of the community services such as nursing and health visiting in order to increase liaison and attachment where possible and desired
- ★ to improve contact with those representing the views of patients, and with academic and planning departments which can provide data to complement this
- ★ to facilitate innovations within the individual practices by providing information, discussion or specific skills required to enable these developments to take place, and to enable those with ideas or skills to share them.

How to attract GPs

Much of the work done so far on GP facilitation assumed that GPs would not welcome or respond to approaches from local colleagues. In Camberwell, the director of the department at King's College School of Medicine and Dentistry, Professor Roger Higgs, reached different conclusions. The growth of a good

quality undergraduate and post-graduate educational programme in the department had found strength in extended contact with GPs all over south east London. Acknowledgement and interest in the department had clearly been demonstrated by a large number of GPs willing to teach medical students and attend educational meetings and courses.

Roger Higgs therefore proposed the appointment of another local GP to undertake sessional work in the department and together the two doctors would interview local GPs in order to establish priorities for action in relation to the objectives outlined in the grant application.

GPs often appear to outsiders to be hard to contact and difficult to manage. In clinical and administrative management meetings, such as case conferences, where their contribution can be most valuable and, indeed, decisions are often taken which influence their practice, they have often been conspicuous by their absence. But a strategy which began by asking GPs about their practical, everyday problems might make sense even to the most isolated practitioners; having their difficulties acknowledged and being taken up might initiate a re-evaluation or a release of energy which would initiate further changes. Horder, Bosanquet and Stocking [37] have pointed out that peer influence is an important part of post-graduate medical education, and may be the only way – short of more stringent outside intervention – which might itself destroy other valued attributes – of initiating and making change in primary care. The original overall intention was therefore for the project to support those educational influences which do not act directly by assessment and correction, or by head-on confrontation, but by allowing GPs to assume a style and pace that individually suited them.

The department sought GP participation and long-term changes: the Camberwell Primary Care Development Project (CPCDP) would receive initial momentum and direction from GPs and would be seen to act on this basis. The King's Fund liked what it saw and in 1984 awarded an £18,000 grant.

The Camberwell Primary Care Development Project 1984

The CPCDP was launched in 1984. Looking back, its work falls broadly into three stages. These are different in terms of purpose, level and source of funding and structure. Each phase was marked by different forms of activity.

Phase I mid 1984 – January 1985

The original team consisted of two GPs, Roger Higgs and Tyrrell Evans, working part-time with some project work undertaken by a GP trainee. This was a period of presenting proposals, seeking approval from supporting organisations and starting the interviewing. By mid-1984 it was clear that two GPs each working one session a week could not conduct interviews and respond to the issues GPs were raising. A full-time project officer was needed.

Phase II January 1985 – mid 1988

Virginia Morley, a social scientist, was appointed as a full-time worker, with secretarial assistance, to liaise with organisations and coordinate work on issues arising from the GP interviews. During the next nine months, from January 1985 to October 1985, a programme of activities was begun which were to be the basis of the project's work over the subsequent three years and are described in detail in subsequent chapters.

Briefly, they were the provision of an information service; the establishment of a committee structure to tackle the issue of clinical waste and the improvement of practice premises; the promotion of teamwork through joint education meetings for GPs and health visitors; the development of an information base for consumers; the initiation of shared clinical protocols for diabetes and asthma.

In December 1985, the King's Fund awarded a £60,000 grant for three years with tapering funding over the period to be taken up by the DHA.

At this point, it was agreed by the funding body and the project team that some kind of steering group should be set up, either an advisory committee composed of people knowledgeable about primary and community care and representing the funders, or a steering committee made up of key local participants, such as FPC and DHA managers. It was decided to opt for the former.

Membership of the project's advisory group was:

- ★ a representative from the King's Fund London Project Executive Committee;
- ★ a senior lecturer from the General Practice Research Unit, Institute of Psychiatry;
- ★ the GP representative on the district health authority also in practice outside the district;
- ★ the project worker from the Tower Hamlets Primary Care Development Project;
- ★ a specialist in medical ethics;
- ★ a community general manager from Riverside District Health Authority (see Appendix 3).

During Phase II, the project was also successful in attracting funding from a number of sources other than the King's Fund. These are shown in Appendix 1.

Phase III mid 1988 onwards

During 1988/89, the project entered a new phase. Funding by the King's Fund ceased and was taken on by the district health authority's community and priority care unit with financial support from the FPC. The project took on more staff. A new form of steering group was established. This represents the

funding agencies and those responsible for providing local services. A new management structure has been established which separates leadership of the project from leadership of the department of general practice and primary care. This is shown in Appendix 8. A major new initiative in the education and training of practice and community nurses is being developed with community nurse management and the FPC.

CHAPTER 3

GETTING STARTED: INTERVIEWING GPs

The project set out to discover what issues were important to local GPs and to work from there. The project's interviewing would be creating an opportunity for GPs to express their needs through individual discussion for the first time and thereby to take part in planning future primary care services.

Laying down the foundations

Before contacting GPs, however, the project decided that it was important to approach all the local organisations involved in or responsible for aspects of primary care for their views on and support for the proposed interviews. This enabled the project team to meet with virtually all GPs, not just those previously in contact with the department.

Table I: Organisations approached prior to interviews

Local medical committee
Community medical liaison committee
Family practitioner committee
District planning team for primary care
Regional medical officer

The agencies above were also asked for their advice and help in the future in the event of problems arising which might be relevant to their expertise. These initial approaches also afforded an introduction of the project to all these organisations.

The interviews were undertaken by the two GP project members. A letter went to all practices requesting a meeting to discuss the strengths and weaknesses of their practice, as well as what worked well or was tough about working in Camberwell. The order of practices to be interviewed was related to the ease of arranging interviews. All doctors within a practice were invited to take part in the interviews, which were held on the practice premises.

The interview began with a discussion of the doctor's priorities and then a topic-based prompt sheet was used to guide the interview.

Table II: Prompts to interviews

Priorities for the practice

Access to DHA facilities

Communication to and from hospitals
Postal services
Investigations, specimens, collection
Outpatient departments
Accident and emergency departments
Health centre facilities

Access to and relationships with other professionals

Community midwives
Speech therapists
Audiology services
Community psychiatric nurses
District nurses
Health visitors
Non-health authority staff such as social workers

Premises

Branch surgeries
Ownership of premises
Plans to improve premises
Current accommodation
Car parking
Financial assistance with improvements

Practice organisation

Record keeping
Staff training/employment
Computerisation
Partnership agreements
Telephones

Education

Use of education resources
Quantity and type of medical literature read
Links with other GPs
Interest in and participation in large and small educational meetings
Involvement in undergraduate teaching

Sixty-one practices were initially identified and interviews carried out in 58: a single-handed GP who was suffering from a long period of illness was not interviewed and two other single-handers did not wish to take part.

A total of 116 GPs were interviewed: 89 from the 31 group practices, and 27 single-handed practitioners. In 1984 there were 128 GPs in the district so this represents 98 per cent participation.

The GP project members were initially funded for only one morning session a week, and time for interviews was therefore very restricted. Interviews began in October 1984. The number of interviews per year is shown below:

1984	–	6
1985	–	41
1986	–	9
1987	–	2

GPs were interviewed with their partners by one of the two GP project members, and in some larger group practices by both. All but five of the individual interviews were conducted by Tyrrell Evans. Interviews lasted between less than half an hour to three and a half hours, and most took place between late morning and mid-afternoon.

Topics needing urgent action

A list of issues emerging from each interview was compiled and some were taken up immediately by the project.

Table III: Areas for immediate action

Obtaining lists of solicitors, accountants and architects who had specific experience of working with GPs.
Sending out information about Whitley Council employment procedures to practices.
Compiling lists of addresses and telephone numbers of local social services and housing offices.
Collating information about voluntary agencies.
Trying to obtain access for GPs to medical school library facilities.

GPs' concerns covered two main areas: first, issues directly related to general practice; secondly, relating to access to and liaison with the other agencies involved in primary health care, that is: the family practitioner committee,

community health services, the local authorities and acute or hospital services. Table IV lists the specific issues GPs raised. Those of most concern were premises and support services to general practitioners, teamwork, and liaison and information links with the hospital, all of which are described in detail in subsequent chapters.

Table IV: Issues raised by GPs

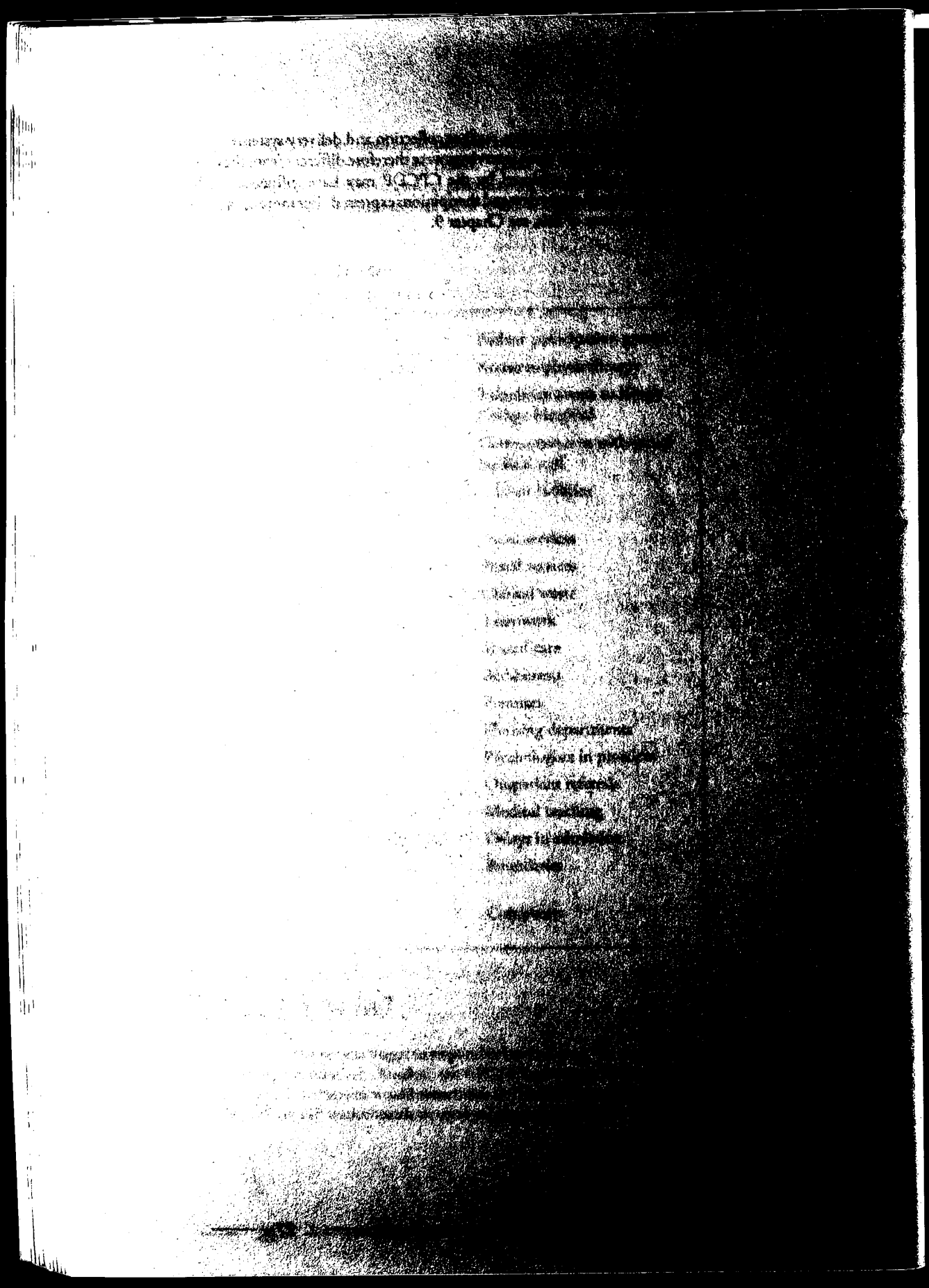
Access to psychiatry	Patient participation groups
Domiciliary visits by consultants	Access to physiotherapy
Health promotion resources	Telephone access to King's College Hospital
Postgraduate medical centre	Communication with junior medical staff
Access to emergency surgical clinic facilities	Library facilities
Delays in discharge reports	Social services
Chemical pathology reports	Postal services
Supplies/equipment/forms	Clinical waste
Hospital waiting list information	Teamwork
Receptionist training	Shared care
ECG services	Bed bureau
Cervical smear recall system	Premises
Personal safety	Housing departments
Community psychiatric services	Psychologists in practices
Local health centre services	Outpatient referrals
Locums	Medical teaching
Access to small educational groups	Delays in admission
Liaison with community health staff	Boundaries
Obstetric shared care	Computers

The chicken or the egg?

As data came in the project began to respond to issues raised. By the time later interviews were conducted, therefore, the CPCDP had become known to local practitioners. Interviewers would sometimes find information bulletins from the CPCDP on GP noticeboards or received comments on new services the

project was helping to develop, such as collection and delivery systems.

The conditions of these interviews were therefore different from the early ones. Work already achieved by the CPCDP may have influenced GPs' responsiveness to the interview and the opinions expressed. For more discussion of the implications of this, see Chapter 9.

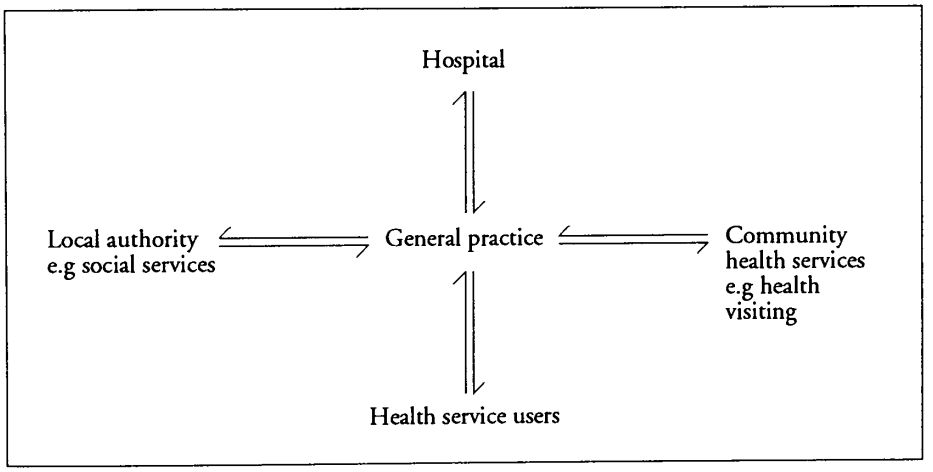


CHAPTER 4

COMMUNICATION

Good communications are essential to an integrated and comprehensive health service. Channels of communication within primary care services, and between them, the public and other parts of the health and social services are complex. The relationships are represented in the diagram below.

Figure 1: Communication in the NHS



Communication has been an element in all the issues which the project has worked on. The idea of sharing information about services on a regular basis is relatively simple, and yet rarely takes place. Changes in services make this process even more important to keep workers within the system up-to-date and able to use the services in the best way.

Making GPs' voices heard

The project has been involved in three levels of work which, essentially, all consist of improving communications between GPs and other providers or users of health services: first, links between GPs and local authorities and other community health services; secondly, links between GPs and hospital staff; thirdly, links between GPs and users of the health services.

GPs' links with community services and local authorities

Despite widespread agreement about the importance of teamwork and liaison between different parts of the NHS and other public services, it may seem surprising that there is no universal system of providing GPs with information on organisations such as local authority social services and housing departments. In interviews, GPs often reported that they found such bodies inaccessible, unresponsive and inconsistent. A very basic step towards improved communication would be, the GPs themselves suggested, a list of the addresses of the local council's area offices. This was compiled and circulated to interested GPs. The project also supplied information to individual practitioners on specific topics. The large gaps which existed, however, in many GPs' knowledge about local services were sufficiently similar to allow a general approach on further topics to be developed.

It became apparent, for example, that many GPs were unaware of the district health authority's health education department. Details of the location of the department and its services were sent to all GPs.

This information on local health education became the first of what were to become monthly bulletins. These are kept, as far as possible, to one side of A4 paper. The next major obstacle was not knowing who and where GPs were. The medical list available from the FPC was at this time more than seven years out of date. The project compiled its own up-to-date list which was also circulated to all local GPs, and managers and administrators in the local health authority.

Table I: Camberwell Primary Care Development Project monthly bulletin topics since 1985

Health education service	Continence advisory service
Audiology service	Stoma care services
Direct telephone lines for GPs to King's College Hospital	Dietetic services
Car parking	Back copies of monthly bulletins
GP premises	District occupational health service
District physiotherapy service	Alcohol counselling service
GP referrals to outpatients departments	GP open access
Rehabilitation officers	ECG service
Ambulance services	Community drug team
Psychosexual problems clinic	Wheelchair assessment clinic
GP premises exhibition	Dental care for handicapped older adults
Drug information services	Health visitor for children with special needs

Continued

Association of carers	Immunisation
Accident and emergency dept.	Child abuse
Surgical emergency clinic	Chemical pathology
The information department	Pharmacy service, community and priority care
Alphabetical list of GPs and GPs by practice	Diabetic foot clinic
GP representatives	Homeless people
Hospital consultants and registrars	Outpatient clinics
Chiropody service	CPCDP new location
Language and behaviour disorders clinic	Speech therapy service

The monthly bulletins are a way of giving up-to-date information and notifying GPs of simple changes in service patterns. But there is also a need for permanent and more comprehensive reference material, particularly for newly-appointed primary health care staff who are unfamiliar with Camberwell. Health workers need to know how to contact statutory bodies, the local hospital and community services, and to know of the help available on specific areas of concern in Camberwell such as the Sickle Cell Centre, and interpreter services.

The project is developing a directory which aims to make it easier for staff to arrange appropriate referrals, to enhance care in the community by better use of services and to encourage collaboration with social services and voluntary agencies. It is being compiled by a local GP using contacts with statutory and voluntary agencies in Camberwell, and information accumulated by the project.

Communication between GPs and hospitals

The main channels for communication between GPs and the district's hospitals are the telephone and public postal services. The King's College Hospital switchboard was notorious. Until 1987 there were few direct lines to departments and calls went through the central switchboard, which could take up to half an hour to answer. The installation of a new system has eased, but by no means resolved, this situation. Nor are general practices always easy for hospital staff to contact especially when they have no list of GPs, or their telephone numbers, or the opening times of their surgeries as was the case when the project began.

Poor communication often arises as a result of such practical difficulties rather than as a result of low motivation or other reasons. The project circulated a list of direct hospital lines to GPs and a list of GPs and their telephone numbers to all consultants' secretaries. Simple though this task may appear, however, it needs continual updating and will need to be taken on jointly by the hospital and FPC for this to be efficiently carried out in the long term.

Postal services were, and in many instances still are, another major source of frustration. Although there is a system of internal post to GPs in the district, many hospital medical secretaries are still unaware of it and use the public postal system. During interviews many GPs complained of 'the low standard of administration at King's'. Discharge summaries and notifications of death were often delayed. Some GPs said they had to rely on patients' own accounts of their stay in hospital.

Delivery and collection

The same internal postal system, using hospital vans, operated a collection and delivery service of equipment and specimens between some large group practices and the hospitals. GPs from other practices had to make their own arrangements to get specimens for analysis to the hospital or one of the community clinics. For some, this meant a daily 20-minute trip to the pathology laboratory either by them or their staff. There was no system for supplying forms for laboratory tests directly to GPs. They had to devise their own way of getting the necessary paperwork by contacting individual hospital departments – radiology, chemical pathology and so on. No list was available to practitioners of the analyses that could be performed. Bottles and jars were available from the chemical pathology department, but again were not delivered to all surgeries.

The results of a questionnaire sent by the project to local GPs formed the basis, by the end of summer 1985, for a detailed costing and timetabling of the proposed service. Five practices were also asked to collect the mail received over a week. This showed that between one third and a half of the post sent from the district health authority went via the public postal system, using both first and second class. It was clear that if internal systems were fully used, substantial savings could be made. The 'components' of what should form a unified system were located within different managerial units. Transport was run from Dulwich Hospital; while King's College Hospital was responsible for chemical pathology and the equipment. Yet the budget for supplies to GPs came from community services. No single body was therefore responsible for taking on the organisation of a service which would require liaison between these units.

The CPCDP met the community unit administrator to suggest a unified system for the delivery and collection of specimens, post, equipment, and forms. A meeting was convened of representatives including: King's College Hospital administration, the chief medical and laboratory scientific officer, Dulwich Hospital's transport manager, the chemical pathology department, the district supplies officer and the community unit administrator.

A key factor responsible for helping to develop the new scheme was the hospitals' need to get GPs to take on more out-patient prescribing, thus relieving pressure on the hospitals' pharmaceutical budget. GPs, through their representatives, agreed to take on the prescribing if they also took over the 'care' of those patients attending outpatient clinics. If care was to be returned to general practice, GPs had to be able to undertake appropriate tests, such as

blood sugar tests for diabetics – hence the need for a collection and delivery system.

The health authority's supplies officer designed a new order form specifically for GP supplies. After an initial mailing to GPs from the CPCDP office, the system is now run from the district central supplies department. The department of chemical pathology produced guidelines on how to take specimens and the services that they could offer. These were sent to GPs, together with information on the new service, order forms for containers and an invitation to contact the project if there were any problems. The introduction of the new system was staggered: the internal postal service began in January 1987, followed at monthly intervals by central ordering for pathology forms and containers, and the daily collection and delivery service.

The mysteries of outpatient timetables

GPs identified a number of problems in relation to outpatient clinics: there was no list of consultants, clinic times or methods of referral; it was difficult to get through to the department to discuss urgent cases; letters on patients were of varying standard, and took a long time to reach GPs; GPs were uncertain how long patients might have to wait for an appointment or to wait to be seen once at the clinic. A GP new to the area suggested that GPs needed a summary of outpatient services, including an outpatient timetable, and details of the consultants and their clinics.

Similar information had been compiled for GPs in the districts covered by Guy's Hospital and St. Thomas' Hospital nearby. These had been well received, although there had been problems getting accurate information. The outpatient manager and patient services manager at King's College Hospital were approached by the project and agreed to investigate appointing a temporary administrative worker to collect information on clinics.

When this information was finally gathered, it was not in a form suitable for publication. What's more, the timing of clinics and sometimes their very existence were reported differently by consultants and outpatient staff. Neither central administration nor patient services were prepared to take the matter further at that time. The project took on the task of producing an accurate booklet and the authority agreed to fund its publication and to update it yearly.

The outpatient booklet (see Figure 2), which was published in 1986, contained referral information, explained how to book appointments, and gave the times of clinics and their consultants, together with direct lines where they existed. It also gave information about all outpatient services at King's College, Dulwich and St. Giles' Hospitals.

By questionnaire, GPs were asked to comment on how useful they found the publication. All respondents found the timetable in general, and the information about emergency services, useful, and all found the booklet well laid out and easy to get around. The booklet was important not only in overcoming a very basic problem of communication, but in drawing the attention of the outpatient clinics and departments concerned to GPs and their

and their needs. By March 1989, however, an updated timetable is yet to be produced, and is all the more urgently needed as King's College Hospital telephone numbers changed at the start of 1988.

The project has now started work to prepare more detailed information about hospital services for GPs (see Figure 3) and is coordinating a steering group of hospital administrative and clinical representatives which, it is hoped, will take the issue on in the longer term.

Figure 2: Outpatient services leaflet

PSYCHIATRY
Friday am Dr. Silverman

***WHERE MARKED THIS INDICATES THAT THE FIRST PERSON IS RETIRING AND THE SECOND PERSON WILL BE TAKING OVER THIS CLINIC.**

ST. GILES HOSPITAL
St. Giles Road, London SE5
Telephone: 01-703 0898

All clinics below are closed on Bank Holidays and the Fridays before the Early Summer Bank Holiday and late Summer Bank Holiday.

ALEXANDA CLINIC - Genito Urinary Medicine, St. Giles Hospital.

New and existing patients may telephone for an appointment. G.P. referral letter not necessary but helpful. Telephone **01-703 0898 Ext. 6202/6024.**

Clinic opening times:

Monday	9.30 - 4.00 pm
Tuesday	9.30 - 6.00 pm
Wednesday	9.30 - 4.00 pm
Thursday	9.30 - 6.00 pm
Friday	9.30 - 4.00 pm

DRUG DEPENDENCY UNIT St. Giles Hospital.

A letter of referral is necessary and booking made by telephoning **01-703 0898 Ext. 6048.**

Clinic opening times: Monday 2-7pm, Wednesday 10-5pm, Friday 10-1pm.

COMMUNITY HEALTH SERVICES

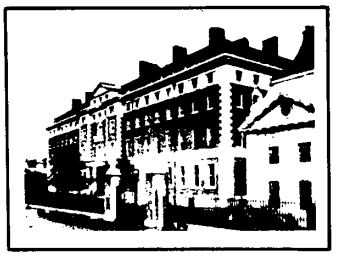
For details of clinics and services offered contact:

Susan Osborn/Susan Williams
Unit General Manager
Community Services
St. Giles Hospital, St. Giles Road, Camberwell, London SE5
or telephone **01-703 0898**

THIS INFORMATION WILL BE REVISED ANNUALLY. PLEASE NOTIFY THE PATIENT SERVICES OFFICER, KING'S COLLEGE HOSPITAL, OF ANY AMENDMENTS OR CHANGES IN SERVICE.

Camberwell
HEALTH AUTHORITY LONDON

OUT-PATIENT SERVICES



Kings College Hospital
Dulwich Hospital
St. Giles Hospital

AUGUST 1986
Produced jointly with the
Camberwell Primary Care Development Project

Figure 2: Outpatient services leaflet (cont/d)

Monday	pm	Dr. McEwan - Referral Clinic GPs should send a letter in advance.
Monday 5.30-8.00 pm		Family Planning Practitioners
Tuesday 5.30-8.00 pm		Family Planning Practitioners
Wednesday	am	Family Planning Practitioners
Wednesday 5.30-8.00 pm		Family Planning Practitioners including Psycho Sex Clinic
Thursday	am	Family Planning Practitioners
Thursday 5.30 - 8.00 pm		Dr. McEwan

GYNAECOLOGY & ANTENATAL *Telephone:* **Switchboard Ext. 2133**

Monday	am	Prof. Campbell - Antenatal
Monday	pm	Mr. Brundenell - Gynaecology/ Terminations
Monday	pm	Ms. Cardozo - Urodynamic Session
Tuesday	am	Mr. Gibb - Antenatal - including Teenage Clinic
Tuesday	pm	Ms. Cardozo - Urodynamic Session
Tuesday	pm	Antenatal
Wednesday	am	Mr. Gibb - Antenatal
Wednesday	pm	Antenatal (except 1st Wednesday)
Thursday	am	Ms. Cardozo - Gynaecology/ Terminations
Thursday	pm	Antenatal
Thursday	pm	Counselling
Friday	am	Ms. Cardozo - Urodynamic Session
Friday	pm	Mr. Brudenell/Ms. Cardozo - Antenatal
Friday	pm	Mr. Studd - Gynaecology

HAEMATOLOGY *Telephone:* Switchboard **Ext. 2772**

Monday	am	Dr. Mibashan - Haemostasis
Tuesday	pm	Prof. Bellingham - Adult Haemo-globinopathy Clinic
Wednesday	am	Prof. Bellingham/Dr. Mufti General Haematology Clinic
Friday	am	Prof. Bellingham/Dr. Mufti General Haematology Clinic

INFERTILITY CLINICS *Telephone:* **Switchboard Ext. 2516**

Monday	pm	Female Infertility
Tuesday	am	Mr. Pryor - Male Infertility
Tuesday	pm	Female Infertility
Wednesday	pm	Dr. McEwan - Female Infertility
Thursday	pm	Female Infertility
Friday	pm	Mr. Whitehead - Female Infertility

LIVER DISEASE *Telephone:* **01-733 2534**

Friday	pm	Dr. R. Williams

MEDICINE *Telephone:* **01-733 2534**

Monday	pm	Dr. Elkington - General Medicine & Gastroenterology
Tuesday	pm	Dr. Costello/Dr. Parsons/Dr. Taube
Thursday	am	Dr. Costello/Dr. Price - Joint Adolescent (every 6th Thursday)
Thursday	pm	Dr. Williams/Prof. Eddleston - General Medicine and Liver Disease
Friday	am	*Prof. Anderson (leaves 1 Oct. 1986)/ Prof. McGregor/Dr. Cundy
Friday	am	Dr. Parsons/Dr. Taube - Nephro-urology
Friday	pm	Dr. Pettingale - General Medicine

MENOPAUSE CLINIC *Telephone:* **Switchboard Ext. 2710**

Monday	am	Prof. Campbell
Monday	pm	Prof. Campbell
Tuesday	am	Prof. Campbell
Wednesday	am	Prof. Campbell

NEPHRO-UROLOGY *Telephone:* **01-733 2534**

Friday	am	Dr. Parsons/Dr. Taube

NEUROLOGY *Telephone:* **01-733 2534**

Monday	am	Prof. Marsden/Dr. Parkes
Wednesday	pm	Dr. Zilkha - Headache
Thursday	am	Dr. Zilkha

NEURO-OTOLOGY *Telephone:* **01-733 2534**

Friday	am	Mr. Ludman

OPHTHALMOLOGY *Telephone:* **01-733 2534**

Monday	am	Mr. Coakes - Ocular Hypertension
Monday	am	Mr. G. Davies - Diabetic Eye Disease
Monday	pm	Mr. Hunter
Tuesday	am	Mr. Coakes - Glaucoma
Wednesday	am	Mr. G. Davies
Wednesday	pm	Mr. Hunter - Corneal
Thursday	am	Mr. G. Davies - Retinal
Thursday	pm	Mr. Coakes
Friday	am	Mr. Coakes
Friday	pm	Mr. Coakes

ORTHOPAEDICS *Telephone:* **01-733 2534**

Monday	am	Mr. Morley
Monday	am	Mr. Holden
Wednesday (1st Wednesday each month)	am	Mr. Holden - Trauma Hand Clinic Mr. Crellin - Children and Congenital Disorder of the Hip Clinic
Wednesday	pm	Mr. Morley
Wednesday (every 8th Wednesday)	pm	Mr. Holden -*Talipes
Thursday (except 1st Thursday)	am	Mr. Morley - Scoliosis

Fracture Clinics *Telephone:* Switchboard **Ext. 2119**

Monday	am	Mr. Crellin
Tuesday	am	Mr. E.M. Thomas
Wednesday	am	Mr. Morley (except 3rd Wednesday)
Thursday (except 1st Thursday.)	am	Mr. E.M. Thomas
Thursday	am	Registrars
Friday	am	Mr. Holden

PAEDIATRICS

Monday	am	Dr. Mowat - Medical (Tel: Switchboard **Ext. 2436)**
Tuesday	am	Dr. Price
Tuesday (every 1st Tuesday)	am	Dr. Gamsu (Tel: **01-733 2534)**
Tuesday	am	Prof. Stroud/Dr. Davis Haematology Clinic (Telephone Switchboard **Ext. 2436)**
Tuesday	pm	Mr. N. Thomas - ENT (Tel: Switchboard **Ext. 2436)**
Tuesday	pm	Dr. Gamsu - Neonatal Dr. Greenough (Tel: **01-733 2534)**
Thursday	am	Dr. Price - Chest (Tel: **01-733 2534)**
Thursday	am	Dr. Pembroke - Skin (Tel: Switchboard **Ext. 2436)**
Thursday	pm	Mr. Howard - Surgical (Tel: Switchboard **Ext. 2436)**
Friday	am	Prof. Stroud - Medical (Tel: Switchboard **Ext. 2436)**
Friday	pm	Dr. Mowat - Liver (Tel: Switchboard **Ext. 2436)**

SHELDON CHILDREN'S CENTRE
(Dept. of Child Health)
St. Giles Road, London S.E.5
Telephone: 01-703 0898 Extn: 6179

Monday — Friday by appointment	Developmental Assessment Care of handicapped children 0-16 years Paediatric Neurology Dr. M. Pollak - Director & Consultant Dr. P. Robson - Consultant
Paediatric Audiology	by appointment *Telephone:* **01-703 0898 Ext. 6179**
Tuesday	am Mr. Sastry - Consultant
Thursday	am Mr. Sastry - Consultant

PAIN CLINIC *Telephone:* **01-733 2534**

Friday	am	Dr. Hanna

Figure 3: Hospital referral information for GPs (King's College and Dulwich Hospitals)

OBSTETRICS & GYNAECOLOGY

OBSTETRIC & GYNAECOLOGY, DIABETES IN PREGNANCY, COLPOSCOPY

OTHER Mr A.N MB BS FRCS (Eng) FRCOG — Consultant Obstetrician & Gynaecologist

Address: Department of Obstetrics & Gynaecology, King's College Hospital, Denmark Hill, London SE5 9RS

Telephone: Mr Other: 670 0743
Secretary: 274 6222 ext 4561
Department: 274 6222 ext 4561

GP Enquiries: Telephone Mr Other or Senior Registrar
Routine Referral: Letter addressed to Mr Other marked Gynaecology or A/N. Appointments at KCH
Pre-referral requirments: None
Urgent Referral: Telephone Secretary or Senior Registrar
Feedback to GPs: Letter dictated same date following first appointment (usually sent within one week). However, may take 1-4 weeks before full results back.

Clinics: General Gynaecology and Colposcopy Clinics.
Antenatal Diabetic Clinic.

Times:

Monday	2pm	General gynaecological problems
Tuesday	10am	Diabetic A/N Clinic
Thursday	2pm	Colposcopy Clinic

Communication between primary care and the public

From its inception the CPCDP aimed to make information about primary care services more available to the public. Our belief was that this would be best produced when we had gained the interest and confidence of those running the services. The lack of information for health users is well documented both locally and nationally. In Camberwell information on community health services is sparse and, with over 400 doctors in the three boroughs – Lambeth, Southwark and Lewisham – covered by the FPC, FPC lists are difficult to keep up to date. It is also probable that access to information is more difficult for groups experiencing particular disadvantage within Camberwell – women, the black population, people with disabilities, and the elderly – than for other groups of the population who are also not such high users of primary care.

The provision of primary care services is the direct responsibility of the Camberwell Health Authority and the FPC, but services are implicitly and increasingly linked with those of the local authorities. Local authorities' responsibility for social services, housing, day care, other facilities for the elderly and children, and many other services, means that they too are providers of primary health care. It is important to remember that, to a large proportion of the public, the distinctions between who provides the different parts of the service become blurred.

The CPCDP coordinated an informal working group on information about local health and social services for the public. This consisted of representatives from: the Camberwell community health services, Camberwell Community Health Council, Camberwell DHA directorate of consumer services, the information department at Lambeth council's directorate of environmental health and consumer services, Lambeth, Southwark and Lewisham FPC, and Southwark council's social services department. The group supported the idea of a handbook and agreed to give advice throughout its production and distribution.

A handbook for users

The aim of the handbook is to give clear information on primary care services. It needs to be easy to update and to be available in several languages. Although a handbook is of limited use to non-literate people, it is an important first step leading to a fuller discussion of the issue of how information is provided to users.

The handbook contains information gathered from three main contributors: the FPC, community health services and the social services departments of the boroughs of Lambeth and Southwark. With the approval of the local medical committee, the following information about GPs was gathered by the project and collated with that held by the FPC:

GPs' names, addresses and telephone numbers;
Whether they work single-handed, in groups, or partnerships; Surgery times;
Date of first full registration of the GP;
Where women GPs work;
Maternity/medical services;
Contraceptive services.

The community and priority care services provided details of:

Clinics – times, addresses and phone numbers
Particular services available:
- ante natal clinics;
- well baby sessions;
- well woman sessions;
- family planning sessions;
- availability of interpreting facilities.

The booklet also explains briefly what community health staff such as health visitors and community psychiatric nurses do.

The local authority social services departments gave information on:

Addresses and telephone numbers of area offices;
Staff working from these offices;
Services offered.

The booklet will explain how to make best use of the services offered. It will give advice on how to register with a GP, and how to contact a GP outside surgery hours, and so on. The information is available for Camberwell health district and is divided into postal districts, which are more familiar to people than their ward or health district. The booklet is to be distributed to one household in ten and, in order to reach more disadvantaged groups, to a number of public places including health centres, pharmacies, schools, religious networks, and housing offices. The booklet will need to be updated and its usefulness has been evaluated through piloting with community groups during the production stages, and by questionnaires distributed with each copy of the handbook.

Figure 4: Handbook for users – sample pages

How to Complain

COMPLAINTS AND ADVICE

How you complain depends on which part of the NHS you think has let you down and how serious you feel the matter to be. Many complaints arise from misunderstandings or lack of access to information and can be dealt with informally.

All Informal Complaints/ Advice

The Community Health Council (CHC)
75 Denmark Hill SE5
Tel: 703 9498

The CHC is the patient's voice in the NHS and they will listen to your problem, provide advice and information and help you to "talk through" difficulties. They will also assist you to write letters.

Complaints about General Practitioners, General Dentists, Pharmacists and Opticians

These are dealt with by the Family Practitioner Committee (FPC). Your complaint must be sent in writing to the FPC within eight weeks of the event giving rise to the complaint. If the complaint cannot be resolved informally, it will be dealt with by an investigating committee at the FPC.

Write to:
General Manager
Lambeth Lewisham and Southwark FPC
75 York Road, SE1

If you wish to make a verbal complaint, contact the FPC. Tel: 620 0414, Mon-Fri 9-5pm.

Complaints about Community Health Services

In Camberwell Health Authority write to:
Unit General Manager
Community & Priority Care Services
St Giles Hospital
London SE5
Tel: 703 0898

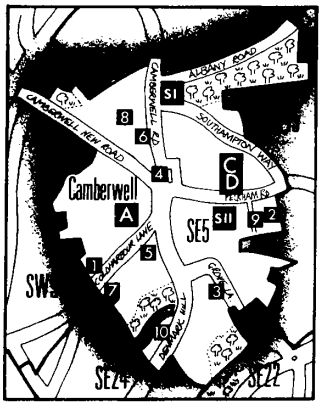
In West Lambeth Health Authority write to:
Unit General Manager
Community & Priority Services
South Western Hospital
London Rd
London SW9
Tel: 733 7755

Complaints about social services

Should be made in writing to the Director of Social Services. See page 15 for addresses.

Complaints about a Hospital Service

Should be sent as soon as possible to the General Manager of that hospital. The Community Health Council will be able to provide assistance.



SE5

For details of GPs, clinics and social services outside of this postal district (SE5), see listings for other postal districts (SE15, SE22, SE24, SW9).

GPs

Arora, S.K. (M reg '69) *By appointment*	**194 Coldharbour Lane, SE5** Mon-Fri: 9-11am Mon Tue Wed Fri: 4.30-6.30pm Sat: 9.30 -10.30am (emergency only) *Contraceptive services available*	**737 3928** *Buses: 35 45*
Bhatt, G.B. (M reg '54) *Walk in & wait your turn*	**38 Bushey Hill Road, SE5** Mon-Fri: 9.30-11.30am Mon Tue Wed Fri: 5.30pm-7pm Thur pm: closed *Maternity & Contraceptive services available*	**703 5874** *Buses: 12 36a 36B 171*
Biswas, U.P. (M reg '75) *Walk in & wait your turn*	**144 Grove Lane, SE5** Mon-Fri: 9-11am Mon Tue Wed Fri: 4-6pm Sat: 10-11am By appointment only *Maternity & Contraceptive services available*	**274 3762** *Buses: 176 185*
Brownsdon, C.E. (M reg '72) **Cotton, H.** (F reg '80) **Durston, R.S.** (M reg '79) **Rowell, M.** (M reg '79) **Vaughan, C.** (F reg 81) *Walk in & wait your turn*	**13 Camberwell Green, SE5** Mon-Fri: 8-10am, 4.15-6pm *Maternity & Contraceptive services available*	**703 3788** *Buses: 12 35 49 45 68 142 161 176 184*
Charles, J.C. (M reg '79) **Puri, V.** (M reg '76) *By appointment*	**99 Coldharbour Lane, SE5** Mon-Fri: 9-11am Mon Tue Wed Fri: 4.30-6pm Sat: 9-10.15am (emergency only) *Maternity & Contraceptive services available*	**274 4507** *Buses: 45 35*
Clark-Jones, A. (M reg '55) **Ephson, P.M.J.** (M reg '69) **Saxena, S.R.** (M reg '75) **Wijetunga, E.** (M reg '66) *Morning: Walk in & wait your turn* *Afternoon: By appointment*	**244 Camberwell Road, SE5** Mon-Fri: 9-11am, 4-6pm Sat: 9-10am (emergency only) *Maternity & Contraceptive services available*	**703 0596** *Buses: 12 35 40 171 176 184 185A*
Branch Surgery *By appointment*	**199a Coldharbour Lane, SE5** Mon-Fri: 9.30-11am Mon Tue Wed Fri: 5-6.30pm Sat: 11-12 noon *Maternity & Contraceptive services available*	**274 6323** *Buses: 35 45*
Dickinson, L. (M reg '79) **Kakad, P.** (M reg '72) **Macmanus G.J.** (M reg '52) *Walk in & wait your turn*	**90 Wyndham Road, SE5** Mon-Fri: 10.30 -12.30pm 5.30 -7pm Sat: 11-12.30pm (emergency only) *Maternity & Contraceptive services available*	**703 2046/7** *Buses: 36 42 45 68 171 184 40 12 36 36A 36B 176 185*
Lomas, D.M. (M reg '54) *By appointment*	**86 Vestry Road, SE5** Mon-Fri: 9.30-12 noon Mon Tue Wed Fri: 4.30-6.30pm Sat: am (emergency only) *Maternity & Contraceptive services available*	**703 4749** *Buses: 12 36 171*
McCune, R.E. (M reg '71) *Walk in & wait your turn*	**170 Denmark Hill, SE5** Mon-Fri: 9-10.30am Mon Tue Thur Fri: 4.30-6.30pm Sat: 10-11am *Maternity & Contraceptive services available*	**274 3939** *Buses 40 68*

As outsiders we have been able to observe many relatively basic examples of the need for more information. Many of these, however, clearly demonstrate the need for a wider discussion about the priority given within primary health care organisations to the provision of information both to their professional and client groups and to their ability to communicate across boundaries with other agencies.

Chronology

1985 onwards	CPCDP information to individual GPs on request
Spring 1985	CPCDP compiles up-to-date list of GPs
May 1985	CPCDP circulates first monthly bulletin
Summer 1985	Questionnaire to GPs on postal service CPCDP approaches community unit administrator with proposal for unified system of post, collection and delivery of specimens
Summer 1986	Group set up to develop and implement new integrated transport and delivery service
August 1986	Outpatient timetable published
January 1987	Postal service started
February 1987	Central ordering begins
March 1987	Daily collection and delivery service started to GPs
June 1988	Part-time worker appointed to work on information handbook for the public
March 1989	Part-time worker appointed to compile directory of health and social services for professionals
January 1990	Information handbook for the public launched.

CHAPTER 5

CLINICAL WASTE

In the last ten years there has been a large increase in general practitioner use of disposable equipment such as plastic syringes, needles, scalpels, vaginal specula, dressing packs, suture equipment and glass phials. With the trend towards improved premises and extended teamwork the range of services which GPs offer from their surgeries is also likely to increase and the government has supported this shift in the 1989 White Paper *Working for Patients* [10]. In such circumstances, the volume of clinical refuse can only increase.

During this same period, with the risk of HIV and AIDS and increased awareness of hepatitis B infection, refuse workers have become particularly conscious of the need for health and safety in the disposal of clinical waste.

Danger to health

In 1984, as the project got underway, the disposal of clinical waste in London was a recognised problem. The second report of the Greater London Council working party on clinical waste disposal stated that the disposal of waste from GP surgeries in normal refuse collections caused a danger to health and put refuse workers at risk [38].

The working party argued that because every doctor and dentist in London was reasonably close to an NHS hospital incinerator, the safest and environmentally most acceptable solution to their clinical waste disposal would be to incinerate it at the local hospital. It suggested that London boroughs should collect clinical waste from surgeries each week and transport it to the hospital. Boroughs, it was suggested, should provide this service from 1st April 1985 at the latest. Also, to avoid the high costs of invoicing and debt collection, and because of the public health risk entailed the boroughs should make no charge for their work. Similarly, since such a relatively small volume of waste would take up very little additional incinerator time, the DHAs should not charge. The working party considered that as FPCs already supplied GPs with syringes and stationery, they should also supply the yellow bags and sharps bins needed to ensure safe handling.

In 1985, the working party reviewed the progress made by London boroughs toward implementing these suggestions [39]. It noted that local authorities had approached recommendations with varying degrees of enthusiasm. Even those who had made it a high priority had needed to engage in lengthy consultation with FPCs, DHAs and GPs and dentists, and this made the target date of April 1985 unrealistic.

Asking Camberwell GPs

In interviews with Camberwell GPs during 1984 all had problems with the procedures for the disposal of clinical waste. In two of the practices refuse workers would not collect domestic rubbish which also contained clinical waste. Some practices stored it loose in black bin bags outside surgeries where it stayed for up to a week awaiting collection; in one practice the GP took it home and burned it.

The project's first response to problems raised in interviews was to compile an information sheet which was distributed to GPs, detailing different options, including the local authority trade refuse service, the health authority clinic service and services provided by private contractors. This, however, seemed a very minimal response. The project team agreed with the GLC working party view that: 'a coordinated system for the disposal of clinical waste would be the most effective in the long term'.

The DHA: talk but no progress

In 1985, as the question of clinical waste was drawn to the project's notice, Camberwell DHA was reviewing its waste disposal procedures. The district invited acute and community managers and the Camberwell Primary Care Development Project to discuss the volume of clinical waste generated in the district by hospitals, clinics, and by GPs.

To assess GPs' views on this issue and to discover how rubbish was being dealt with, the project sent a questionnaire to all practices in Camberwell. This confirmed that many of the methods being used were unsanitary and unsatisfactory. Most practices used the local authority domestic refuse collection and a member of staff took 'sharps' for disposal by the health authority. One practice even reported that: 'a patient takes it to King's', and in another a private contractor was used. Most GPs requested a monthly collection system for sharps and a weekly collection for bags of clinical waste.

Despite the health authority review, the question of a disposal service did not make progress. The health authority was reluctant specifically to offer free transport of clinical waste from GPs. The project therefore arranged a meeting with the following participants: the environmental health departments of Lambeth and Southwark councils, the unit administrator from Dulwich Hospital who, at that time, was undertaking the DHA review on clinical waste, the unit administrator from community services, and an officer from Lambeth, Southwark and Lewisham FPC. This revealed quite different perspectives on the issue.

The FPC officer considered that since few GPs had complained to the FPC about this problem it was not of widespread concern. The environmental health officers, on the other hand, were worried about the health risk being run by the clinical waste entering the domestic refuse disposal system. Using the experience of its members and the survey information, the group began to consider the practicalities of a collection system for Camberwell GPs. It looked

at the capacities of incinerators, the supply and replacement of containers, and the specifications for such a service going to tender. The perennial problem of differing health district and local authority boundaries emerged with borough representatives pointing out that such a service would overlap into neighbouring health authorities, and so the proposed service would have to be run in each of the three boroughs of Lambeth, Southwark and Lewisham and the health authorities within them. The group also considered expanding the services to dentists, pharmacists and vets: eventually dentists and pharmacists were invited to take part in the scheme and vets were canvassed separately by the local authorities.

Breaking the deadlock

Despite these efforts lack of finance impeded real progress. The solution to this appeared in the form of a change in the DHSS regulations on reimbursement to GPs for waste collection. In the 'red book', (DHSS 1986) an amendment was made. It now stated: 'Where local authorities levy a separate charge for the collection of trade refuse from surgeries, this charge or, where suitable arrangements exist, the charge made by the health authority or private contractor, whichever is the lowest, may be reimbursed subject to the production of receipts'.

GPs could now be reimbursed for the costs of an effective and efficient collection and disposal system.

By mid-1986 the FPC had become fully committed to the provision of an effective system and undertook to draw up a specification for tender to borough councils and commercial companies. Unfortunately boroughs at that time were precluded from providing services beyond their boundaries and could not therefore tender to provide a joint service; they tendered separately. On the basis of the range and quality of services they offered, the local authorities won the tender. They undertook to supply a weekly collection and delivery service to practices in their respective boroughs and to supply yellow bags and sharps containers. Waste would be collected regularly and incinerated at hospitals within the FPC area, although finding a local incinerator for regular use was initially a difficulty. A comprehensive service started on 1 July 1987. The FPC encouraged practices who had standing contracts with other companies to stop at renewal date and enter the scheme.

What next?

The clinical waste group set up by the project continues to meet, less frequently now, twice a year. As well as monitoring the system, it has looked at some of the other disposal problems of clinical waste, such as: dressings and needles used by district nurses who treat patients in their homes and who are faced with placing them either in the domestic system or taking them away; the disposal of needles by renal patients who dialyse at home; and diabetic needles, which

are now obtainable on prescription, although the DHSS guideline which made them available failed to consider the disposal question.

Now that local authorities are permitted to tender for services outside their borough, they are investigating a form of consortium in an endeavour to contain costs. They are also making their own approaches to local chiropodists and veterinary surgeons. Links have also been proposed with needle exchange schemes.

The system has been welcomed. Local practitioners are making good use of the scheme and, according to the FPC, it has been particularly welcomed by dentists. The extension of the scheme to dentists has helped to keep administration costs low, but neither pharmacists nor district health authority community clinics have joined the scheme, although at the beginning it was hoped they would do so.

Chronology

1984	Second report of GLC working party on clinical waste disposal
May 1985	CPCDP collate information on clinical waste disposal procedures
1985	Third report of GLC working party on clinical waste disposal
January 1986	Camberwell DHA start review of clinical waste procedures
February 1986	CPCDP survey volume of clinical waste from GPs in Camberwell
March 1986	CPCDP call first joint meeting of clinical waste project
May 1986	New DHSS regulations on reimbursement for waste collection
February 1987	FPC administrator replaces previous FPC delegate to meetings
May 1987	FPC invite tenders for clinical waste disposal
July 1987	Borough-wide collection of waste by local authorities begins in Lambeth, Southwark, and Lewisham.

CHAPTER 6

GP PREMISES: ROOM FOR IMPROVEMENT

During interviews with Camberwell GPs, it emerged that the main obstacle which the doctors saw as preventing them developing their services and promoting good primary care was the problem of obtaining decent accommodation for their surgeries. The lack of suitable accommodation from which a full primary health care team can operate remains a major obstacle to the development of quality general practitioner services in the inner city. Not only do premises affect what an individual practitioner can do, and the kind of services which can be offered in a given locality, but information on the location and standard of surgeries and health centres is a fundamental part of strategic planning in primary care.

The Acheson Report [1] placed considerable emphasis on the importance of appropriate accommodation as a factor in the development of good primary care. The 1987 White Paper, *Promoting Better Health* [7], also drew attention to the need for action on this issue. Unless there are adequately designed premises, general practice will continue to be restricted in the range of services provided and the staff employed. Premises development will continue to be slow and patchy unless the process is simplified and sufficient support given to both practitioners and agencies involved in the planning and organisation of primary health care.

The obstacles for GPs in Camberwell

In Camberwell, surgery accommodation ranges from specially designed buildings, accommodating a range of professionals and giving easy access to clients, to cramped, unheated surgeries with little ground floor space and poor access. Through interviews with GPs the project established that just over half owned their premises (although information from a recent survey looking at likely developments in local general practices [40] indicates this number is increasing). The kind of problems GPs experience were related to the type of occupation of the premises. Some GPs in privately rented accommodation were trying to negotiate for extended leases on poorly maintained properties; GPs working from health centres belonging to the district health authority reported problems trying to get repairs done. Many of the GPs who rented from the local authority said their premises were unsuitable and that they faced restrictions on how the accommodation could be used.

Table I: Ownership of premises by practice 1984 – 7

GP owned	Rented, privately or from the DHA or local authority
25	21

(Data on 11 practices not available)

GPs who were trying to change sites or alter existing premises reported having to negotiate a maze of regulations, financing, and organisations. Even when GPs found out just who and what was involved, they confronted a bewildering array of options which they said were complex and difficult to evaluate.

These problems are by no means specific to Camberwell. A body with a wider perspective, the Inner London General Practice Premises Unit has identified some of the more extreme problems that general practitioners face[41]. These include: rising costs of property construction and land which are, in any case, above average in London; a diminishing number of suitable sites and properties, due both to little undeveloped land remaining and existing buildings being unsuitable for development; vandalism and harassment; and costs of vacating rented premises which have to be restored to previous use.

To the project a major component of the problem appeared to be confusion over what help was available. GPs have no professional expertise in this area, nor should they be expected to have. The needs of practices vary considerably; possibilities and problems in development may be quite different in one part of London from another and financial assistance is subject to numerous, often obscure conditions. GPs need specialist advice on the financial and other implications of their options. They should also, if they are to develop good primary care, have access to data on the size and characteristics of the population they serve.

In 1985, when the project began to consider how to respond to problems GPs were having with premises, there was national concern over the issue. The spiralling price of land and buildings in inner London made the allowances available to GPs inadequate to cover their costs. At that time, however, the development of GP premises was not a priority for any of the authorities locally responsible for the planning and organisation of primary care.

Where angels fear to tread

On the face of it the role that the project ought to be playing on the issue of GP premises was straightforward enough:

to examine the options available, their local implications and the role of agencies involved to see what steps could be taken towards a more rational development and distribution of general practice and primary care buildings in Camberwell health district.

In June 1986 the project invited all local GPs and representatives of the agencies which seemed to be relevant to premises development to a halfday meeting. Those who attended included: Lambeth Directorate of Town Planning and Economic Development, Southwark valuer and property surveyor, general practitioners, the medical architecture research unit of the inner London GP premises unit, and the family practitioner committee. These five furnished speakers for the meeting. Others attending included health authority community unit representatives, the district valuer from the Inland Revenue, representatives from the DHSS, the regional medical officer, the local community health council, and housing associations.

The aims of this meeting were:

1. to share the experience of GPs of premises development;
2. to look for 'models of good practice' which could be useful to GP colleagues from Camberwell and other parts of London;
3. to make GPs aware of the numerous agencies that can be involved in premises development, particularly the Inner London GP Premises Unit which had hitherto been under-used in Camberwell;
4. to make the agencies involved aware of GPs' needs and stimulate them to offer more help and expertise;
5. to encourage agencies to coordinate their efforts and put forward joint procedures on GP premises.

The meeting highlighted the chaos. Services which were available to GPs were disparate and uncoordinated. While some local GPs had improved their premises they did not have the necessary expertise to advise their peers. The meeting, however, did succeed in publicising the roles which the many agencies involved could play in helping practitioners. The following sections describe the agencies' general roles and outline how they have variously helped in Camberwell.

The family practitioner committee

The Acheson report described the responsibility of FPCs as: 'Inspecting medical practice premises and assisting doctors to improve such premises by telling them of, and guiding them through, the improvement grant and cost rent schemes.'[1]

Until 1985 FPCs' official remit in relation to surgery accommodation was very restricted and the committees had insufficient funding, staff or experience to be able to plan a rational distribution of well-designed practices. In Camberwell, past FPC activity on this issue had been minimal. Vacant premises were subjected to an unwritten 'like for like' rule whereby single-

handed surgeries were often replaced by the same type of practice. This philosophy served to maintain inappropriate buildings for primary care without regard for demographic change and the new demands placed on primary care. Since 1985 all FPCs have had a duty to undertake strategic planning and ensure that premises in their area meet minimum standards. A prerequisite to such FPC planning is building up information profiles about practice developments. This is notoriously difficult, yet it is a prerequisite to planning.

FPCs need to know how old general practitioners are. This is a critical variable in planning as it allows for a planned succession. At present, GPs' retirement is to some extent a matter of guesswork for FPCs, but when statutory retirement for GPs is introduced in 1991, they will have a better picture of when and where vacancies for new principals will arise. Anticipated vacancies provide a useful opportunity to review both primary care provision and the siting of services. As can be seen from the graphs below, the age structure of GPs has changed over the last four years, and the effect of statutory retirement of GPs at 70 means that by the year 2000, over 10 per cent of GPs in Camberwell will have retired.

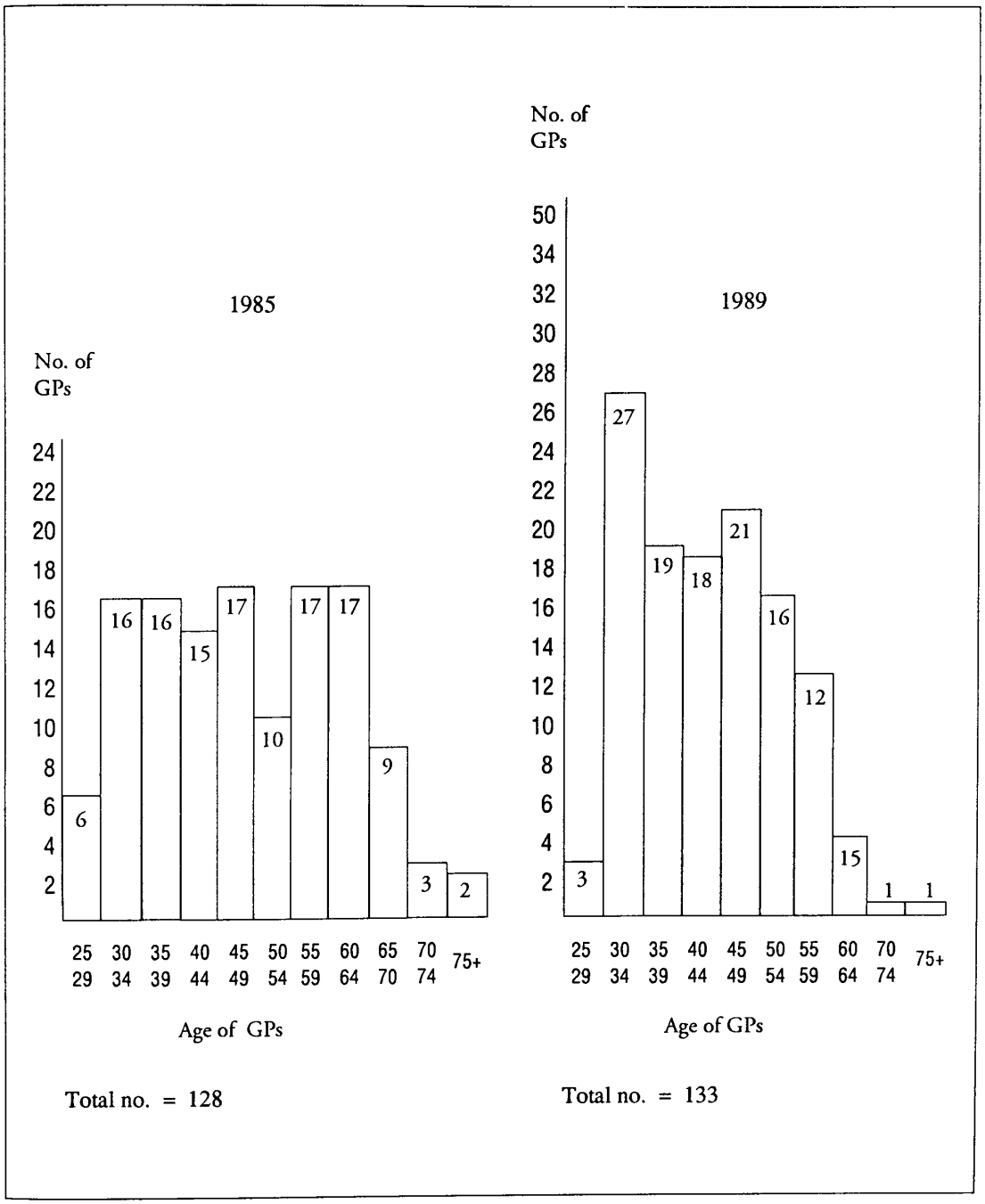
Since 1985 the FPC has played a more active part in assessing the development of practices when changes in personnel occur. Where vacancies have occurred in single-handed practices the FPC has tried to encourage the development of new or group practices by appointing young vocationally trained GPs. On some occasions two GPs have been appointed to share the development of a previously single-handed practice and in one case three single-handed vacancies were reorganised to create two new two-person practices.

While financial incentives certainly help to encourage otherwise reluctant GPs to improve sub-standard premises, it seems doubtful whether such inducements alone are enough to influence the majority of practitioners to undertake major developments of their premises in the future. The financial inducements are overshadowed by the problems of locating suitable premises, liaison with numerous authorities involved and all the other obstacles.

Bewildered local authorities

Local authorities have a big contribution to make in encouraging GPs to improve their surgeries. Borough valuers and surveyors have an important role to play in identifying and developing potential sites for GP premises when plans for new housing are being considered and a neighbourhood's health care needs are being assessed.

Figure 1: Age distribution of GPs in Camberwell 1985 and 1989



Prior to the premises meeting organised by the project, the boroughs of Lambeth and Southwark had no system for contact with local GPs. Representatives at the meeting spoke of difficulties they had had in liaising with individual practitioners who work as independent contractors, as distinct from the majority of their clients which are often organisations such as housing associations. GPs' needs enjoyed precious little official recognition in the local authorities' thinking, as the then director of planning for Lambeth put it: 'There is only one sentence in our planning document about GPs'. Another local authority officer wondered whether GPs should be regarded as entrepreneurs or as welfare agencies.

One of the difficulties for the council departments was that GPs were not visible as an identifiable interest group. Through the liaison meetings set up as a result of the meeting which first brought everyone together, borough representatives have been helpful in supporting GPs proposing developments, providing information on the advisory services they offer, including a computerised system of vacant land by ward, which can be used by any GP through the borough valuer's office, and compiling demographic data for individual practices who request it.

Health authorities

It is impossible to achieve effective long-term planning of GP premises without considering the development of district health authority premises. During the lifetime of the project, there have been increasing restrictions on capital expenditure within the community by Camberwell District Health Authority. Several clinics have been threatened with closure and many of the buildings are in poor repair.

Although several possibilities for joint buildings shared by GPs and district health authority community services have emerged, it is difficult to bring together the FPC and the health authority, given the differences between them in priorities and in arrangements for capital expenditure.

Housing associations: a growing factor

The most common form of collaboration between housing associations, GPs and health authorities across the country as a whole has been where health services and special needs housing have to be jointly provided, often as a result of moves from long stay hospitals to community care. In 1989, as health authority central funding becomes increasingly restricted, it looks as if housing associations will become more and more important to GPs as partners in future primary care developments.

A helping hand

Though not a statutory agency, the Inner London GP premises unit was set up with the aim of providing a comprehensive and independent premises advice service to London GPs. It was the only source of such help. Set up in 1983 in the medical architecture research unit of the Polytechnic of North London, it was at first funded by the King's Fund and then received DHSS funding until 1988. GPs could seek free advice on issues such as how to buy a specific property, how to improve existing premises, how to find a site, how to liaise with local authorities, and how to interpret cost-rent allowances.

Enquiries from Camberwell GPs to the unit included requests for comments on architects' proposals, advice on how to modify, extend or rationalise use of premises, and advice on the improvement grant scheme. Practitioners have also asked for the unit's opinion on the potential of a house for modification under the cost rent scheme, for alternative proposals for rebuilding of premises on an existing site, and so on.

As a consultancy agency both to individual practices and to other organisations, such as FPCs and health authorities, involved in developing premises across inner London, the unit offered skilled architectural advice and a detailed and comprehensive knowledge of health premises planning and development. This breadth of experience with different organisations across inner London provided an expertise which was able to develop solutions in a way which was unlikely to occur to agencies with a narrower perspective.

Since January 1989 DHSS funding has been withdrawn and staffing has been reduced to one consultant working privately.

The next steps in Camberwell

The meeting served to highlight the very differing perspectives of the groups and the narrow definition of their responsibilities which allows them to develop services on sites in isolation from one another. It made everyone realise how important it was to overcome the enormous barriers to good liaison. It was agreed that some form of joint working between the FPC, Camberwell DHA and the two local authorities was needed to begin to plan developments in primary care premises and to rationalise the help available to individual GPs.

In September 1986, it was decided to follow the example of City and East London FPC, which together with representatives from the London Borough of Hackney, had set up a 'liaison group' to tackle premises problems. The project sought to set up a group with representatives from Camberwell district health authority, the boroughs of Lambeth and Southwark, and the FPC, which covers the local authority areas of Lambeth, Southwark and Lewisham. Immediately the fact that the boundaries of the areas covered by these bodies do not coincide led to difficulties. Camberwell health district is, for instance, within parts of both Lambeth and Southwark boroughs, but any decisions taken by these boroughs also affect the health authorities of West Lambeth as well as Lewisham and North Southwark. The FPC boundaries cover the three entire boroughs of Lambeth, Southwark and Lewisham (see map on page 11).

The whole point of having a liaison group was to bring key representatives of relevant agencies 'face to face' for effective discussion. The group was therefore expanded in 1987 to include representatives from the borough of Lewisham, the additional local authority and the other two health authorities included within FPC boundaries, together with representatives of all three community health councils. The group became known as the strategic liaison group. It now has bi-annual meetings to discuss policy questions. Its most significant achievement has been the policy statement reproduced below. In order to make councillors and FPC members aware of the premises question, the document was taken to full planning committees at all three local authorities, and to full committee member level at the FPC. However, with the health authorities, it has remained at officer level with the community units. It has been endorsed by the three boroughs of Lambeth, Southwark and Lewisham, the FPC, and by the officer level district health authority committees.

Policy document

Aims

- ★ To raise the quality of premises for primary care in the area.
- ★ To create opportunities in which appropriate developments can take place.
- ★ To consider jointly all proposals for premises developments from those organizations taking part in the group. It is hoped all organizations will feel able to discuss their development proposals with the group before deciding on a single course of action if the spirit of collaboration and co-operation is to be maintained in practice.
- ★ To achieve equality of opportunity in access to services across the district.
- ★ To promote improvements in premises in areas where developments are most difficult.
- ★ To encourage the principle of inter-organizational working. This might be repeated in other areas of developing primary care in inner cities.
- ★ To act to try to solve the problems associated with individual practices/ clinics looking to make improvements or move premises within the framework of an agreed strategy.
- ★ To gather and maintain a detailed and quality information base of:
  - (i) present buildings and services in Camberwell;
  - (ii) all future developments which may affect the provision of premises for primary care.
- ★ The need to discuss sensitive information within the group is clear if goals are to be achieved. All information brought to the group is considered to be given in confidence.

Recommendations

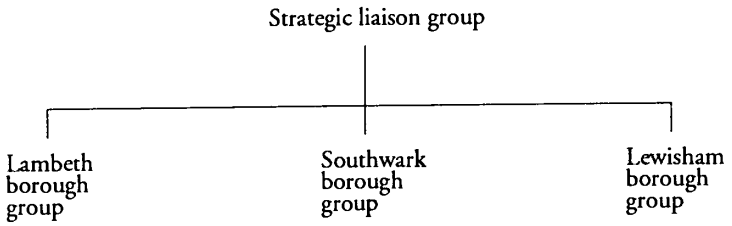
The strategic liaison group with representatives from the family practitioner committee, district health authority, local authorities and Camberwell Primary Care Development Project be formally established to:

(a) compile information about present primary care buildings through continued review;
(b) consider all individual applications for new and improved premises from GPs;
(c) act as a liaison forum for all premises developments relevant to primary care;
(d) examine areas with particularly poor premises and high social deprivation;
(e) prepare detailed guidance on availability of funding for projects and desirable standards of construction;
(f) look at future demands for general practitioner and primary care premises;
(g) develop a programme of improvements in GP and primary care premises.

Borough groups tackle specific problems

Since the size of the strategic liaison group and the infrequency of its meetings made it an unwieldy body for tackling GPs' specific problems, borough-wide meetings are now held every three months run by the FPC.

Structure of liaison groups on premises



These groups consist of: the FPC; borough valuer representatives; the district valuer (from the Inland Revenue); community health services planners and local authority planners; and CPCDP representatives and/or GP facilitators. Each borough is divided into four localities and the problems of GP premises within each are reviewed. These meetings are given tight agendas in order to tackle the very specific problems of one area at a time.

It has been difficult to get the right balance of representatives: for example, there are times when someone from community health services with good local knowledge is needed and other times when a wider strategic view is desirable. Similarly, continuity of membership has been difficult to sustain since these are quarterly meetings and sometimes the authorities concerned have not delegated the right person for the meeting. How to decide which GPs' premises need to be developed first has not yet been resolved and priorities are still to a large extent determined by the demands of the more motivated GPs.

Tailor-made support for GPs

Where it has proved impossible to solve the problems of particular premises in borough meetings, or when the group has felt an opportunity has arisen that should not be missed, the GPs are invited to a meeting with representatives of agencies. These meetings have sometimes only been concerned with supporting the GPs concerned to pursue a course of action, although this in itself has been important in moving developments forward. In most cases, revisits have been made to the particular premises to review the situation and discuss possibilities with individual GPs. Once a plan of action becomes clear, these groups have been disbanded.

What has been achieved?

The current arrangement of working groups at different levels has required an enormous amount of work and commitment on all sides. While the structure is relatively simple, it has allowed for progress on different fronts, from broad-based borough policy to work on the problems of a particular practice involving staff from various agencies. The benefit of the strategic liaison group has been to get together individuals who might otherwise never meet, encouraging officials to leave the confines of their organisations and consider the priorities of others. Because of the different political agendas of the FPC, the local authorities and the district health authorities, negotiations between these organisations are not always smooth.

The borough-wide groups were set up to give joint consideration to specific proposals. The local authorities' contribution has been central by offering GPs news of important developments, such as new housing estates which could overstretch GPs, as well as notice of vacant sites and details of the planning process. The FPC can then act as a link as to how best to apply for planning permission. However, the FPC's continuing reluctance to set priorities in taking up the problems of particular practices means that help may still not be getting to practices in areas of most need. Rather than the FPC and therefore the groups actively promoting improvements in premises which are worst and/or are in areas of highest social need, the groups still have a large number of premises in active change to discuss from each locality, at every meeting.

The location and design of primary care facilities and GP premises directly affects the users of health services. For example, mobility and access to buildings pose major problems for the elderly, the disabled and those with young children. Women are major users of health services, especially as carers of other adults, people with disabilities and children. Promoting equality of opportunity in terms of access to primary health care services is now an objective of all the organisations involved, mainly as a result of prompting by local authority representatives.

It is hoped that enabling information to be shared between organisations will make the advice given to individual practices more appropriate and

consistent than before. Confidentiality in meetings has been important in ensuring a good exchange of information.

Room for improvement

A management information base about all practices, their premises and plans has yet to be developed. This needs to be gathered from professional and community sources of the highest quality and regularly updated in order to assess individual requests for help with improvements to premises. Information needs to be collected on practice needs, current services, plans to improve, in addition to practice population details, such as increasing numbers of over 85s, and levels of social deprivation. In the long term this could be combined with district health authority details of clinics – where they are, what services they offer and local authority housing and development plans. The level of time, expertise and resources needed to produce and maintain such a base should not be underestimated. However, the advantage it would offer organisations in planning cannot be understated, particularly for the FPC.

Strategic planning has still to become a reality. According to the (1989) White Paper, money for cost-rent schemes will be limited and FPCs will need to decide between competing applications. It is difficult to see what criteria they will be able to use to select. They will need both resources and staff, to collect data, process it and make use of it. District health authorities and, to some extent, local authorities, are notorious for their crisis management, now exacerbated by recent cutbacks. Working jointly in the long term around specific issues such as premises may help to identify opportunities for developments and thereby lead to planned capital investment in the primary care building stock.

The local FPC has completed a review of all premises in its area. After a visit from an officer of the operations section of the FPC, premises have been placed on a four-point classification from cost-rent equivalent to minimum standard. This may roughly indicate a priority classification, but does not give information on the size of a clinic or surgery, services offered and where, the facilities, size of rooms and the restriction that all these factors place on further services and staff. Nor does it allow for comparisons to be made between premises. The FPC does now have information on list sizes, ancillary staff, and so on but it is held in different files, is difficult to access, and is not combined to give a full picture of premises and practice organisation. The lack of computerised management information for FPCs is clearly an important factor.

Detailed guidance on funding and construction standards has still to be tackled. Information sheets on the services offered by Lambeth and Southwark were prepared by CPCDP, and the Inner London GP premises unit has compiled data on funding sources and other help.

Wider lessons

The priorities of the district health authorities, the FPC and GPs still differ with regard to primary care premises developments. It is ironic that while national policy documents and other policy research constantly underline the need for teamwork in primary health care and acknowledge the need for adequate premises to achieve it, there is little national commitment to help GPs to develop or change premises, other than some additional monies for inner London. Not surprisingly, in such a context it is difficult to get health authority staff to contribute to meetings which they do not see as directly relevant to their day-to-day work, even though members of the primary care team other than GPs are employed by the district health authority. Shared information and early joint planning between community health services and general practitioners is essential.

The cost-rent scheme will be changed to make allowance for the high cost of sites in London, but is unlikely to cover costs incurred by GPs, ie the extra costs of London over and above those incurred elsewhere in the UK. Despite the problems, an analysis of cost-rent schemes indicates that there has been a significant increase in the number of applications submitted over the last two years by local GPs wanting to improve the premises from which they practise (see Table II).

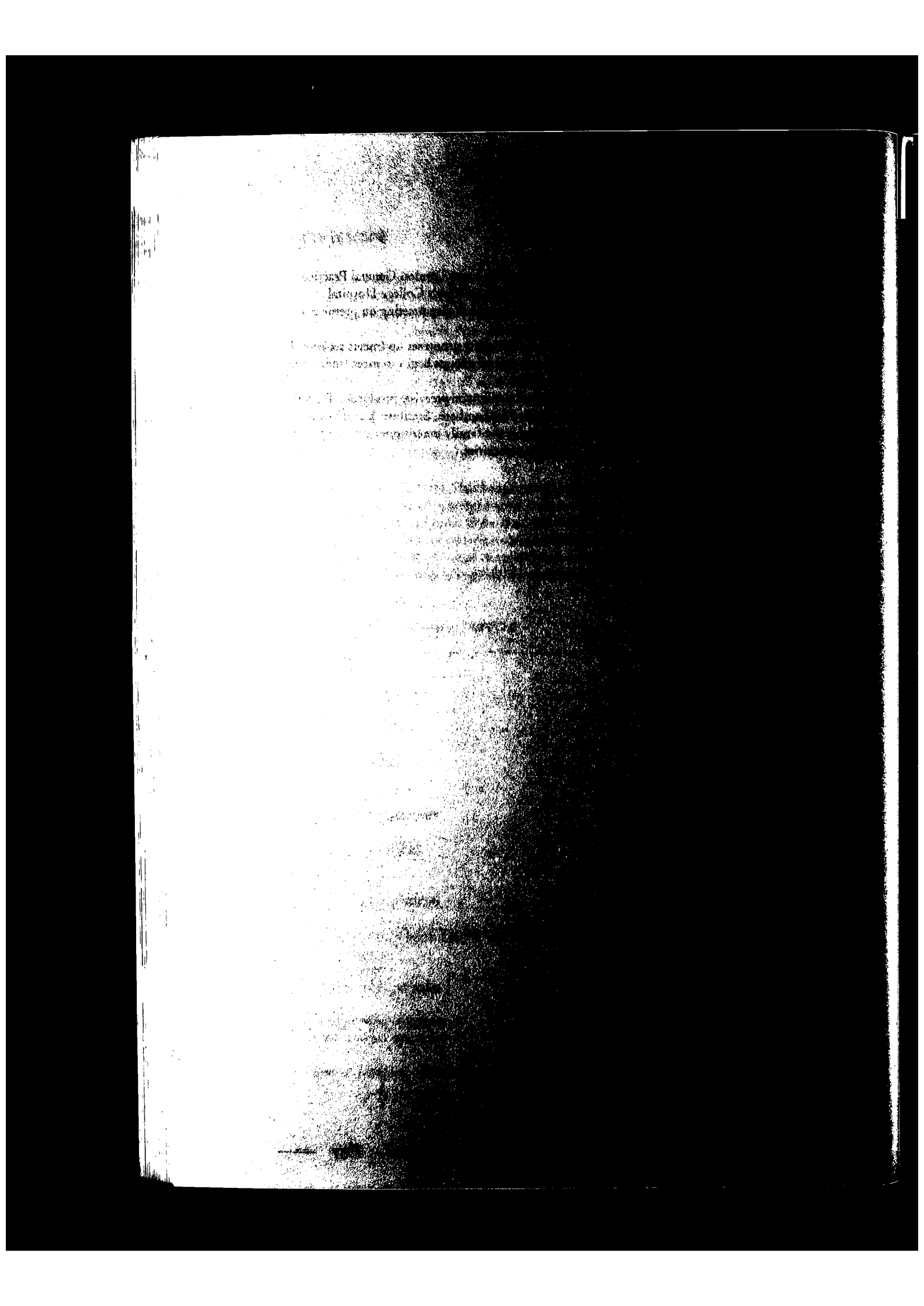
Table II: Cost rent schemes 1985 – 8

	Changes 30/6/85-30/6/86	Changes 30/6/86-30/6/87	Changes 30/6/87-30/6/88
CAMBERWELL			
– in progress	0	11	12
– completed	4	5	5
Total number premises	49	56	55
WEST LAMBETH			
– in progress	0	6	7
– completed	3	4	4
Total number premises	42	43	42
LEWISHAM & NORTH SOUTHWARK			
– in progress	3	11	13
– completed	7	11	11
Total number premises	84	80	87
Total number cost rents	17	48	52
Total number premises	175	179	184

Source: Lambeth, Southwark and Lewisham FPC annual reports, 1986-9

Chronology

May 1986	Exhibition by Inner London General Practice Premises Unit at King's College Hospital
June 1986	CPCDP holds half-day meeting on premises in Camberwell
September 1986	Strategic working group set up (meets six-monthly)
December 1986	Three borough groups begin to meet (meet three monthly)
March 1987	Policy document on premises produced. Document approved by Lambeth, Southwark and Lewisham boroughs, the family practitioner committee, and health authorities.



CHAPTER 7

NURTURING THE SEEDS OF TEAMWORK

A large slice of the project's work has been spent exploring the barriers to the development of primary care teams, and finding ways of encouraging Camberwell GPs to work more closely with primary care professionals. The reason for making this a priority for the project has been partly the CPCDP's support for the widely accepted health service policy that 'a team is the most appropriate setting for the provision of coordinated health care to the majority of the population'[1] (para 5.1). Teamwork in Camberwell is still under-developed. Secondly, interviews with GPs showed that they themselves were concerned about unsatisfactory working relationships with professionals who were potential members of the primary care team.

Many GPs did not know how to contact district staff such as physiotherapists and speech therapists, or how to contact social workers. GPs reported good links with district nurses, although the time district nurses actually spend with GPs in their surgeries is limited, and because of staff shortages is often intermittent. More fundamental was the confusion in GPs' minds about the role of other primary care workers and how their work was or could be linked to the work of a GP. Counsellors and community psychiatric nurses seemed to be especially mysterious groups, it emerged from the interviews. Only a few GPs said that they could not see any need to develop relationships with other professionals, but no one was opposed to the idea. Those who had attached liaison staff found working together useful, if not essential.

Teams in inner cities

If general practice is to shift away from its traditional emphasis on providing treatment for patients, to a more preventive and anticipatory care role, it requires a range of services beyond those which a medical practitioner alone can provide. Nowhere is this need more evident than in socially deprived areas of Camberwell health district such as Brixton and Peckham, where the needs of residents are too many and varied to be dealt with by a single discipline. In Camberwell the number of single-handed GPs has fallen from 23 per cent of all general practitioners in 1984 to 14 per cent in 1989, although GPs have moved into partnerships rather than large group practices. There are currently nine full-time health visitors attached to practices, and three part-timers; the remainder of the 56 HVs in the district work from community clinics. All district nurses in Camberwell are aligned to general practitioners. In July 1989 there were 16 practice nurses in Camberwell, none of whom worked with single-handed practitioners.

GPs' links with other professionals are patchy. All but a few social workers work from local authority social services departments. There are at least four practices in the district employing counsellors, according to research by Dammers in the medical school's department of general practice, and one full-time psychologist whose employment is shared between three practices and the district health authority [42].

Selecting the professionals

There are many professionals besides GPs whose skills could be used in a primary care team:

Audiologists	Midwives
Chiropodists	Physiotherapists
Community psychiatric nurses	Psychologists
Practice managers	Continence advisers
Practice nurses	Counsellors
Receptionists	Diabetes health visitors
School nurses	Dietitians
Social workers	District nurses
Speech therapists	Health visitors
Stoma care sisters	Macmillan care team.

Taking account of the project's resources and influence in 1985, the method chosen to tackle the issue of teamwork was to examine the relationships between GPs and one other professional group. Project members believed that exploring the issues and strategies for the promotion of teamwork which this threw up, might shed light on wider questions and might also stimulate the professionals themselves to begin to work together.

Why health visitors?

Camberwell health district has a high proportion of young and single parent families with high fertility and abortion rates, and high incidence of child abuse. In interviews, general practitioners had indicated a wish for closer links with health visitors who have particular responsibilities in these areas. Secondly, when the project turned its attention to the question of 'teamwork', only seven of the 56 health visitors in Camberwell were attached to general practices in the sense that they worked on the same site as part of a named team, compared to district nurses who were all 'aligned' to practices, that is, as part of a named team but not working on the same site. There were very few practice nurses employed locally at all.

What's more, the district's director of nursing services (health visiting) supported the idea of stimulating collaboration between general practitioners and health visitors. For all these reasons, health visitors seemed a promising professional group on which to focus.

Health visitors are employees of the district health authority. In Camberwell most cover a 'geographical area', and have a caseload of clients drawn from different GP practices. Some health visitors have as many as 15 or 20 GP practices on their 'patch', with whom their clients are registered. Practices with an 'attached' health visitor are either the large group practices or those who are deemed 'good' practices by nurse managers.

Wariness among health visitors

To complement the information from and perception of GPs, the project conducted interviews with all community nursing managers. Senior nurses recognised that collaboration was poor. In part they blamed this on GPs' attitudes, but they also felt that because of understaffing, recruitment problems, and chronic lack of financing, as managers they had had too much stress and too little time to promote alternative ways of working.

Some also expressed concern that, in addition to the difficult logistics of attachment, health visitors working in GP surgeries could become isolated and there was a danger that the duties they undertook might come to reflect GP needs rather than the policy of the health visiting service. If 'attachment' worked out badly, nurse managers were worried that the only response which the health visiting service could make would be the negative one of withdrawing staff. It was clear that, in 1986, when the interviews were conducted, there was no clear policy on continuity and liaison with GPs.

As well as interviewing managers, the project asked the senior nurse responsible for the four health visitor areas within Camberwell each to nominate four health visitors to be interviewed in 1986. Despite their obvious commitment to the job, morale among health visitors was low: they particularly mentioned the fear of violence, and the pressure of crisis-led work. Staff turnover was high and caseloads heavy, a reflection of working in a deprived area.

Most HVs simply did not meet with GPs locally; some had never been in a surgery except as a consumer. One summed up the contact: 'My relationship with GPs here is nil; I have been here two years and I have only contacted GPs for my clients about ten times'. Geographically-based HVs felt they were able to get to know an area well, and build up contacts in it. Sharing an office base with other health visitors reduced professional isolation. Some HVs mentioned that they enjoyed the professional autonomy of working 'freelance' and were concerned that attachment to a GP would impinge on their style of working and affect the kind of care they offered clients: 'GPs can strike clients off their register ... a lot of homeless people would be lost, these are families in greatest need'.

Apart from the administrative difficulties of contacting GPs, there was a general impression that GPs were not interested in collaboration, and put no effort into fostering it: 'We had to 'phone them and it was all obstacles. Professionals were downgraded and quite often you'd have to loiter in the corridor waiting for the GP to be free. You felt like the milkman waiting to collect your money'. Pressure of work left health visitors with little time to dedicate to working on this area, and they were critical of their management structure for not taking up the issue: 'Our health visitor management doesn't support communication with GPs at all. It could be very much more supportive and really we are left out in the cold'. They felt their professional training did not equip them well for the job they had to do, and subsequent in-service training was seen to be limited.

Despite such experiences, health visitors were generally keen to meet GPs and welcomed the suggestion of joint educational forums: 'It's a great thing and I would welcome anything new which would broaden attitudes but I don't know what they'd think about doing things with us'.

Ice breaking

The view which emerged from the interviews was that the majority of general practitioners and health visitors wanted closer working links, though not necessarily wholesale attachment. Working against this general move in the direction of teamwork stood the conflicting demands and structure of the respective professionals' work. The barriers to improving contact and collaboration were also being strengthened by widespread misunderstandings about what the other group did and how.

The project decided to break the ice by bringing local general practitioners and health visitors together to meet and discuss issues of common concern. The decision to call this an 'educational forum' or study day was based partly on the experience of being in an academic department, which meant the project knew it could attract general practitioners to educational meetings, and partly as a response to the health visitors' own requests for joint in-service education. Such a meeting had the practical merit of being something which was realistically achievable within the project's scope and resources at that time.

Friend or foe? The study day

Information from the interviews was fed back to nurse managers and their support obtained for a study day of GPs and health visitors. To ensure this day would be relevant and interesting to the participants it sought to influence, the project followed the example of Tower Hamlets health visitors [43] and set up an organising committee of two GPs and four health visitors, one of whom was a manager, which set the aims for and ran the study day, under the title of 'General practitioners/health visitors – friend or foe?'. The small organising group defined the aims of the study day as follows:

- ★ To allow for 'face-to-face' meeting between health visitors and general practitioners in comfortable surroundings.
- ★ To allow for recognition of each other's professional strengths and difficulties in achieving and maintaining high standards of care and commitment in areas of high social deprivation.
- ★ To reflect on their strengths and start to solve jointly the problems they face.
- ★ To offer an opportunity for GPs and HVs jointly to discuss the organisation and planning of services at the present time and for the future in a realistic framework.
- ★ To develop new alternative and innovative ways of tackling problems and offering solutions.
- ★ To encourage better liaison in the long term between the two groups.

To encourage everyone attending to participate, the numbers and range of those invited was restricted: 17 GPs and 18 HVs attended. An exhibition at the meeting showed the characteristics of Camberwell and the areas of overlap between the work of GPs and health visitors. The meeting focused on the similarities and differences between the roles of HVs and GPs and on social conditions in Camberwell, with participants being asked to discuss how teamwork could be improved.

Feedback from the study day confirmed the mutual misunderstanding that had been detected in interviews. GPs were taken aback by the strength of HVs' feelings. One GP wrote: 'Shaken by the HV view of GPs, but found it interesting. Enjoyed the chance to meet HVs and discuss'. An overall willingness to see 'the other side' came across strongly. A health visitor reported that she had particularly enjoyed 'the small group sessions, because it allowed me to get to know more about them and discuss with them informally and in a relaxed way'.

Most of the GPs attending had previously met one or two of the health visitors, but only two GPs had met more than five. Nine of the HVs said they had not met more than two GPs. The strong opinions held about the other group were, it seemed, based on very limited contact.

From this day a list of recommendations was compiled:

Recommendations from the study day

1. That the themes emerging from the joint study day be considered by a mixed group of senior officials and members responsible for Camberwell. Participants from the DHA and FPC would be invited.
2. That annual joint meetings between health visitors and general practitioners be organised on issues of relevance to both groups.
3. That a small mixed group of eight to ten GPs and health visitors meet regularly to consider liaison and communication issues and other relevant issues and that this group have access to the planning cycle of the relevant authorities.

4. That 'locality' meetings for GPs and HVs be established and that time and priority be given to these meetings.
5. That when new staff come into post on either side they are given the time, opportunity, encouragement and support to develop teamwork in their locality.
6. That the model of general practitioners and health visitors jointly planning their own in-service education be continued and built upon.
7. That multi-disciplinary meetings be organised to include other members of the primary care team such as midwives, district nurses and social workers at a local level.
8. That an overall review of the basic paper information exchange between GPs and health visitors takes place, i.e. lists of health visitors' names and addresses sent to GPs and vice versa, and procedures for information about children sent between GPs and health visitors reviewed.

The first of these recommendations was fulfilled when the organising group presented a review of the study day to a joint meeting of the FPC, community and priority care unit general managers, and nurse managers. Managers supported the recommendation for 'locality meetings' and an increased sharing of information.

Face-to-face and local

The organising group has developed a system of quarterly small group meetings. To avoid creating another boundary these are held within four geographical localities of the health visitor units. Meetings are held in clinics or surgeries in turn, to enable participants to see the working environment of colleagues and become familiar with different premises. Participants are encouraged to attend in their own locality, but where they cannot, they can attend elsewhere.

The principle behind the meetings is that colleagues working in the same geographical area have an opportunity to meet face to face on a regular basis, and to discuss topics of common concern. At first the same topic was discussed at each of the meetings for that quarter, for ease of organisation, but this has changed to different topics to give variety and to avoid overloading specialists who are occasionally invited. Topics are chosen by participants themselves and areas covered so far are shown below.

Table I: Topics discussed at joint GP/HV meetings 1986 to 1989

Child sexual abuse	Race and health	Vaginal discharge in children*
Domestic violence*	Dealing with violence*	Well women and health promotion
Travellers' families	Vaccinate in '88	The naughty child
Hearing testing	Homeless families	The ill baby/young children
Post-natal depression	Tranquilliser use in families	Infant feeding
Sleep problems in children		

(* Meetings held subsequent to the evaluation project)

The meetings are structured around a case presentation by a general practitioner and a health visitor during which their professional skills and role are discussed and any resource people present, such as an invited specialist, are invited to comment. This method encourages participation and is a formula which has proved relevant to the practical work experience.

After a year, one of the locality groups became too large and was split into two. The meetings of the five different groups vary. Two of the groups, one from the affluent, southern part of Camberwell and one from the deprived Brixton area, are functioning well, in the sense that there is a continuity in the attendance of GPs and HVs. This, the project members believe, has encouraged a steadily rising standard of discussion. Conversely, two of the groups are having difficulties in achieving regular attendance, which makes continuity and cohesiveness hard to foster.

A team approach to child abuse: a study day

Following up one of the recommendations from the first study day for multidisciplinary meetings, a second study day was held about one year later, over two half-days. An equal number of GPs and HVs attended with child protection specialists from the police and local authorities, social workers with experience in the field, and representatives from Inner London Education Authority.

A case presentation by GPs and HVs was followed by small group work. During the second afternoon the responsibility of professionals to themselves and to their team was examined and working networks in primary care considered as a means of overcoming the barriers to communication. Evaluation

indicated that interchanges with those from other disciplines had been one of the most enjoyable parts of the days.

What had the project achieved?

A nursing student undertook a small study to evaluate the success of the regular GP/HV meetings. In summary she concluded that: 'While the study was unable to show the extent to which the Camberwell Primary Care Development Project has had an impact on improving teamwork within the district, it has identified other positive outcomes from the seminars. Expectations of obvious and immediate changes as a result of the meetings were perhaps unrealistic but small and slow developments are being made. Contacts between health visitors and GPs have definitely increased and the seminars have achieved the aim of increasing face to face contact between team members. They have provided a forum for GPs and health visitors to gain knowledge of one another's views and for exchange of practical information. It has been possible to generate the idea of shared areas of interest and promote the idea of continuing education to keep up with new developments' [44].

The marked variations between localities, and the fact that some topics were discussed only once, whereas others were considered by all the groups, made it hard to compare the success of the various groups. 'Travellers' families', for instance, was a one-off meeting of particular relevance to Southwark, while there have been four meetings on 'Vaccinate in '88'. From comments made, the meetings up to December 1988 which were best received were those which bear direct relevance to day-to-day work experience, e.g. Vaccinate '88 and those in which participants receive practical local information, eg addresses for referral. The project's choice of study days as a mechanism for examining the relationship between GPs and HVs has been a realistic approach both in terms of the capacities of the CPCDP and in view of the nature of blocks to teamwork which the project identified. There was indeed little alternative. At the time that the project started this work in 1986 it had very little influence to work effectively with management on their attachment and alignment policies.

More effective joint working between GPs and health visitors requires a change in the organisation of health visiting, since named liaison makes more sense with more group practices. Alignment or attachment policies require strategic planning and co-terminous boundaries for GP catchment areas and health visitor patches. As these factors change GPs and HVs will increasingly find themselves on the same premises. But until this becomes the norm, the project has shown that the two groups can share views and experiences in a fruitful way. The regular meetings have also served to respond to health visitors' requests for more education, and to foster links between the project and Camberwell DHA's nurse management.

Adverse side-effects

Three negative points have emerged which are worth mentioning. The first is the amount of time spent organising more than 20 meetings a year. This is certainly time-consuming. Five locality groups meeting quarterly, each requiring venues to be arranged, suggestions for topics to be followed up, speakers to be found from participants, and help with the mechanics of presentation, organising food and arranging invitations. It is the project's time which has been absorbed in achieving all this. The second difficulty relates to frustration for the project in assessing success. It is hard to know whether the current increasing contact in meetings between GPs and health visitors is leading to more collaboration in day-to-day working. If so, or if not, how long should such a shift in practice be expected to take? A more detailed review of working patterns is necessary to assess the effects of our work in this area.

Lastly, more fundamental changes will also need to take place within primary care teams if health visitors are to be allowed to fulfil their potential as health educators and be taken on board as colleagues and co-workers with GPs within the primary care team.

Moving on: practice nurses

With the work on encouraging teamwork between GPs and health visitors underway, the project was asked by the FPC to turn its attention to practice nurses. At the time of the interviews with GPs in 1985/86 very few practitioners employed or had experience of working with practice nurses. Many wanted more nursing support within the primary care team, because they recognised this as a way of developing new patterns of care.

In a survey in autumn 1988 [40] on how local GPs were planning to develop their services, and their relationship to Camberwell district health authority, the project had an opportunity to include questions on whether or not GPs employed a practice nurse and the duties they would like nurses to perform. Results showed that 45 per cent of respondents wanted to employ a practice nurse, but had been unable to. The major reasons given for this were (in priority order) inadequate space in their surgery, cost, and recruitment difficulties.

How nurses are employed by GPs

FPCs offer a reimbursement scheme to GPs to encourage them to take on ancillary staff up to a maximum of two full time staff per practitioner. Under this scheme, principals in general practice can claim 70 per cent of salaries and 100 per cent of National Insurance contributions for specified staff who work a minimum of five hours a week and are employed in either nursing and treatment or reception and secretarial duties.

The view of practice nurses

To find out how practice nurses in Camberwell viewed their role, in May 1988 the project interviewed nine of the twelve practice nurses identified as working in the district. This work was funded by the FPC, which wanted to find out why there were so few practice nurses in order to encourage greater uptake of the ancillary staff reimbursement scheme.

The nurses interviewed had been in post from between six weeks to nine years. Most learned of opportunities through chance meetings or personal contact: 'I hadn't actually thought what a nice job it must be to do that type of work. I think it's word of mouth, or a little ad stuck in somewhere'. All these nurses had some experience of qualified hospital nursing and it was dissatisfaction with this which had prompted some of them to look for community-based work. Others had gone into practice nursing part-time on their return to work after absence.

The nurses undertook a range of activities, from changing dressings to running well woman clinics: 'I concentrate on the treatment rooms, so I will be doing the bloods and the immunisations, syringing, checking blood pressures – and any situations that crop up if the doctors are under pressure'. Another reported: 'In the afternoons I do mostly screening work, to do with diabetes, hypertension, family planning and immunisations ...'.

Most worked solely from the practices, but some did occasional home visits and others thought this could be an important part of their work. All the nurses reported very good relationships with GPs, and in some cases a considerable degree of autonomy in the work they did. One commented: 'We are just so fortunate here to have such an accessible, helpful team, and the doctors are so good that it makes a tremendous difference to the way we work'. Another said: 'The doctors have said that I can have a free rein, basically set things up as and when I want, but obviously I will go back to them when I have finally decided what I want to do.'

Relationships with other members of the primary care team seemed to vary according to the way the practice was organised. Where health visitors were attached, district nurses seen regularly or where there were joint patient-orientated meetings, relationships were very good. According to one practice nurse: 'I have a good working relationship with the people who share my room, ie the health visitor and the district nurses, and that's very fortunate. I think it's something you have to work at.' Another remarked: 'I think you could get very offhand with somebody who breezed in once in a while and did their clinic, and breezed off again.'

There was quite a lot of uncertainty about the nurse's role in certain areas, particularly immunisation, shared care and counselling. There was no common training – some of the nurses were trained by other members of the primary care team, but almost all of them wanted more.

Isolation was a major problem: some of the nurses had attended forums at the Royal College of Nursing, or knew a small number of practice nurses in the area to whom they turned for support and practical advice if needed. Others felt anxious: 'I just worry about getting narrow-minded, and set in my ways, and not meeting anyone else much or no one telling me what I should be doing'.

Breaking down the isolation

The practice nurses' enthusiasm and commitment to flexible working with other team members and their wide range of skills came across strongly during the interviews. What also emerged, however, was their sense of professional isolation from other practice nurses and their uncertainty in some clinical areas.

There seemed good reason to suppose that the Camberwell nurses' experience of practice nursing was common to practice nursing itself. In order to establish whether a regular lunchtime meeting for practice nurses would be welcomed, the project organised a trial meeting on immunisation and vaccination, a topic which the nurses had shown concern about during interview: this meeting was well attended and the forum was therefore set up to offer an opportunity for nurses to meet regularly.

The nurses were also invited to a meeting to identify more closely their skills and the areas in which they felt they needed further training. The range of skills or roles noted are shown in the table below:

Table II Practice nurses' skills or roles

Abnormal cervical smear follow-up	Child development clinics	Infant immunisation
Abortion counselling skills	Diabetic shared care	Midwifery
Allergy testing	Diet advice	Plastic surgery and burns (one nurse had specific skills in this area)
Anorexia counselling	ECGs	
Ante-natal	Exercise class	
Audiometry	Family planning – comprehensive – counselling	Weight loss – groups and individuals
Blood pressure screening	Well men	

The nurses also made a list of skills and areas which they wanted to learn more about, as follows:

Assessment and management of common childhood illnesses
Asthma care in the practice
Contraception
Counselling, psychotherapy, stress management
Diabetic care
Health education
Management of leg ulcers

Organisation and administration in primary care including use of computers
Physiotherapy
Research methods and audit
Resuscitation
Suturing and minor operations
The 'extended role' of the practice nurse including legal considerations
The practice nurse as teacher
Well man/well woman.

Nurses develop their skills

This list gave the project a base on which to plan meetings. For the first meeting, the nurses chose the subject of positive health screening and wellwoman clinics and for the second diabetic shared care. Their interest in teaching was an unexpected finding which it was felt needed to be further explored.

The project's approach to policy with the practice nurse groups, as with other groups, has been to centre meetings around a presentation by one of the nurses taking part who is experienced in the area in question. This makes meetings relevant and gives nurses an opportunity to develop their skills in case presentation. In describing their work, the project has encouraged nurses to bring in audit and review at all stages.

Attendance at these meetings now averages around 25 - 30. Nurses from outside the district have learned of the meetings through colleagues. Practice nurses are also invited to the 'Meet the Department' meetings (see Chapter 2, page 17), and to diabetic shared care meetings.

Opportunities for training

There is a clear need in Camberwell and nationally for comprehensive nurse training. The nursing department at South Bank Polytechnic, the newly appointed community nurse tutor from Camberwell and the project have together developed a joint 15-day course for nurses with English National Board approval. The course focuses on experiential learning and is suitable both for those already in post and for new recruits: it aims to be self-financing.

The development of primary care teams and a practical exploration of the barriers to their development has been a major focus of the project. The relationship between GPs and health visitors has highlighted the need for more liaison and joint working between different groups of primary care professionals. Feedback from the project's work with practice nurses has demonstrated this group's felt need for further training. The lessons from both these areas of work underline the need for service development in general practice to be linked to the professional development of the service providers. It is also clear that the project's work reinforces the view that for the extended range of primary care services to be provided will require a range of health professionals to combine and complement each other's skills in a flexible, cooperative way.

Chronology: teamwork

	Work with health visitors	Practice nurses
May/June 1985	Interviews with community nurse managers	Work begins on draft proposal for joint employment of practice nurses between Camberwell DHA and FPC
September-December 1985	Interviews with health visitors	
Spring 1986	Feedback from interviews to nurse managers Committee to organise joint educational meetings set up	
November 1986	First HV/GP study day	
March 1987	Meeting to review study day with FPC, community and priority care unit general managers and nurse managers	
June 1987	Joint GP/HV local groups set up Quarterly meetings begin	
March 1988	Second study day	FPC funds CPCDP to investigate lack of practice nurses in Camberwell DHA
May 1988		Interviews with practice nurses
June 1988		One of the locality groups splits in two
Autumn 1988		First meeting of practice nurses forum (bi-monthly)

		Investigation of GP views about employment of practice nurses through King's 2000 survey
January 1989		Negotiations for practice nursing course at South Bank Polytechnic
April 1989	Community and priority care unit appoints a community nurse tutor	
March 1990		First intake of practice nurses to ENB approved course jointly between dept. of general practice and primary care and South Bank Polytechnic.

CHAPTER 8

SHARED CARE

The views of Camberwell GPs

The project became involved in the development of shared care through two major areas of concern expressed in the initial interviews. These were the lack of communication received in the practices about patients with long-term illness, and also that, once referred to hospital, their patients 'disappeared' into outpatient clinics. Many GPs complained about not receiving discharge summaries or letters from outpatient clinics, or receiving information long after the patient had been seen or discharged.

Some GPs who wanted to offer integrated care felt that their skills in the management of certain conditions were under-used, and had become rusty. The GPs in Camberwell work in the shadow of large and renowned specialist departments at King's College, Guy's and St. Thomas' hospitals, all of which are nearby. This may well have served in the past to make them less confident about their own clinical skills than colleagues elsewhere in the country. The provision of care in the 1960s for long-term illnesses was through hospital departments. This is now recognised to be impossible financially and logistically, and inappropriate in terms of the developed skills and expertise now available in general practice.

The proposal for a 'shared care' approach came from GPs, who cited the example of antenatal care as a developed scheme with clearly identified roles and responsibilities for GPs and hospital departments. Diabetes and asthma were chosen because they are common conditions affecting approximately 1.5 per cent and 5 per cent of the population respectively. Both relevant hospital departments were very keen to develop good links with local GPs. It seemed important for the project to work in one or two clinical areas as well as the organisational, information, and teamwork areas already covered.

Principles of shared care

Shared care, namely ongoing patient care which is shared by general practitioner and hospital specialist, at the same time, is familiar to many in the field of antenatal care. It is less common to find GPs sharing their skills with hospital specialists in the care of patients with chronic conditions.

The principles behind 'sharing clinical care' are that the highest quality of care should be offered to the patient, combining continuing and personal care

from the primary care team with the support and expertise of hospital specialists, both working within an agreed framework for the management of illness. Care should be provided in a manner accessible and appropriate to the individual and there should be support for individuals and their families to take increased responsibility for the management of their illness.

The development of shared care schemes for diabetes and asthma is the area of work in which the project has had the greatest opportunity to explore the relationship between primary and secondary care in a clinical context. The two schemes are at very different stages of development, but both have been set up through extensive collaboration with GPs, hospital consultants and district staff, with the Camberwell Primary Care Development Project acting as catalyst (see diagram on p79).

Delicate negotiations

Negotiating a new balance of care is complex. It is not a case of simply passing a group of patients back from hospital care to their GPs, and expecting the GPs to cope with problems they may not have handled for years. Careful discussion is needed. No one in Camberwell had any experience of the process of negotiating care and developing shared management guidelines.

It is difficult for local GPs to take the lead. They rarely, if ever, come together with colleagues in large numbers, so getting a collective expression of their views is difficult. It may not be hard for specialist hospital departments to construct a strategy but this might not be appropriate for the district as a whole. The hospital specialists seldom meet GPs face to face and the poor information exchange between primary and secondary care does little to foster positive relationships between GPs and consultants. It is important to ensure that schemes in which collaboration between hospital and primary care is vital do not fall foul of poor communication and, equally, that resentment on either side is not aroused by initiatives which appear to be imposed from outside.

Diabetes

The idea of a diabetic shared care scheme was first proposed within a small working group looking at the possibilities of a joint strategy for care in diabetes, which was convened by the Camberwell Primary Care Development Project. The group consisted of the two diabetic consultants from King's College Hospital and three local general practitioners with a particular interest in diabetes. The working party discussed the likely areas of concern to GPs, their needs and the mechanics of setting up a shared care scheme.

It was essential to canvass the idea of a shared care scheme as widely as possible among local GPs. This was done through one of the regular 'Meet the Department' meetings run by the department of general practice and primary care, which attracted GPs from Camberwell and its immediate neighbouring health authorities, as well as chiropodists, dietitians, nurses, and other professionals involved in diabetic care.

Basic ground rules

At the meeting, those present established what they regarded as guidelines for a prospective shared care scheme, which was an idea they greeted with enthusiasm. They recommended that most new patients should normally attend the diabetic clinic for initial diagnosis, education and stabilisation, and that it would also be the clinic's role to establish a system of annual or bi-annual screening of patients in the shared care scheme for diabetic complications. Secondly there would need to be close liaison between the hospital diabetic department and general practitioners, and all general practitioners would have access to help from the diabetic department at any time. It was important that all those involved in the scheme followed similar policies in treatment, so standards of diabetic care would have to be agreed. A new system would also need to be developed for diabetics' GP records.

The hospital diabetic team agreed to consider how it might conduct joint sessions with GPs in some practices. And when the meeting focused on staffing needs, people agreed that additional trained diabetic nurses/health visitors, based in the community, would be needed. It was also recommended that a full-time dietitian for diabetes should be appointed to work both within the department and in the community. Finally, the modernisation of the present diabetic department computer system was urgently called for.

A month or so after the meeting, all GPs in Camberwell and those who had attended the meeting, were asked if they would like to join a diabetic shared care scheme. 90 GPs in 30 practices said they did. The mechanics of the scheme were worked out stage by stage, taking both clinical and administrative issues into close examination in meetings which took place during 1987. Those involved in diabetic care in the district attended a total of five meetings and by the time the scheme was launched in January 1988, its shape and content had been fully discussed.

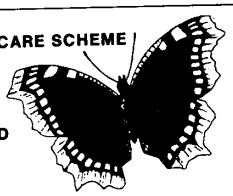
What kind of shared care card?

At the first of the planning meetings, a GP member of Camberwell Primary Care Development Project and one of the consultants concerned with diabetes reviewed other shared care booklets and produced a draft layout. This draft differed from others in that, as can be seen in the reproduction below, it allowed for the representation of one year's care per page, whereas booklets in use elsewhere had the regular visits noted in one section and the annual review in another. At the meeting, valuable additional items for inclusion in the booklet were proposed by the participating GPs. Patients carry the booklet (see page 76) which gives them a critical role in improving communication and their treatment. The booklet reminds the patient, hospital physician, and general practitioner of the areas to be regularly reviewed.

The Camberwell Primary Care Development Project funded the initial production costs of the booklet (£600 for 2,000 booklets) which, it is planned, will be given to all registered diabetics, whether or not they have shared care.

Figure 1 *Diabetic record card*

CAMBERWELL SHARED CARE SCHEME



DIABETIC RECORD CARD

Name: .....

Address: .....

.....

.....

Tel No: .....

GP Name: .....

Address: .....

.....

Tel No: .....

Diabetic Clinic
King's College Hospital, London SE5 9RS
(Dr P.J. Watkins and Dr P.L. Drury)

Hospital number: .....

Special notes:

PLEASE BRING THIS BOOK AND ALL YOUR TABLETS WITH YOU AT EVERY VISIT TO SURGERY OR CLINIC

Produced jointly with the Camberwell Primary Care Development Project

DIABETIC HISTORY

Date of diagnosis: Weight then:
How confirmed?: B.Gluc at diagnosis:
Symptoms then:

Subsequent treatments Date

.....
.....
.....
.....

Special points:

.....
.....

OTHER MEDICAL PROBLEMS (Long-term)

.....
.....
.....
.....

Special points:

.....
.....

LONG TERM DRUGS

Date Dose

.....
.....
.....
.....
.....
.....

Allergies, etc: .....

Exemption certificate? .....

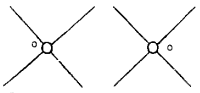
Year 19

		Blood		Urine			
Date	Wt(kgs)	Gluc	HbA1	Gluc	Alb	BP	Treatment

REVIEW 19..... Date.....

Eyes: Acuity R..... L..... Glasses: Yes/No Dilated: Yes/No

Fundi:



Cataracts?: R..... L.....

Pulses Reflexes Sensation

Fem Popl PT DP KJ AJ Vibn Temp LT Pain

R .....

L .....

Foot condition?:

Injection sites? Auto. neuropathy?

Comments (e.g. hypos, problems, treatment plan)	Next visit	Init

DIET .....g CHO Spread + + + + + Dietician:.....

Other special diet: ....

DRUGS/INSULIN .....

..... Chiropodist .....

....

....

HOME MONITORING: Method ..... When .....

Control?.....

Risk factors/medical problems (incl smoking) .....

.....

Action: .....

.....

Standards of care

Everyone agreed that for the scheme to be successful, standards of care and treatment policies needed to be agreed to and adhered to by all participants. The scheme was based on the three 'Rs' of chronic care: registration of all diabetic patients; recall, to ensure patients are seen regularly; review – agreed clinical areas which should be assessed each year by the health professionals with the patient.

The administrative underpinning necessary to achieve this target was to be a central, computerised register, set up in the diabetic department. This would enable all diabetic patients in the district and their status in the shared care scheme to be identified. A two-part form was devised for each patient, one part to provide the computer with registration details, the second part to be kept by GPs as their own manual register of patients. Each year GPs would receive a list of all their patients seen and reviewed at the hospital diabetic department.

All diabetic patients in Camberwell are registered in the scheme in one of three categories:

(i)	hospital care:	where the care is provided entirely by the diabetic department, eg pregnant women or children with diabetes, diabetics with major complications, and/or other associated medical problems such as heart disease, kidney disease.
(ii)	shared care:	where both GP and hospital are involved. The GP provides the majority of care with an annual review by the diabetic department.
(iii)	GP care:	where the care is provided entirely by the GP including the annual review, e.g. housebound elderly.

Next the meetings explored clinical questions in diabetic care and began the process of working towards shared management protocols. Clearly the contrasting working structure for GPs and for hospital specialists, their different professional orientation and the kind of patients they see, mean that achieving common management strategies requires careful negotiation. Those attending the planning meetings also discussed the need for training opportunities in diabetic care for practice nurses, opticians and other staff.

A final meeting before the scheme's launch reviewed registration, completion and use of the booklet, indications of good diabetic control, information for patients, and 'shared care' stationery.

The scheme has now been underway since early 1988. How successful has it been? The project needs to evaluate this, considering not only the views of professionals, but also assessing the value of its own contribution to the inauguration of the shared care scheme and the GPs' collaboration with hospital colleagues.

What do GPs think?

During the three months before the scheme started, GPs who wanted to join in completed a postal questionnaire to assess the organisation of diabetic care in their practices, and their knowledge about diabetes. The survey covered areas such as:

- how GPs identify diabetics
- screening procedures used
- number of diabetics on practice lists
- current review procedures
- the extent to which other professionals are involved in diabetic care
- problems with hospital services for diabetic care
- education and training
- resources necessary to improve patient care.

The intention is to repeat this survey in 1990, allowing an assessment of change over that time span.

As well as the survey, the project has attempted to assess the style, content and usefulness of the meetings on shared care and to review progress of the scheme.

Assessing the project's efforts

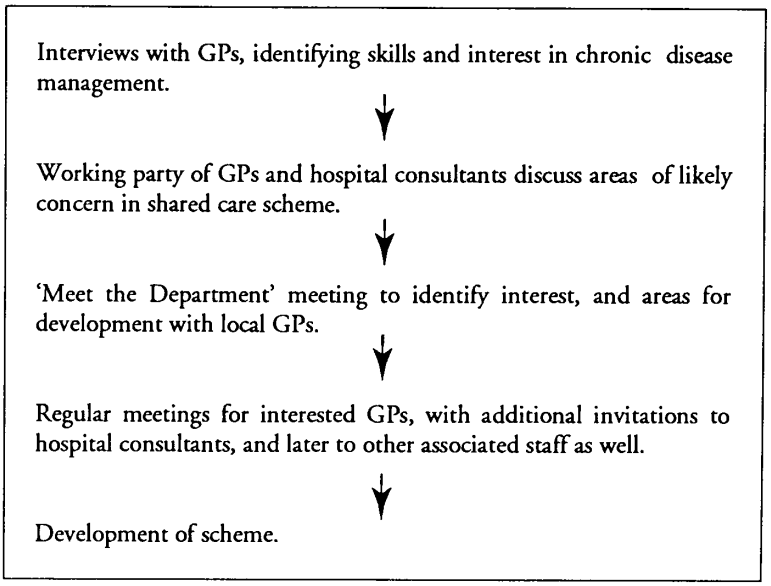
The principle of working from the 'ground up' has advantages and disadvantages. It is not easy to involve large numbers in discussion. Wide consultation has resulted in valuable additional ideas and in practices accepting the scheme as 'their own', rather than as something imposed by the hospital. When asked for their views of the progress of the scheme and the usefulness of the meetings, GPs have particularly mentioned: 'the fact that the system was set up by consulting local GPs' and 'the fact that our hospital colleagues respond to our needs rather than telling us what to do'.

The meetings have continued on a regular basis, though they have become more multi-disciplinary and patient-oriented and regularly involve small group work around skill development. Topics discussed in 1988 and 1989 included oral hypoglycaemic medication, diet and diabetes, the foot in diabetes, and the eye in diabetes. Participants also held meetings to discuss problems in the management of insulin-dependent diabetics and 'the patient as the expert'.

One major hurdle to the scheme so far has been the delay in updating the diabetic department computer. This has meant that the planned annual feedback to practices has not yet happened, and so far review has had to rely on a manual system.

Those involved in this initiative are aware that, so far, it has largely been professional led. As extra staff and so more resources become available to work on the project it is hoped that the involvement of diabetes patients in the project will increase.

Figure 2: Shared care schemes – the process



Chronology

Autumn 1986	Working party meet to discuss proposals for a shared care scheme in diabetes.
November 1986	Concept taken to GPs for discussion at 'Meet the Department' meeting. Needs of such a scheme identified: strong support indicated.
December 1986	Proposal circulated to over 300 GPs in and around Camberwell. GPs invited to join scheme.
1987	Meetings to formulate scheme, participants include GPs, consultants and nurses.
November 1987	Questionnaire to collect baseline data administered to GPs.
January 1988	Shared care scheme begins. Registration of patients with diabetic department begins.
February 1988 to December 1989	Diabetic meetings continue, focusing mainly on clinical topics and skill development.
March 1989	Two specialist diabetic development nurses take up post.
May 1989	Practice nurses forum discusses diabetes and shared care.

Asthma

A similar process to that which the project instigated on shared care for diabetic patients has developed more slowly on shared care for patients with asthma. In September 1986 a working group of the two consultants in thoracic medicine at King's College Hospital, three general practitioners with an interest in asthma, and two members of the project, began meeting regularly. During the following three months they looked at the likely needs of GPs, the hospital department, and patients in the development of asthma care locally.

In the spring of 1987 a questionnaire was distributed to Camberwell GPs to obtain baseline data on their ideas and views on asthma care. Of the 136 GPs circulated, 77 responded, of whom 61 said they would be interested in a scheme of increased co-operation between themselves and the department of thoracic medicine. Most wanted greater access to diagnostic facilities, agreed guidelines, and a district strategy for the care of asthma and a worker to link the GP, hospital department and families. Seventy per cent of respondents supported the idea of a physiotherapist specialising in asthma care to work with them in their practice and to co-ordinate and develop a scheme of shared care. A proposal to fund an asthma physiotherapist to develop the scheme further was successful.

Once again, the project made use of the 'Meet the Department' meetings to stimulate discussion on the proposal for shared care. The meeting, held in November 1987, highlighted topics such as guidelines for good management of asthma, patient education, education for teachers and relatives, the role of practice nurses, and the correct use of nebulisers. Draft guidelines for good management of asthma drawn up by the working group were discussed and amended at the meeting. These guidelines cover chronic therapy for adults and children, and the management of acute severe asthma in the home. During 1988 the working party continued to meet, drawing up a job specification for an asthma physiotherapist, who eventually took up the post in April 1989.

This initial work is being built on by joint work with practices to develop improved care, liaison between the hospital and the community and to develop educational initiatives.

The way ahead

The development of shared care schemes for chronic illness is becoming an increasingly relevant and appropriate option for both hospital specialists and general practitioners in managing the medical care of people with longterm problems.

In diabetes particularly, a number of schemes have been in existence for some time, particularly Poole, Southampton and Islington[45,46,47,48]. In our local schemes the project has involved as many GPs and members of the primary health care teams as possible in all stages of development in the belief that such involvement and ownership will promote much greater participation and support, than if the initiative is seen as coming from an individual or department. The schemes are intended to lead to agreed standards of care and to be flexible enough to take into account local needs, facilities and expertise.

Chronology

September to December 1986	Working group meets to discuss GPs' likely needs in asthma care.
March 1987	Questionnaire to Camberwell GPs on asthma to collect baseline data of their ideas and views of asthma care.
November 1987	Discussion of scheme with GPs at 'Meet the Department' meeting.
	Production of draft guidelines on good management of asthma.
1988	Asthma working party meets regularly, to draw up application for grant for asthma physiotherapist and then, to organise advertisement and appointment.
April 1989	Asthma physiotherapist takes up post.
January 1990	Practice nurses forum discusses asthma and shared care.

CHAPTER 9

REFLECTIONS – ON A LEARNING CURVE

Before and after

Although this chapter resembles in many ways an assessment of the project's success and the conclusions which can be drawn from its experience, the account below is very far from the traditional model of scientific research 'results'. It is quite impossible to expect to be able to make pure 'before' and 'after' comparisons when assessing a development project of this kind. Therefore to label what follows an 'evaluation' would be misleading.

Even if the project's goals and boundaries could have been more clearly defined at the outset – in itself quite possibly an unrealistic aim – the realities of social research in combination with a development approach would have combined with the harsh realities of life in the health service in the late 1980s to frustrate any model of pure research.

The project underwent several important changes during the period covered by this report – staff changes, funding changes, to mention just two. What follows is a review, from the perspective of those directly involved in the project, of the approach to development which was adopted, and its strengths and weaknesses. This is complemented in chapter ten by the commentary compiled by Judith Allsop – an outsider to the project's work.

Selecting the objectives

While the structure and strategies of the project have changed, project members' ideal of primary health care has changed little. It is characterised by equality of access and comprehensive services of good quality which are readily available and accessible. The very general outline brief with which the project started (see p18) was useful since, five years ago, the priority areas for general practice development were still undefined. The approach to development grew out of the philosophy of the department of general practice and primary care and has become more clearly defined as the project has gained experience. The first nine-month stage of the project concentrated on interviewing GPs and defining specific aims. From the GP interviews three major areas emerged: communication, teamwork, and premises. From this work terms of reference were formulated into a funding application to the King's Fund, which accepted the proposed plan of action.

Underlying strategies

The project's method of working has been characterised by three important elements – peer review, a commitment to all Camberwell practices, and ensuring that whatever the project does, it seeks local support and consultation. While other strategies have had to be modified, as is described later, these three elements have been sustained.

Peer review

A distinctive feature of the project has been its use of local general practitioners, as opposed to GPs from outside the district, in its activities. It has been most directly used in interviews. The continuing presence of local general practitioners in the CPCDP has helped to keep the project in close contact with medical reality, give it status within the district, and to maintain the support of local GPs.

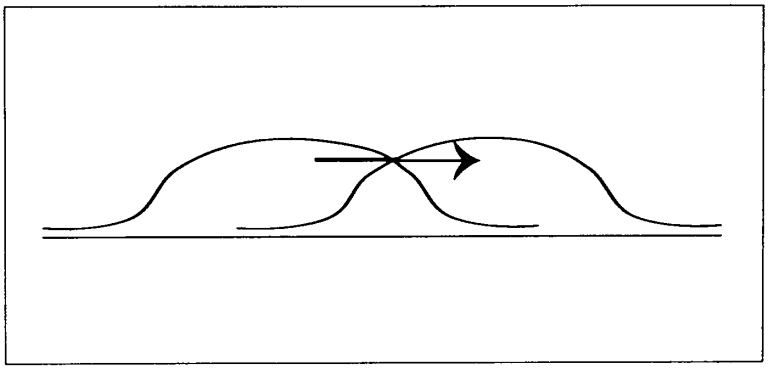
Interviews, however, require a lot of time. It is unrealistic to expect GPs to have the skills of social scientists. This is a disadvantage which has to be set against the benefits arising from initial personal contact. The project is convinced that this contact has been instrumental in gaining support from GPs and in raising the profile of both the department of general practice and primary care and the CPCDP.

Reaching out to all practices

A second theme related to the philosophy of the general practice department and its desire to reach out from the medical school and into the community is the project's policy of working with all Camberwell general practitioners rather than piloting an idea or scheme in a small minority of selected practices. Selection of this kind often leads exclusively to the practices involved in teaching medical students or the eager group practices. There is then a danger that the kinds of problem found by lower profile practices, perhaps in the more deprived parts of the district, are never really confronted.

General practitioners, like many other professional groups, can be thought of as somewhere within a normal distribution curve of professional standards. There are the very good and very bad at either end, but the vast majority are somewhere in the middle. The project's aim was to concentrate on moving that curve to the right, and so raise standards overall.

Figure 1: Normal distribution curve of professional standards in general practice



The project has consistently sought to consult and liaise with all practices in the district and this process of consultation has enabled the project to check that what it is doing is relevant, at all stages, to GPs of all kinds.

Which leads to the third element underpinning the project's methods. Peer review and district-wide consultation are part of a philosophy of working from the 'ground up'. As a further expression of this the project has made it its business to tackle problems identified by health workers in the field.

In contrast to the research model, in which information is gathered from all sources before decisions are taken on how to proceed, the project's approach to development meant that issues of obvious local concern were taken up before all GPs had been interviewed. Nor, without rigorous experimental conditions, is it possible to state categorically that it is more effective to use local colleagues to conduct interviews than either non-medical interviewers or general practitioners of different characteristics from the population under survey. There is no doubt, however, that the peer approach has been successful in Camberwell. Almost all GPs have taken part, discussion has been frank and on several occasions we have been asked to offer personal work at an intra practice level concerned with practice organisation. GPs find it easy to communicate with colleagues who, to a greater or lesser extent, operate under the same conditions as themselves. Although confidentiality was guaranteed, it is of course possible that some GPs did not say as much as they would to someone from outside the district and they may have been inhibited by the fact that the interviewers were academic, as well as practising, GPs.

In the five years since the CPCDP started, the project's activities and those of the academic department, in particular attendance at meetings such as 'Meet the Department' and the diabetes shared care scheme, it seems, fostered a stronger sense of a locality. During and since the original interviews, local GPs have been sent a number of self-completion questionnaires on a variety of issues, ranging from their surgery opening times to their knowledge of diabetes. Personal contact established through the interviews has contributed to the good response rates achieved in these postal surveys and the interest expressed through them.

An honest broker is not enough

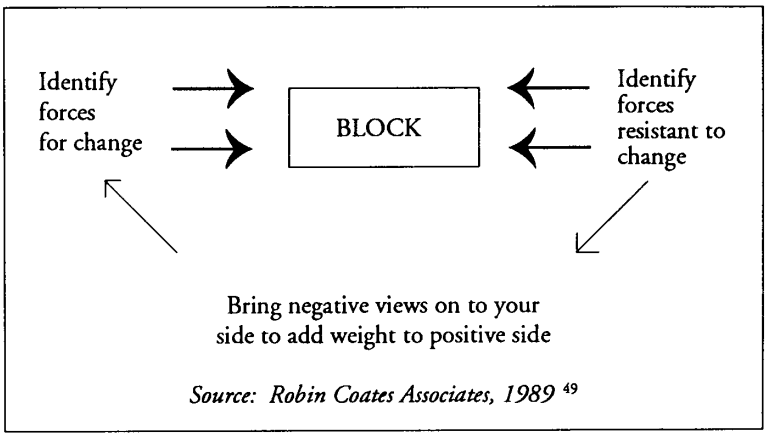
An initial and implicit strategy was that as issues for action emerged from interviews, the project would play the role of 'broker'. This would involve putting clients – the GPs – in touch with colleagues (other GPs) and agencies who could assist them to achieve the required change. But the idea that lack of change is due to poor communication and the solution is to bring everyone round a table to find their problem solved is only partly true.

The idea of the project acting as an honest broker is based on an assumption that there are common problems in practices and that solutions do exist, but are simply not being shared with others. This can happen, certainly, and the project's work has often relied on an extension of this idea, namely, using 'key actors' to work through problems, but it has never in itself been enough. Rarely are there ready-made solutions merely requiring to be communicated, from the haves to the have-nots. The problems GPs and other primary care workers faced often required expertise or a combination of skills which did not exist among them. They did not exist because the need to promote change is not readily accepted.

Responsibility for development is not built into the remit of most health professionals. There are set patterns of working and day-to-day overload which are not conducive to a dynamic vision of change within work. So if those in the field cannot see the wider questions of change which so often underlie the day-to-day problems, blocks occur and inertia and resistance set in. In a context such as this the project found it needed to act as a catalyst, rather than simply as a broker. Project workers found they were formulating questions in such a way as to enable the blocks to be cleared and new ways forward perceived.

The promotion of change entails a complex process of identifying reasons as to why it should occur, the structures or ideas that prevent it and the forces that foster it, as shown in Figure 2.

Figure 2: Strategy to bring about change



Source: Robin Coates Associates, 1989 [49]

Where no ground level support has been identified, promoting change is an uphill struggle. It is more fruitful to use emerging ideas and innovations and follow them through the support and resistance they engender. Proposing ways around problems and a willingness and ability to spend the energy necessary to follow the solution through to implementation is time-consuming; designating mechanisms to monitor and maintain subsequent progress is a longterm commitment.

Recognition of this process and the inadequacy of the broking concept led to a re-think. The project now sees itself as a catalyst for change, still working on the margin, but in liaison with the statutory bodies to achieve change, and to ensure it becomes incorporated into permanent structures.

The role of catalyst requires different skills and it is important to have sufficient flexibility to know when to bring in new skills, and to identify and work with these within structures. In some cases the project members have acquired the necessary skills through experience: applications for funding training work with groups of professionals. In others it has sought expert help: Inner London General Practice Unit; and in others the team has undergone further training: questionnaire design and analysis, consulting skills.

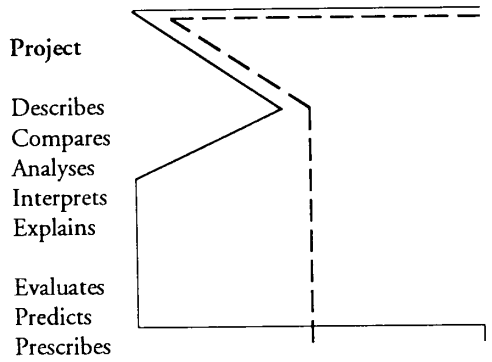
Making innovation stick

Promoting change is only one aspect of development work: laying a solid foundation so that innovations take root and flourish requires deliberate and delicate care. It is widely agreed that promoters of change should only hold the reins for a short time: ownership of meetings or committees should be temporary, for instance. Retaining responsibility, however, has advantages. In the premises strategic liaison groups the project is perceived as having a useful, independent monitoring function. In the health visitor/GP meetings the

project provides speakers and offers continuity of management. Encouraging others to take over this role is an integral step; knowing when a scheme will continue without input from outside is difficult, and is an area to which the project needs to devote more attention.

The project adheres to a developmental approach of working with organisations to foster change, as shown in the diagram below.

Figure 3: Ownership – patterns of working with organisations



Traditional approach: the project goes into the organisation, makes a diagnosis of the problems and withdraws to formulate a solution. It returns to prescribe a course of action. In this case, the sense of ownership and commitment to the suggested action within the organisation may be weak. This is shown by a single continuous line.

Developmental approach: the project works in collaboration with the organisation to describe, analyse, interpret, explain and plan a course of action. This strategy ensures that responsibility for change in the long term within the organisation is likely to be greater. This is shown by the dotted line.

Source: Robin Coates Associates, 1989 [49]

The strengths and weaknesses of the CPCDP

The project team believes that the combination of different professional backgrounds and skills has been a major strength of the project. Using local doctors to interview their peers had notable advantages, not only in putting those doctors being interviewed at ease, but in allowing facilitators to form and

maintain contacts on behalf of the project. This had the effect of giving GP project members a strong sense of accountability. On the other hand, because the GP project members have a long-term commitment to Camberwell district through their own medical practice, they have to live with the successes and failures of the project and any repercussions of its work which may spill into their other roles. By appointing a social scientist, the CPCDP found it had shifted itself from a predominantly medical model of development to one much more explicitly rooted in a broad conception of primary care. It had also introduced a different methodology to the project's work.

In similar kinds of facilitation project across the country, the GPs employed are either part-time or retired or both[50]. The Camberwell project, however, has tackled areas which demand a greater investment of time and a broader kind of expertise which is not particular to general practice. Having a non-GP has made it easier to collect data from bodies such as local authority staff, health visitors and district management staff, all of whom expressed views about general practice in a way they might not have done, had they been face-to-face with a general practitioner.

The doctor's status: help or hindrance?

The presence of GPs in the team is a double-edged sword. It has certainly helped to raise the project's profile in local health circles. But also, from time to time, the CPCDP has become confused with the other roles of the doctors involved. And sometimes, public and professional appreciation of the status of the doctor has meant that the professional neutral social scientist's role and status has been discounted. Working with medical colleagues in a predominantly medical area makes it difficult to get a broader, social perspective accepted, even where, as in 'premises' and 'clinical waste', medical skills are not the foremost requirement. It requires effort for GP project members to keep a primary care rather than a general practice orientation when, through their day-to-day experience, they can fall easily into medicalising areas other than clinical issues.

In a small team, the status of the doctor is a difficult element to grapple with, particularly, on a pragmatic, day-to-day level, when it can seem attractive and expedient to make use of the professional or personal characteristics of a doctor-member of the team. If the project allocates a task to one member because it seems that his medical qualification will smooth the path, it is colluding with the notion that doctors 'do it better'. Where individuals from other backgrounds are appointed it should be because their contribution is valued, not because their skills are cheaper to purchase.

Project workers' isolation

There is a limit to the extent to which any one project member, whatever their status, can influence a large bureaucratic structure. It is vital for other team members to offer encouragement to colleagues when, through close contact

with an issue, they feel bogged down. Support should be formalised in development projects and, the project team believes, isolated workers should not be appointed. In shared care and teamwork the project members most closely involved have on occasion become overwhelmed both by the volume of work and a pessimistic view on progress. In both cases, however, participants in the schemes have remained enthusiastic, and feedback from them has checked the project workers' slide into demoralising self-criticism. When appointing new workers now, the project tries to set up support networks for them, in addition to formal steering groups.

A medical school base

The project's base in a medical school department, with local workers who have brought and developed links with health authority structures, has had the advantage of making the project independent in the local context but also involved. The independence has enabled the project team to respond flexibly and pragmatically to local issues. Setting up special working groups in areas outside the health and local authority existing sub-committee structure, has made it possible to achieve more informal, but effective discussion, leading to rapid action. The combination of being outside and yet having a recognisable stake in local affairs has made it possible to pick up an issue, and oversee its progress through health authority structures, where necessary intervening to ensure its success, as was done in the case of the transport and delivery service.

As outsiders to management structures, the project's influence will always be limited; there is a delicate balance between independence and isolation. Being associated with the department has its price, too: if the project goes badly, this would have repercussions on the other related areas in which individual members are involved and on the general practice department as a whole. Development work is not common in academic departments; the project is perhaps a standard-bearer in the field and its failures could jeopardise the idea of similar departments in other medical schools taking on such work. By the same token, the project's dependence on being associated with a generally well-regarded department means it could suffer if the actions of other workers in the research, development, or teaching sections of the academic department had an adverse effect on the goodwill of local GPs.

Finally, conscious of its position within an academic institution, the project has taken special care to document and evaluate its activities which, however small in scale, have nevertheless made use of traditional research and evaluation skills. This has afforded a simple, direct way of reviewing progress and helping plan the next steps.

An advisory group

When the King's Fund London Project Executive Committee made its generous £18,000 grant in 1984 and, as part of an agreed three-year tapering

arrangement, its £30,000 in 1986, it imposed few conditions. Different approaches to facilitation were being tested elsewhere, some of which were also receiving King's Fund support. The Fund was non-directive towards the project.

But with so little experience or precedents in the field of facilitation, and such a fluid context in which to operate, it was not long before it became clear that the project needed an outside reference point, a forum in which those involved could discuss their problems and benefit from consultation with others. Should it be an advisory group, or something with a remit to be more directive, say a steering group?

A steering group was rejected, largely because of news which reached the project, via the King's Fund networks, of difficulties which had arisen in the Tower Hamlets facilitation project [3]. Here, it was reported, steering group members who also had a local stake in the problems the project was attempting to tackle, seemed to be using their position to hinder the project's progress.

An advisory group, on the other hand, composed of people who knew about primary care in London, would ensure a flow of outside ideas, and help boost the project in the face of local obstacles. It would be less formal, and there was, with hindsight, an implicit recognition that it would be more acceptable to the medical members of the project who were not accustomed to anything that impinged on their clinical or academic autonomy. The advisory group was in place from 1986 to 1989.

CPCDP has entered a new phase now, with funding from multiple sources often each with its own objectives for a part of the project. The project's aims and strategies are more specific and clearer to outsiders. The need for discussion is less important than direct communication with and accountability to the funders and a steering group has been set up.

Multiple sources of funding

Gradually the project's financial base has broadened as other funders have joined the King's Fund. The advantage of funding from multiple sources is that the project can enjoy a large measure of independence. The obvious disadvantage is the time that must be spent in looking for funding. It has not proved too hard to get funding for specific areas and particularly for areas of clinical interest. Action which would lead to significant improvements in primary health care often needs to be taken around apparently mundane issues, which do not easily attract the interest of funders. It is not easy to find financial support for work towards the rational development of primary care. Although the DHA has made a grant to support the core funding, its commitment is only for one year. The FPC has allowed for the continuation of a generalist approach to strategic development through its three-year funding programme.

At a time of financial crisis in many parts of the health service the project team has felt awkward about competing for funds against other priorities. This is a particularly acute dilemma with DHA money, which comes out of the budget for direct patient care. The project hopes to produce long-term benefits

rather than visible short-term effects. Those with a stake in the project may have different and even conflicting interests in its direction and style.

Though one body may designate funding for a given area, it cannot dictate the direction and outcome of the project's work as a whole. Funders may have a well intentioned but vaguely expressed idea of primary care development. Such lack of definition and the problems of communication that may arise can lead to misunderstandings and dissatisfaction on both sides.

Camberwell limits

The CPCDP set out to work with GPs within the boundaries of Camberwell health district, but the work done on premises, clinical waste and, to a lesser extent, shared care and teamwork has all highlighted the need for flexibility given the multiple boundaries between local authorities, health authorities and the FPC. Although using a defined area as a starting point is helpful when trying out ideas, it would have been short-sighted to proceed only in Camberwell district, itself an arbitrary boundary for GPs, who are actually organised in an FPC area. It is probable that the difficulties faced by Camberwell GPs are common to their colleagues in neighbouring West Lambeth and Lewisham and North Southwark. Taking proposals and policies beyond a single district creates more work and requires negotiation, but is ultimately a more rational approach.

How funding can distort the pace

Even with close links to local structures, it took a full year before the project was in a position to define specific strategies. Many development and facilitation projects are funded for 18 months. The project team believes this indicates a misconception of the nature of development work and of how long it takes for a project to become established, set up strategies, and follow them through with some degree of success.

A project may have long-term aims, but be forced by the timing of its funding support, into short-term solutions. Some of the work carried out in Camberwell has seemed deceptively basic, such as compiling lists of GPs, but it required a great deal of effort and time. The apparently straightforward task of setting out and publishing a timetable of hospital outpatient services, the nexus of primary and secondary care, took almost 18 months to complete. Getting a commitment from the DHA to repeat the exercise has yet to be confirmed. Other areas of work have required a longer-term investment of project time and predicting how long stages will take is difficult, although important in judging how much the project can realistically take on.

Development work is not a linear and continuous process. Undoubtedly, some issues can be dealt with as they arise and change occurs quickly. But more often, an area will gradually emerge as important and require different levels of effort over a longer period of time. The project first began to explore, for

example, shared care, in 1985 and found that it had anticipated the widespread interest in this form of development. When the opportunity arose to put in a proposal for funding, some of the groundwork had already been done. During the time that the shared care schemes were being prepared the project team was also involved in other areas and put in varying amount of work according to the maturity of the idea. Juggling the many strands of work has been an essential part of the project. How much time is given to a particular area is also determined by what is happening in other fields. The work on asthma was delayed by the unexpected investment of time required on the diabetes scheme. The timing and planning of meetings for practice nurses were influenced by the demand on resources by the health visitor/GP meetings.

It is equally important for funders to understand the pacing and priorities of organisations whose collaboration is needed. In a number of areas, even when the issues and key actors are clearly identified, progress may not occur until a change in some outside factor 'unblocks' the path. This cannot always be predicted. In clinical waste, for instance, this kind of breakthrough came with the change in DHSS regulations which allowed a free service to be offered. Such unpredictability means that funders need to be tolerant of delays and sometimes unavoidable drift in projects' targets.

Political channels

The project's achievements could not have been made in isolation, but depended on using existing contacts and influence and reaching out to new networks. To begin with the GP members of the project had access to medical and educational networks. A secondary aim of interviewing local GPs was to develop liaison and contact between the doctors and the project. Using these medical networks effectively brings the project status and influence, and eases contacts with the health authority.

Such access to political channels has allowed the project to be more ambitious in developing its aims than it might have been with a more distant relationship to the health authority and professional structures. On the other hand it makes it hard to assess objectively what has been achieved through the CPCDP, and what is due to the personal skills and other links of its members.

The project has also developed extensive contacts with local authorities, the FPC, voluntary agencies and other projects across London. In bringing together representatives from different bodies, on premises and clinical waste, in particular, the project needed to identify individuals not only with good day-to-day knowledge of the field but also sufficient decision-making power in their own organisation.

The FPC, the DHA, and the local authorities are bodies with very different structures, priorities and agendas. Although local authorities were at first much cooler in their response to approaches from outside, they were subsequently more open to joint working than were the NHS organisations. The local authorities have liaison staff who are effective in their own organisations and are willing to take responsibility for promoting change. From experience

the project has learned the value of approaching senior top officials as well as the officers to whom the task will be delegated. Health authorities, despite the fact that one would expect from them a more immediate understanding of the project's aims, have proved in the long run more inaccessible. It has been difficult to get an appropriate level of DHA representation on committees or to get continuity of participation.

Expectations and achievements

Uncertainty is an inherent part of development work which all projects have to live with, whatever approach they choose. Funding is short-term. Aims are fluid since, in order to advance, a high degree of flexibility is needed. And even though there are an increasing number of facilitation projects, it is still hard to set in advance realistic expectations of what can be achieved.

The Camberwell Primary Care Development Project has been part of and consciously used existing trends to generate change. Moving in the same direction as existing trends has been the key to influencing the development of primary care services at key interface points – the links between primary and secondary care, the link between general practitioners and other primary care team members and the interface between the public and primary care services. This makes it difficult to point to specific project achievements, since it is impossible to assess accurately how far developments might have occurred eventually, either naturally or fuelled by other forces acting in the same area.

At first, the CPCDP did not suffer so much from inflated expectations as much as naivete as to what skills were necessary to meet the demands which emerged from interviews with local GPs. As objectives became more clearly defined, it became easier to see what would be required to support improvements in local primary care. But with few precedents in primary care development, the project's hopes and ambitions were not tempered by any practical experience of what could and could not be achieved. For instance, an educational forum to bring together health visitors and GPs is a device which has been well-received, yet at times the project team has found itself questioning how much progress can be made without changes at a management level also occurring. When expectations of success are high and progress seems slow, a small project team pioneering in fairly new territory can fall prey to frustration.

The project's explicit commitment to taking on issues in a demand-led way can make it difficult to refuse to decide priorities and set boundaries. At times the project team has found itself overstretched.

Key management issues

For those involved in running the project, key issues have emerged in two main areas – the project's links with other bodies and its own internal organisation.

External

Preserving the foundation on which the project depends – the goodwill of GPs, collaboration with colleagues in the department, networks, regular mailings, monthly meetings and bulletins – while also developing new areas of work.

Keeping activities relevant – 'ears to the ground'.

Managing conflict arising from outsiders' role expectations related to project members' different professional backgrounds.

Liaison with the three critical organisations: The FPC, the DHA, and the local authorities.

Gaining access to other organisations.

Internal

Managing the direction of priorities.

Setting reasonable goals and phasing the work realisitically.

Supervising and managing others within the team.

Evaluating constantly changing projects.

Writing up and publicising the work at the same time as developing action.

Reconciling the aims of disparate funding bodies.

CHAPTER 10

AN OUTSIDE ASSESSMENT

The report's final chapter is a commentary by Judith Allsop

As I was already working for the King's Fund on a review of facilitation projects, I was asked to contribute 'an evaluation' for this report. The King's Fund, a major funder of the Camberwell project, wanted to establish what lessons could be learnt from the CPCDP about the advantages and disadvantages of this particular type of intervention in the field of primary care. The particular characteristics of the project, which is the only one of its kind, are first, that it consists of a small team of people; second, it has an independent existence outside the main health authorities; and third, two of the team members are, and will continue to be, practising local GPs.

The bulk of this report describes the content of the work of the CPCDP, its local context and the processes adopted to bring about change. However, the perspective of the account is *from the inside.* In this final chapter, the aim is to examine the project from the outside, presenting first the views of people who worked with CPCDP or were beneficiaries of it and, second, giving my own commentary.

Why a commentary?

What follows is a commentary rather than an evaluation. This is for two reasons. Evaluation implies more rigorous research methods than I have been able to adopt here. Bulmer [51] outlines a classic natural science model for the evaluation of an intervention. This rests on setting objectives; deciding on indicators to measure these and collecting data to assess outcomes. In practice, it is rarely possible to follow the model in policy research. Smith and Cantley [52] provide an alternative approach which they term, pluralistic evaluation. This acknowledges the political context of much policy-based research. In any social setting there are a number of participants or, as I have called them here – stakeholders – whose perspectives and interests vary and who will therefore assess success or failure differently.

I aimed to follow this method in Camberwell. Therefore representatives of four groups of primary care stakeholders were interviewed: the funding body; managers from the DHA and FPC; GPs and community nurses, and all members of the project team. Some caveats about CPCDP were expressed by local stakeholders but these should be seen in the context of the position of their organisation and their assumptive worlds [53]. All accounts are in themselves partial and subjective. Taken together, they give a more rounded view.

A second reason for calling this a commentary is the difficulty of accurately describing, let alone evaluating, a multi-faceted, developmental and evolutionary project like CPCDP. In a number of obvious ways the project has been a success. Over a six-year period it developed from one person's idea through three phases of change and remains in place to meet the challenge of the 1990s. *Working For Patients* [10] and the revised GP contract mark a new phase in general practice.

In another obvious way the project has fulfilled the expectations of its funding bodies. It has defined a role and carried out a number of diverse activities which have been fully described in this report. It has fulfilled the terms of its original remit (p18) to improve contact with and between a range of organisations.

It is more difficult to pin down whether any general lessons can be learnt from the project and whether the experiment is replicable elsewhere. Were the positive outcomes due to specific circumstances and personalities in Camberwell? During the 1980s, the national policy context changed rapidly. This provided opportunities. At the local level there was a vacuum which CPCDP filled. However, there were aspects of the project related to process and strategy which contributed to its success and which may have general relevance. I aim to discuss these in the final part of the chapter.

Stakeholders interviewed

A stakeholder is defined here as an individual or group with a concern for primary care and with the power to affect policies or resource distribution.

At the beginning of my research the project participants were interviewed and the information they provided was supplemented by subsequent informal discussions. The aim here was to find out what the participants had done and their separate reflections on the outcomes of their work, both successes and failures. Even more important were their views on their way of working: the processes adopted to achieve development and change. This enabled me to build up a picture of the project and its context, on which to base my commentary.

Subsequently, interviews were carried out with a number of key stakeholders. These included the project funders, originally the King's Fund, and later the DHA and FPC. The two latter bodies were also 'beneficiaries', in the sense that the CPCDP supplemented and complemented the primary care work of the DHA and FPC. The King's Fund was represented by the secretary to its London committee, who acted in a liaison role between the Fund and the project until 1988; the DHA was represented by the joint unit general manager of the Camberwell community and priority care unit, who was familiar with the work of the project over the period from 1984. The general manager of the FPC who came into post in 1986 spoke for that stakeholding, while a previous FPC chair commented on the earlier period. I also talked with the community nurse manager and with a local GP who is now the adviser for general practice for the South East Thames Regional Health Authority.

Interviews with GPs and community nurses were considered, but rejected on the grounds of insufficient time and funding. Quantitative and qualitative data on attendance at meetings and evaluations of training initiatives were collected by the project and are discussed in previous chapters. The way in which the project has been used is a testimony to their general involvement and satisfaction.

Figure 1: Stakeholders interviewed

Secretary to the King's Fund's London Committee

Joint unit general manager of Camberwell DHA's community and priority care unit

General manager of Lambeth, Southwark and Lewisham FPC

Chairman of Lambeth, Southwark and Lewisham FPC

Community nurse manager for Camberwell DHA

Regional adviser for general practice for SE Thames RHA (also a local GP)

The project members:

The director of the department of general practice and primary care

The acting project director

The research fellow

The interviews revolved around a number of general questions: what were the major activities of CPCDP perceived to be? How had it assisted the development of general practice and primary care in the area? What had been the most valuable areas of work? Had there been omissions from its programme? Was it the most appropriate agency to tackle some of the issues it had taken on? Was the way in which the project was structured appropriate? What did the stakeholders expect of CPCDP, and had these expectations been fulfilled?

Almost without exception, those interviewed indicated some uncertainty about three aspects of the project: its identity, the boundaries of its role and the lines of accountability – to whom it was responsible and for what. It is necessary to describe these because they provide an insight into how the project was perceived.

The project's identity

The department of general practice and primary care was so closely associated with the activities of the project, that funders, beneficiaries and sometimes project members themselves found it unnecessary to distinguish between the

two. The funders initially supported the project because they were attracted by the link between a medical school and general practices; managers in the district and clinicians saw the 'Meet the Department' meetings as an intrinsic part of the local networks linking GPs to the hospital, the medical school and district management. This blurring indicates an important symbiotic link between the two organisations.

This was reinforced by overlapping membership. Roger Higgs and Tyrrell Evans were core members of the project and the department. The latter was also part of district management as a member of the corporate advisory board. These networks provided a powerful nexus of influence but had the effect of blurring stakeholders' perceptions of the boundaries. For many, the project was personified by the department. This was aided by the fact that they shared a portakabin on the King's College Hospital site.

Uncertainty about roles

Stakeholders in management positions had different notions of the project's role. They had only a partial knowledge of its activities but there was a general expectation that it could aid primary care planning and increase collaboration. For example, the community unit general manager emphasised the project's role in providing a focal point for information and advice on local general practice and as a resource for the community unit to use in planning care: 'The FPC had been opposed to planning and there was a lack of information on GPs and what services they were providing. We had no idea what they thought was important'. However, these expectations could only be partially met by the project. It could not become a substitute planning authority nor was it a source of definitive data.

Certainly, it was the case that the interviews with GPs had generated a considerable amount of information which could be valuable in planning. Yet interview data was necessarily kept confidential to the project. Control over knowledge made the team influential. However, it was a cause of some frustration to managers that they could not have access even in aggregate form. One stakeholder commented: 'They have a lot of information but they cannot let us have it'; and a second: 'They have so much to say, why hasn't more been written?'. The project was well aware that its relationship with GPs and nurses could be jeopardised if the project was seen to be too closely aligned with management.

In contrast, GPs and those speaking for them were much clearer about the purpose of the project. For example, the regional adviser in general practice saw CPCDP as a resource for general practice: 'to combat the almost total isolation of GPs' and to 'prevent the hospital becoming an ivory tower with no knowledge of what was going on in general practice and no interest in it'. Local GPs shared the implicit understandings which underpinned the project. They were based on shared professional colleague relationships and GPs had a sense of ownership in both the department and the project.

Finally, project members themselves indicated some concerns about their respective roles and relationships. Although they shared a common commitment

to primary care, there was some divergence of aims and interests as well as different skills. Although a division of labour emerged – the GPs concentrated on general practice education while the full time member took a lead in extending collaborative work with the FPC and the local authorities – the fluid organisational structure which characterised the project's second phase did not make prioritising tasks easy.

Uncertainty about accountability

Stakeholders acknowledged the project's value but were uncertain about what could be expected. 'We would have liked them to have done more in relation to child abuse and GP/health visitor liaison', 'we would have liked to put more input into their programme of work but there was no steering group'. The comments indicate uncertainty about the scope of the project's work, about how to influence it, and unease about whether it should be more directly accountable to local stakeholders.

The project's relationships to local GPs also raised issues of accountability. Local managers wished to use the project as a channel of communication but also as a 'sounding board' of GP opinion. In reality, there is no such thing. Each GP is an independent contractor and is not managed through a representative structure. Managers, however, seek ways of understanding the GP culture. Williams [30] and Marks [8] in their studies of planning for primary care refer to the tendency of districts to see the GP member of a planning team as representative. Project members were sensitive to this and were at pains to disclaim any notion of representativeness. Yet it was inevitable that they were used in this way. Their network of contacts gave them an informal authority. In response, they frequently initiated surveys to assess GP views.

The funding body also expressed some unease about accountability. On making the initial grant in 1984, the King's Fund had asked for annual reports. In 1986, it asked for a more general evaluation of activity. This presented difficulties. Evaluation is more problematic when targets have not been set.

Project team members saw themselves as being accountable to groups within the community: to the GPs who were interviewed; to those who expressed an interest in developing shared care protocols; to the health visitors who came to study days; to individuals who asked them for assistance. There was a commitment to street level providers and in presenting their view of the world to managers. The decision in 1985 not to have a steering group but an advisory group reflects this emphasis.

In summary, for stakeholders in Camberwell the status of CPCDP was ambiguous. This has advantages for the project itself as it gave considerable independence in choosing which initiatives to take up and how to carry them forward. It may have minimised clashes of interest because the project could define its own territory and fill the vacuum in primary care policy. Indeed, as the burden of funding has shifted towards the district and FPC, so accountability arrangements have changed. There is a steering group now but, as one project member commented, 'conflicts are beginning to arise'.

Assessments of success

Most stakeholders believed that the project had made a significant contribution to enhancing the status of primary care in the district. They stressed the inherent difficulties in Camberwell with the existing patterns of general practice and stressed 'successes' which reflected their particular interests.

The regional adviser in general practice highlighted the importance of the project's base in the medical school. He argued that this had enabled relationships to be built up between GPs and the hospital. The department meetings and GP interviews identified problems, and strategies for change emerged as a consequence. The project had set the pace for change; had represented the interests of general practice at a number of levels; had faced up to the needs which existed and had provided able administrative support.

For the community unit manager, the project's success lay in its opening up a channel of communication with all GPs, something which was especially valuable in the context of introducing community health programmes. In the recent past, managers' attention had been focused on a few excellent practices, but the project had drawn in almost all practices and it was possible to establish what they wanted and to identify which factors inhibited change. Since the start of the project, primary care agencies had begun to work together much more closely although the process of improving premises and developing teamwork was inevitably slow.

The community unit nursing manager also valued the project as a local resource. Community nurses had been brought within the ambit of the project through the study days for health visitors and GPs. More recently, a senior tutor had been appointed to develop community nurse education. The project had also played a role in developing a training programme for practice nurses with the district, the FPC, and South Bank Polytechnic.

The relationship between the FPC and the project was potentially sensitive. In many FPCs, the general manager has taken a lead in developing policy; has closer relationships with GPs and a better database on practices than in Camberwell. In recent years, the project has been seen by the FPC as a valuable asset. It now contributes to funding and is a member of the new steering group. The general manager of the FPC commented: 'They have galvanised general practice in the district, have established important links with district management and often acted as a catalyst to get things going'. However, he expressed some reservations, about the CPCDP's separation from the FPC.

He argued that the project could identify issues, shortcomings or problems in particular practices, but it had no way of prioritising changes, nor of taking action. It had to rely on persuasion. Nor could the project plan for change, but was required to follow the enthusiasms of particular GPs or groups. It also lacked the information held by the FPC and as a consequence effort had been duplicated. Furthermore, the FPC had not always known about educational programmes and would have liked to have had more input into their content. In some areas of activity, such as the clinical waste disposal service, the solutions reached after project intervention were not necessarily the most cost-effective. In short, this stakeholder argued, it would have been better if the project had subscribed more closely to the FPC's priorities for change.

Clearly, the comments of the stakeholders with managerial responsibilities reflect the positions they occupy and their desire to control the agenda. There were tensions between the stakeholders, which were partly due to role ambiguity, and partly reaction to the strong lead taken by the project.

Strategies for change

The main strengths of the project's way of working arose from its context, its structure and its sense of mission. In 1984, the statutory agencies in Camberwell, in common with many other parts of the country, had not developed an overarching view of primary care. The collaborative networks between the DHA/FPC and the local authority were weak. Attempts had been made in the community and priority care unit to develop a strategic plan for primary care, but this had been abandoned. The community nurses worked within geographical areas and were only loosely attached to practices. There were shortages of nurses, relationships with GPs were not well developed, and there were high levels of social need in the area. The FPC had been inwardlooking and inactive.

CPCDP galvanised various agencies into collaborative activity. So it can be argued that part of its success lay in compensating for the weaknesses of other stakeholders. In many areas of activity which were identified by providers as being important, it took a lead. The project's independent status and its link with the academic department enabled it to build powerful networks. Concrete outcomes were achieved and further resources raised for primary care. Here, the skills and qualities of individual project members were a significant factor and so was their ability to work as a team. These characteristics are a key aspect of the process and will be elaborated further.

Independence from a powerful base

The CPCDP derived strength from its independent position and its ability to be flexible, responsive and react quickly to requests. It could do things without getting permission. It did not have to present papers to committees and get approval. Moreover, it had both legitimacy and authority as a consequence of its links with a department of a medical school in a major teaching hospital and the external sources of funding. Initially, the project networks were academic, medical and largely male. Later, they radiated out in a number of directions into community nursing, the FPC, local authorities and community groups. The networks, and the project team's discussions, provided coherence to the project's many and varied activities.

As a stronger focus for primary care developed in the DHA and FPC, the role and focus of the project changed and, in its third phase, there is a greater clarity about its role and position within the department. The project itself, with a new management structure, is tied into district funding, and has a steering group on which the major stakeholders are represented. The aim of the present phase of work is on issues strongly supported by the FPC and DHA, that

is to increase the number of practices employing practice nurses and to provide a framework for training them.

Another key aspect of the project/department link is that it was underpinned by a clearly articulated educational ethos. The approach was summed up by the department director thus: 'In the absence of comprehensive planning measures (in the FPC and DHA) education forms the only, and in many cases the most powerful, influence on service development'. He argued that education in such a context could promote substantial change. The department depended on local GPs to provide teaching and offered something back to them – the opportunity to enhance professional practice. The project was an adjunct to this work, and each acted as a resource for the other. The project conducted the GP interviews, was a focal point for GP enquiries and, in the absence of any alternative, provided a forum to develop policy and strategy, while the department provided a meeting place for clinicians and managers. It had an identity acceptable to the professional and managerial hierarchies. Together, they represented a base for general practice and primary care within the major district power base – the hospital.

The power base was enhanced by project member and GP Tyrrell Evans' place on the district general manager's corporate advisory board and on the local medical committee. These gave the project access to decision-making within the district. Through Evans the interests of primary care were represented on two key local bodies and the implications of decisions could be spelt out to local decision-makers. Sometimes the policies were modified. The consultative network was wide and the available evidence suggests it was effectively harnessed.

Being financially independent gave the project considerable flexibility in determining aims, priorities and strategy. Its position matched that of GPs who have traditionally sought to avoid too close an identification with the managerial hierarchies of the district and the FPC. Independence enabled it to withdraw from activities when this seemed appropriate, as occurred with the premises and the clinical waste. Independence also gave it the opportunity to engage in activities which posed a threat to existing interests or were simply not high enough on managers' agendas. Examples were the supply and delivery system for GPs and the provision of information on outpatient clinics.

The project as a team

As local GPs, Roger Higgs and Tyrrell Evans knew the problems of local primary care at first hand. Each had different networks; Roger Higgs primarily within the department of general practice and in the medical school, and Tyrrell Evans within the local medical committee, the DHA and the FPC. Virginia Morley developed links with nursing managers, the FPC and with other organisations. As the only full-time worker she had the managerial and administrative task of initiating and supporting activities in the district; seeing that reports were written and sustaining the fund-raising activities. As a team, the members shared an energy and enthusiasm for primary care and made decisions collectively. However, each had their own discrete area of work in which they took the lead.

Building coalitions

Elmore, a policy analyst from the United States, argues that the best way to bring about change is first to identify what is preventing it at the lowest organisational level ... 'the connection between the problem and the point of contact is the critical point of the analysis' [54]. He suggests that thereafter, the most effective way of bringing about change is through building coalitions. The project team worked in this way to good effect.

The relatively high profile of the project was due to the team's success in building networks. The coalitions were of three main types: first, the political and professional networks; secondly, the working groups established to steer particular issues; and lastly, the project itself was a focal point around which looser coalitions could form. It was used as a communications point by a variety of statutory and voluntary agencies.

Value for money

The project had considerable success in raising additional funding, and in drawing on existing skills in the district. The practice nurse initiative has brought in FPC funding through the ancillary staff scheme. Grants were given by a number of bodies besides the King's Fund (see Appendix 1). Such grants represent a revenue gain to the district. The project was able to mobilise support in kind as well as cash. Teaching staff within the department of general practice helped to run courses and provided skills lacking in the project itself.

Last, but not least, the CPCDP has been a low-cost initiative overall and particularly for the FPC and DHA. Local agencies have drawn on the project because it could provide services at a lower cost, or more effectively than they could themselves. For example, hard-pressed nurse-managers welcomed the GPs/health visitors initiative. The FPC acknowledged the need for an updated medical list, and a booklet on local services, so the tasks went to the project, which had the time and the skills to do this at reasonable cost.

A model for wider application?

Within some of the project's strengths lay some of its weaknesses. Its independence set limits to the type of issues it was able to take on, because its resources were limited. Sometimes it was unable to push through policies because it lacked the resources and power to do so. In areas where collaborative activity was necessary, it was much more difficult for the project to implement change. Areas such as developing teamwork initiatives had limited effects when not tackled at a senior management level, by the statutory authorities.

Such difficulties are not unique to Camberwell. Other studies have indicated the difficulty of achieving change in the absence of strong support from managers [31, 55]. In retrospect, the lack of a steering group with local

stakeholders where common objectives could develop may have been a mistake. However, such a group might have stifled the project, rather than steering it.

The openness and flexibility of the project incurred costs to team members. With one full-time, and two part-time staff members, plus secretarial assistance, there were times, particularly in phase II, when resources were stretched. The pressure to raise funds was constant. Considerable effort was put into supporting new initiatives, which squeezed out time for analysis and reflection. As the demands increased, priorities had to be reassessed. Pressures were inevitably greatest on the full-time member who was working without the back-up of an organisational structure with its attendant benefits of security, career structure and colleague support. Some of the project's activities in support work: setting up meetings, getting people together, developing agendas, taking the minutes – until ownership was taken on by another person, or group, tend to be taken for granted.

Lessons for whom?

There are a number of problems in attempting to draw lessons from Camberwell. First, the project was a creature of its context. A unique set of difficulties and opportunities existed in Camberwell. Secondly, the project team had specific, personal qualities and talents which contributed in tangible but immeasurable ways to successful process and outcome. These could not necessarily be replicated elsewhere. Thirdly, the policy context is changing. The proposals in *Working for Patients* [10] and the new GP contract will order local priorities differently. Finally, it has to be asked, lessons for whom?

Since 1984, the Department of Health has urged authorities to collaborate in primary care. The project's work indicates how difficult that task is. In comparison with other facilitator projects [50], CPCDP achieved a good deal but as long as the organisation of primary care remains divided between FPCs and DHAs, such gains will have to be made against the organisational grain.

For regional health authorities, which now have a responsibility for primary care development, CPCDP has demonstrated that a small team can initiate and sustain a range of activities. The presence of at least one full-time worker is important in maintaining momentum and a permanent contact point. The strategy of initiating activities and withdrawing when they have been brought into mainline programmes enables a project team to move into new areas where they can have an impact.

There are two tough lessons to be learnt from the way in which the CPCDP was structured. Project tasks are more likely to be linked to the strategic aims of the statutory authorities with a steering group made up of local stakeholders so that co-ordinated executive action can then be taken.

The second lesson is that, if evaluation is expected, the objectives and criteria for measurement should be set in advance. Ideally, monitoring and evaluation should involve someone external to the project.

Finally, there are lessons for departments of general practice studies. Local GPs responded to the department and the project in a positive way. Almost all

were involved in the interviews. The department meetings were attended by numbers representing a third to a half of the GPs in the area. The department was committed to addressing practical issues arising in everyday practice and in so doing provided a forum for the improvement of professional standards and peer review. No other departments of general practice in London have developed in this comprehensive way.

In conclusion, and looking forward to the 1990s, perhaps the greatest contribution of CPCDP will be to provide the leadership so that all professional groups concerned with primary care can discuss, develop and negotiate the changes envisaged in *Working for Patients* and the new GP contract. These proposals aim to improve general practice: to have better premises; more attached staff; increased information for patients and higher clinical standards. They also draw general practice into the NHS management culture and impose greater controls. They re-draw the line between the management tasks of the FPC and autonomous clinical practice. CPCDP has created a culture and a structure where these changes can be viewed positively and the opportunities offered, taken. This is surely in the interests of patients.

APPENDICES

Appendix 1 Funding the Camberwell Primary Care Development Project

Sources of funding

Date	1984/85	1985/86	1986/87	1987/88	Feb 1988
Purpose				To fund core staff of project of 2 GPs, a project officer and admin. post	To support the appointment of a diabetic specialist health visitor
Lambeth Southwark & Lewisham FPC					
Camberwell DHA			£10,000 Joint consultative committee (single payment)	£10,000 Community and priority care unit	
Regional Development Fund					
Charitable Sources	£18,000 King's Fund (LPEC)*	£30,000 King's Fund (LPEC)*		£20,000 King's Fund (LPEC)*	£36,000 Baring Bankers (2 years)

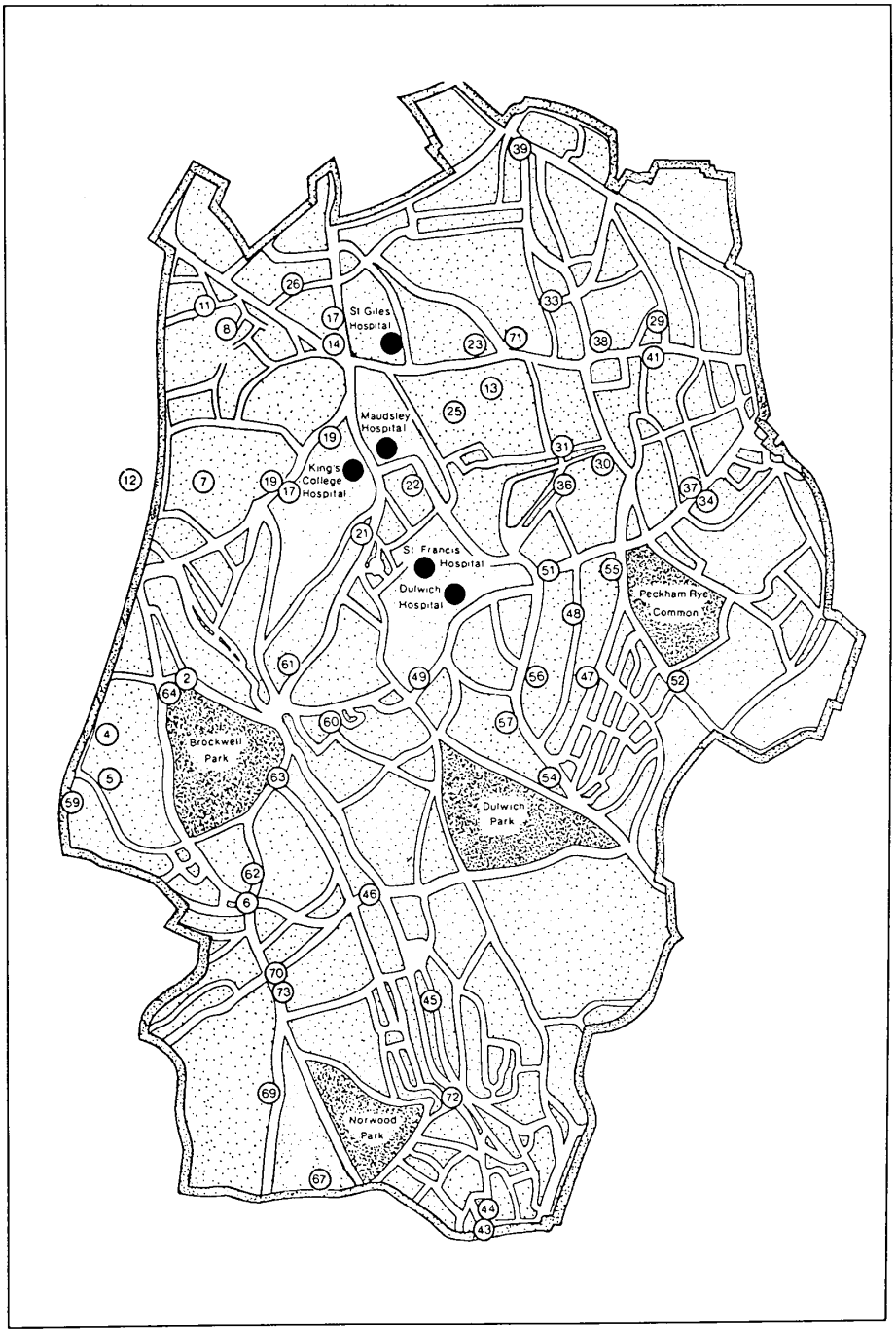
* LPEC London Project Executive Committee

1988/89	May 1988	July 1988	July 1988	July 1988	April 1989
To fund core staff	To start work on information handbook for the public	To fund work to examine low uptake of ancillary staff scheme in Camberwell and initiate action	To appoint an asthma physio. to develop the asthma shared care scheme in Camberwell	To support the appointment of a second specialist health visitor in diabetes	To print information handbook for the public
		£6,000 (single payment)		Some of this money was reimbursed under the ancillary staff scheme from FPC	
£20,000 Community and priority care unit	£6,500 Directorate of consumer services (single payment)				£5,000 Community and priority care unit (single payment)
			£38,000 (2 years)	£40,000 (2 years)	

Date	Apr 89/90	Apr 89/90	Oct 1989	Dec 1989	TOTAL
Purpose	Core funding	Funding for additional project officer and admin. post	Funding for development of practice nurse forum	Contribution to fund writing up of project report for publication	
Lambeth Southwark & Lewisham FPC		£15,000 Posts reimbursed under ancillary staff scheme from FPC	£1,000 (single payment)		£22,000
Camberwell DHA	£30,000 Community and priority care unit				£85,800
Regional Development Fund					£50,000
Charitable Sources				£2,000 King's Fund (LPEC)*	£116,000

* LPEC London Project Executive Committee

Appendix 2 GP practices in Camberwell Health District 1989



Appendix 3

Advisory Group

Camberwell Primary Care Development Project

1986 – 9

Linda Benson	Unit General Manager, Community Unit, Riverside DHA
Ros Corney	Senior Lecturer, Institute of Psychiatry, GP Research Unit
Nancy Dennis	National Development Worker, College of Health, previously Project Officer in Tower Hamlets
Pat Gordon	Director, Primary Health Care, London Programme, King's Fund Centre for Health Services Development
Jane Hughes	Secretary to the London Project Executive Committee (until May 1988)
John McEwan	GP Member on Camberwell DHA
Rabbi Julia Neuberger	Lecturer in Medical Ethics
Mary Whitty	Unit General Manager, Riverside DHA, previously FPC Administrator, Kensington Chelsea and Westminster

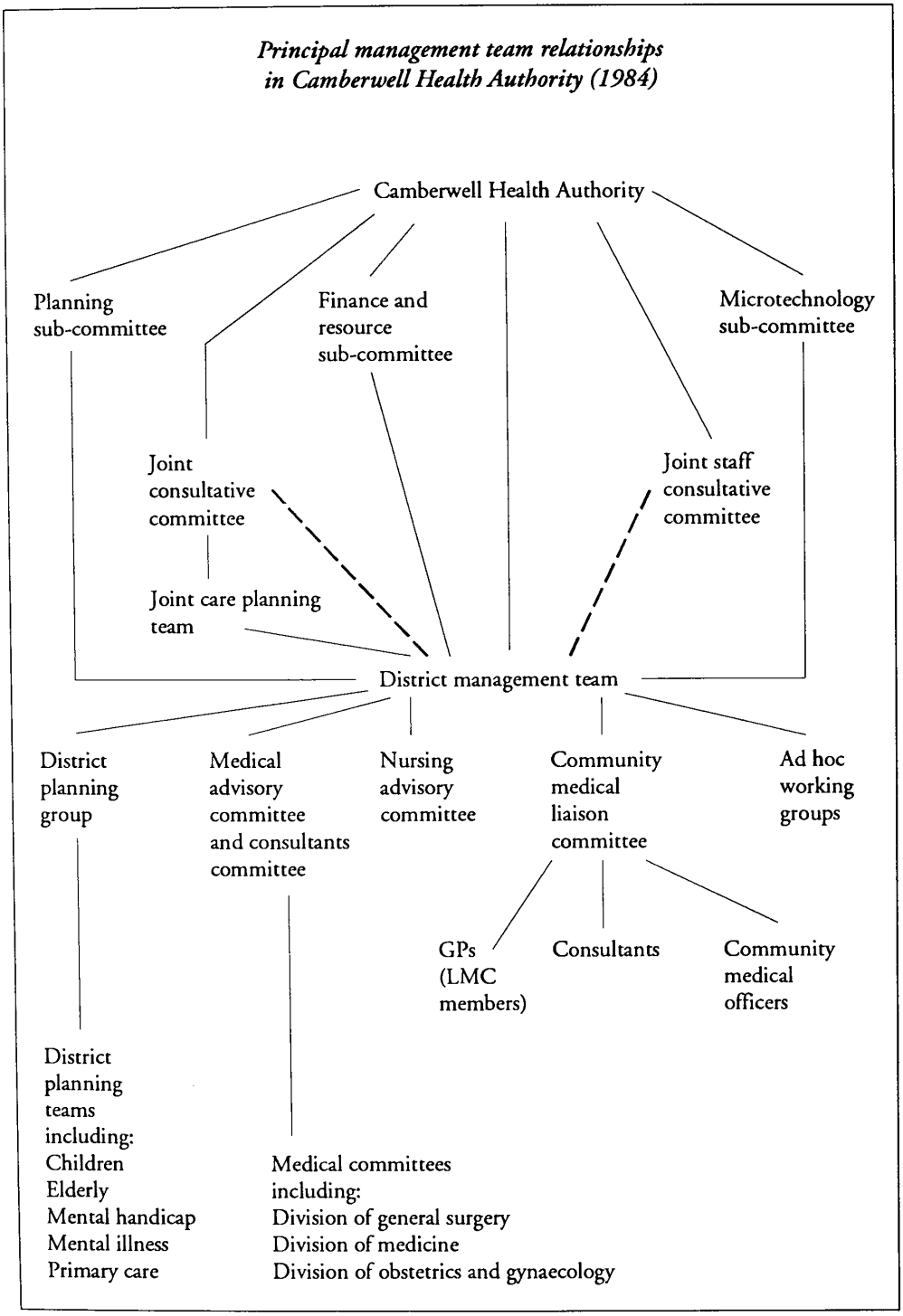
Appendix 4

Abbreviations

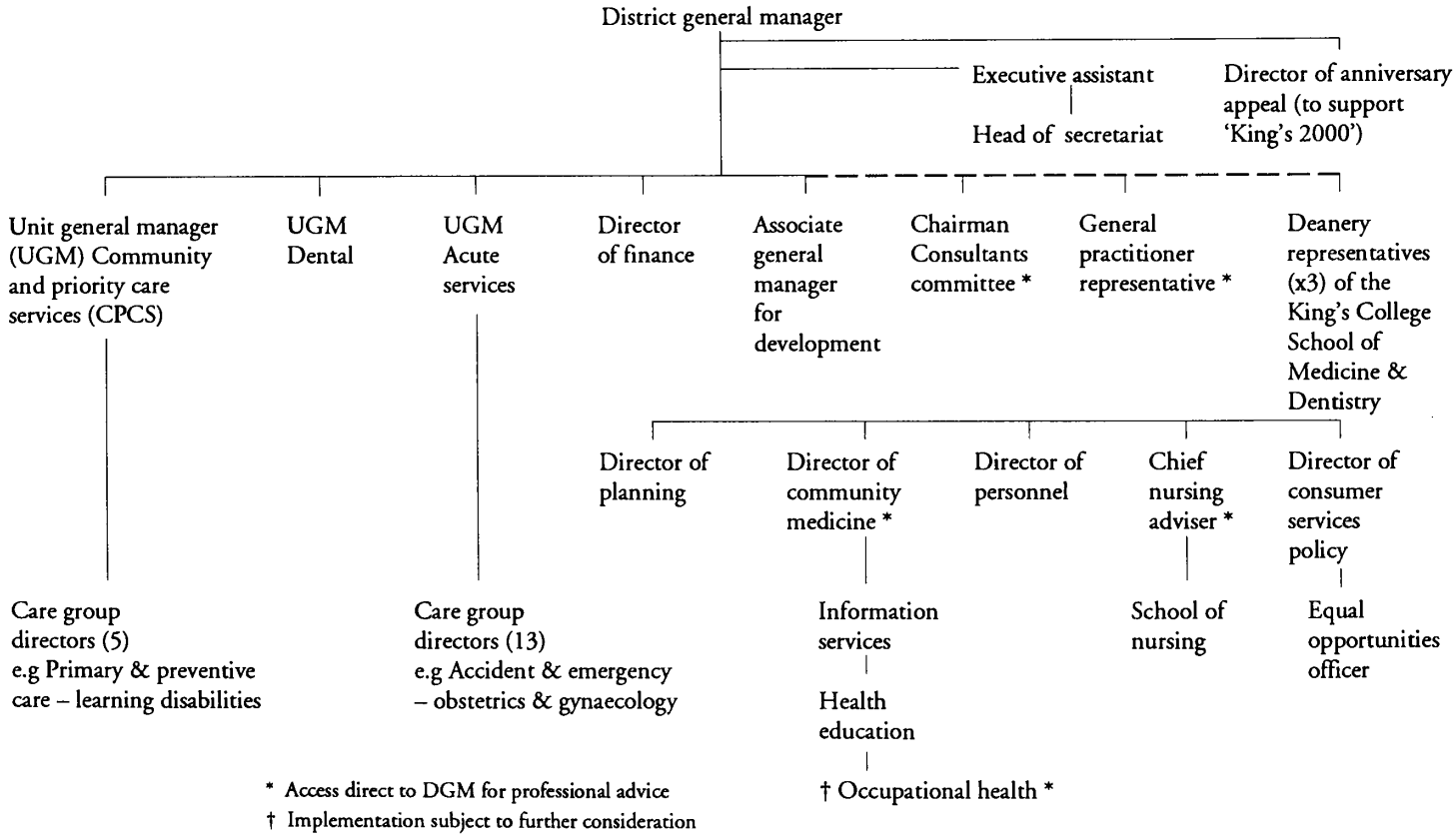
CHC	Community health council
CPCDP	Camberwell Primary Care Development Project
CPCU	Community and priority care unit
FPC	Family practitioner committee
GP	General practitioner
LMC	Local medical committee

Appendix 5

Principal management team relationships in Camberwell Health Authority (1984)



Principal management arrangements April 1988 – Camberwell Health Authority

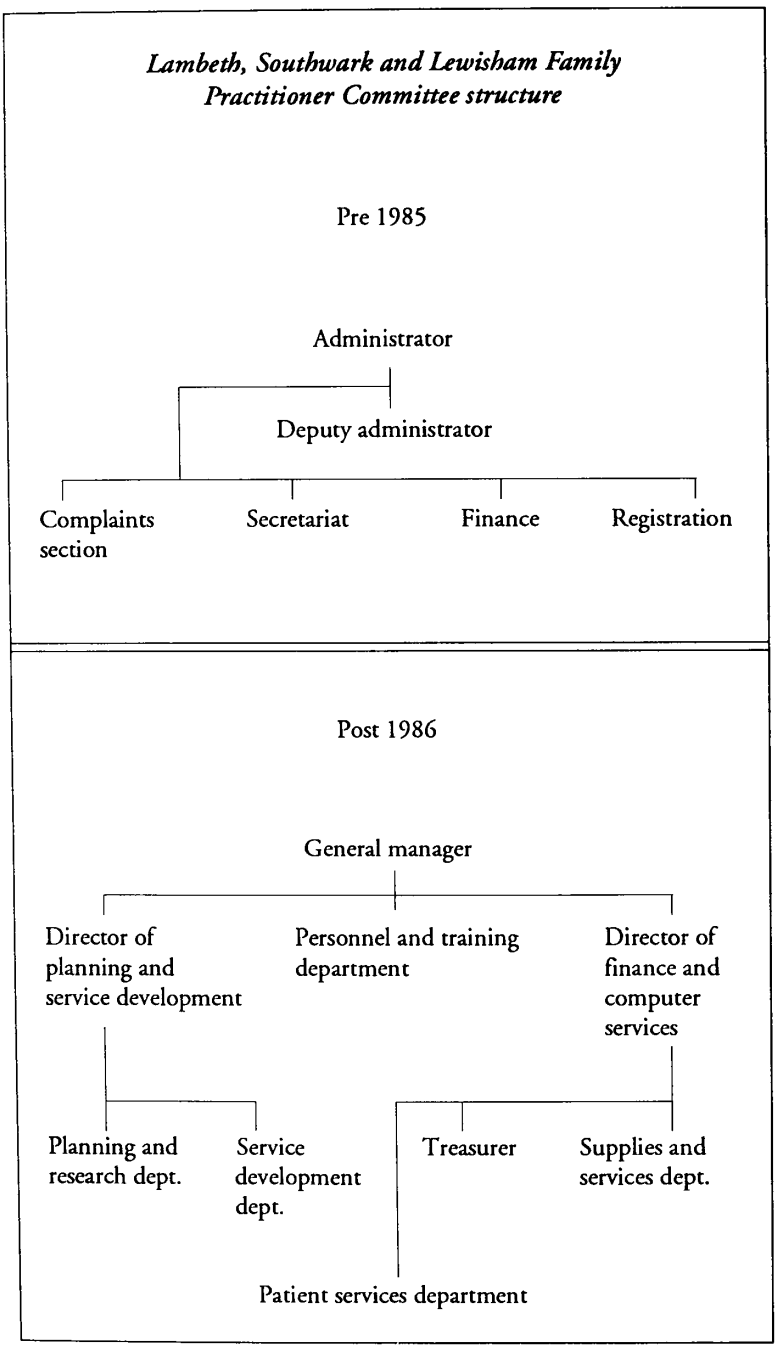


* Access direct to DGM for professional advice

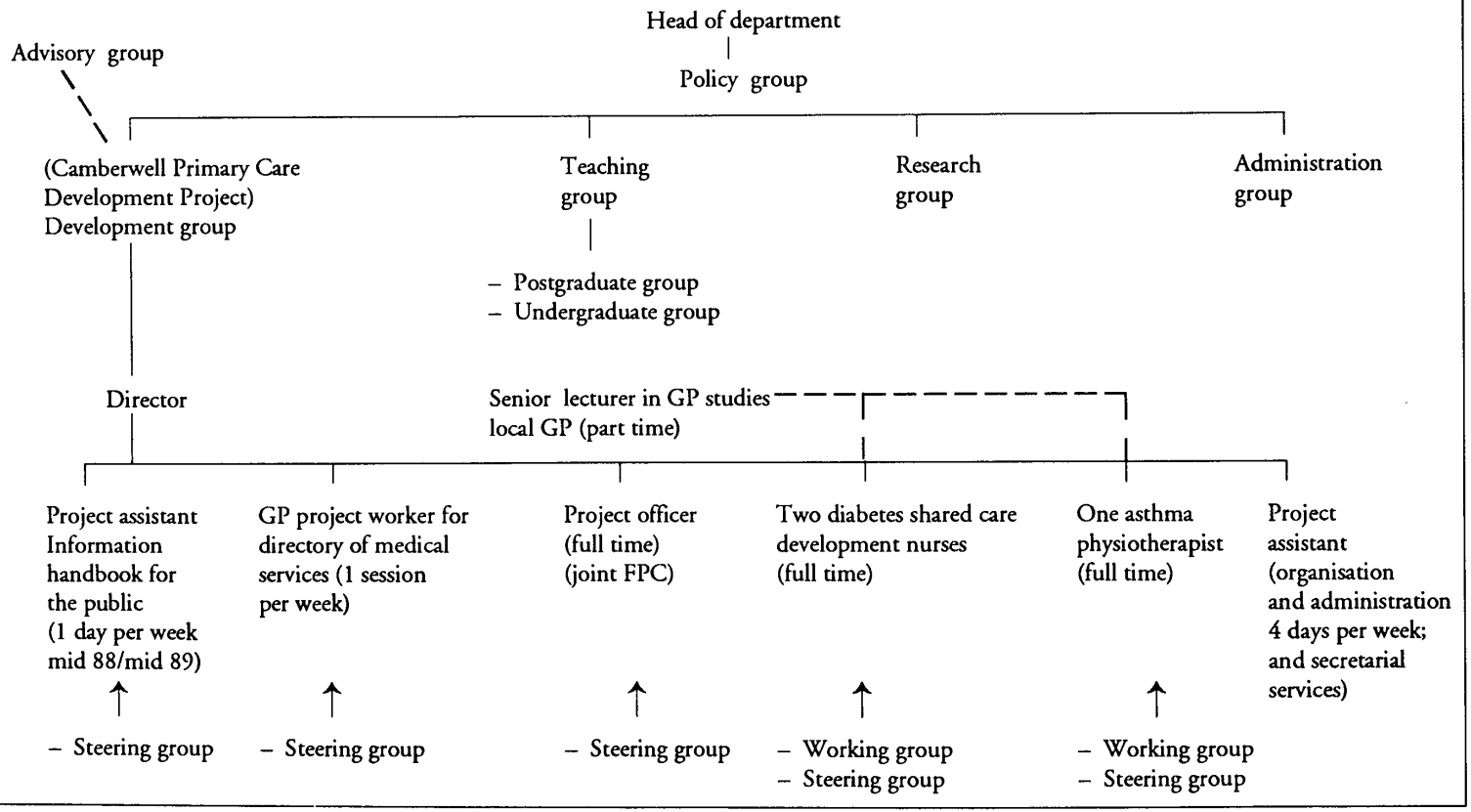
† Implementation subject to further consideration

Appendix 7

Lambeth, Southwark and Lewisham Family Practitioner Committee structure



Structure of the CPCDP in relation to the Department of General Practice and Primary Care at King's College School of Medicine & Dentistry 1989



REFERENCES

1. London Health Planning Consortium, *Primary Health Care in Inner London* (Acheson Report) London Health Planning Consortium, 1981.
2. Elliott, A. 'General practitioner facilitator: A personal view', *Health Trends* 16, pp.74-76, 1984.
3. Dennis, N. 'An inner city primary health care project', *Times Health Supplement*, March 1987.
4. Department of Health, *Primary Health Care: An agenda for discussion*, London: HMSO Cmnd 9771, April 1986.
5. Department of Health and Social Security, *Neighbourhood Nursing: A focus for care*, Report of the Community Nursing Review (Cumberlege Report), London: HMSO, 1986.
6. House of Commons, *Primary Health Care* Vol. 1, Social Services Committee, First Report Session 1986-7, London: HMSO, 1987.
7. Department of Health, *Promoting Better Health: The government's programme for improving health care*, London: HMSO, Cmnd 249, November 1987.
8. Marks, L. *Promoting Better Health? An analysis of the government's programme for primary care*, King's Fund Institute, Briefing Paper 7: London, 1988.
9. Department of Health, *General Practice in the NHS*: A new contract, London: HMSO, 1989.
10. Department of Health, *Working for Patients*, London: HMSO, 1989.
11. Office of Health Economics, *Compendium of Health Statistics*, Table 4.9, 1987.
12. Doll, R. 'Major epidemics in the 20th century', in Central Statistical Office, *Social Trends*, 18, London: HMSO, 1988.
13. Honigsbaum, F. 'Reconstruction of general practice: failure of reform', *British Medical Journal*, 290, pp. 823-26, 1985.
14. General Medical Services Committee, *General Practice: A British success*, London: British Medical Association, 1983.
15. St. Mary's Medical School, *A Survey of Primary Care in Inner London*, Report of the Royal College of General Practitioners, Occasional paper 16: London, 1981.
16. National Audit Office, *Management of Family Practitioner Services*, London: HMSO, 1988.
17. Wilkin, J. Hallam, L. Leavey, R. and Metcalf, D. *Anatomy of Urban General Practice*, London: Tavistock, 1987.

18. Prashar, U. Rhodes, G. Young, K. *After Acheson: Primary health care in the inner cities*, London: Policy Studies Institute, 1986.

19. Irvine, D. '*Quality of care in general practice: our outstanding problem*' Journal of the Royal College of General Practitioners, 33, pp521-23, 1983.

20. Royal College of General Practitioners, *Towards Quality in General Practice*, London: RCGP, 1985.

21. Royal College of General Practitioners, *What Sort of Doctor? Assessing the quality of care in general practice*, Report on general practice 23, London: RCGP, 1985.

22. Central Statistical Office, *Social Trends*, 19, p. 135, HMSO: London, 1989.

23. Tudor-Hart, J. *A New Kind of Doctor: The GP's part in the health of the community*, 1988.

24. Huntington, J. *Report of a Project to Investigate the Training and Development Needs of Family Practitioner Committees with particular reference to their Management Development Needs*, London: King's Fund College, 1987.

25. Bowling, A. and Stilwell, B. (eds) *The Nurse in Family Practice*, London: Scutari Press, 1988.

26. Department of Health and Social Security, *The Primary Health Care Team* (Harding Report). London: DHSS, 1981.

27. Bowling, A. *Delegation in General Practice: A study of doctors and nurses*, London: Tavistock, October 1980.

28. Department of Health and Social Security, *Joint Working Group on collaboration between DHAs and FPCs (Chairman Mrs B Petrie)* London, 1984.

29. Allsop, J. and May, A. *The Emperor's New Clothes: Family practitioner committees in the 1980's*, King Edward's Hospital Fund for London, 1986.

30. Williams, S. 'Case studies in collaboration', *The Family Practitioner Services Journal*, 13, 3 pp. 39-43, 1986.

31. Marks, L. *Collaboration between FPCs and DHAs*, Vol. I, King's Fund for Health Services Development: London, 1989.

32. Public Health Report, Academic Department Community Medicine, King's College School of Medicine & Dentistry: London, 1989.

33. Jarman, B. 'Identification of underprivileged areas', *British Medical Journal*, 286, pp. 1705-1709, 1983.

34. *Camberwell Public Health Report*, 1989. Academic Department of Community Medicine, King's College School of Medicine & Dentistry: London, 1989.

35. Department of Health and Social Security, *NHS Management Inquiry* (Griffiths Report), London: 1983.

36. Heller, R. *General Practice in South East London: an uncompleted study,* Department of General Practice, United Medical Schools, St. Thomas Street, London SE1, c1980.

37. Horder, J. Bosanquet, N. Stocking, B. 'Ways of influencing the behaviour of general practitioners', *Journal of the Royal College of General Practitioners,* 36, pp. 517-521, November 1986.

38. Greater London Council, *2nd Report on Disposal of Clinical Waste.* London, 1984.

39. Greater London Council, *3rd Report on Disposal of Clinical Waste.* London, 1985.

40. Evans, T. and McEwan, J. *Survey of GPs in Camberwell,* King's 2000: London, 1988.

41. Noble, A. GP *Premises and the Provision of Primary Health Care Facilities in Inner London,* Inner London Practice Premises Unit, Medical Architectural Research Unit, North London Polytechnic, May 1984.

42. Dammers, J. *Counselling in General Practice,* South East Thames Primary Care Development Fund: London, March 1989.

43. King's Fund Centre Workshop report by health visitors from Tower Hamlets, *A Fresh Look at Health Visiting within the Bangladeshi Community.* London, August 1984.

44. Cowburn, C. *An Evaluation of an Innovation in Teamwork for General Practitioners and Health Visitors,* Undergraduate Thesis, May 1989.

45. Hill, R.D. 'Community care service for diabetics in the Poole area', *British Medical Journal,* 1, pp. 1137-1139, 1976.

46. Yudkin, J.S., Boucher, B.J. and Schopflin, K.E. 'The quality of diabetic care in a London health district', *Journal of Epidemiological Community Health,* 34, pp. 227-280, 1980.

47. Foulkes, A., Kinmouth, A-L., Frost, S. and Macdonald, D. 'Organised personal care: an effective choice for managing diabetes in general practice', *Journal of the Royal College of General Practitioners,* 39, pp. 444-447.

48. Wood, J. 'A review of diabetes care initiatives in primary care settings', *Health Trends,* 22, pp. 39-43, 1990.

49. Coates, R., Robin Coates Associates, 43 Woodstock Road North, St. Albans, Herts, personal communication, 1989.

50. Allsop, J. *Changing Primary Care: The role of facilitators,* King Edward's Hospital Fund for London, 1990.

51. Bulmer, M. *The Uses of Social Research,* London: Macmillan, 1977.

52. Smith, G. and Cantley, C. *Assessing Health Care: A study in organisational evaluation,* Open University Press: Milton Keynes, 1985.

53. Young, K. 'Values in the policy process', *Policy and Politics,* 5, 3, pp. 1-22, 1977.

54. Elmore, R.F. 'Backward mapping: implementation research and policy decisions', *Political Science Quarterly*, 94, 4, pp.601-616, 1980.

55. Dennis, N., Malin, S. 'General practitioners' plans for developments in the inner city: A review by a primary care project', *Journal of the Royal College of General Practitioners*, 38, pp. 366-369, August 1988.

FURTHER READING

Bickler, G. *Southwark's Health*, A report of the health of Southwark for the London Borough of Southwark, Public Protection Department, 1987.

Bolden, K.J. *Inner Cities*, 19 occasional papers, Royal College of General Practitioners, Exeter Department of General Practice, 1981.

Bond, J. and Cartlige, C. *Interprofessional Collaboration in Primary Health Care Organisations*, Health Care Research Unit, University of Newcastle upon Tyne, 1985.

Brooks, D. 'Teams for Tomorrow: Towards a new primary care system', *Journal of the Royal College of General Practitioners*, June 1986.

Brooks, D. 'The tensions within teams', *Update*, 1 December 1986.

Camberwell Primary Care Development Project, *Interim Progress Report to King Edward's Hospital Fund for London*, December 1985.

Campbell, S. *Survey of Primary Health Care Facilities*, Department of Community Medicine, King's College School of Medicine & Dentistry: London, April 1984.

Department of Health, *FPS Service Indicators 1987/88*: London, May 1989.

Draper, J., Farmer. S., Field, S., Thomas, H. and Hare, M.J. 'The working relationship between the general practitioner and the health visitor', *Journal of the Royal College of General Practitioners*, May 1984.

Grace, J.F. *The Role of a GP Facilitator in the Delivery of Health Services to the Population of Medway Health District*, November 1988.

Hammersley, M. and Atkinson, P. *Ethnography*: Principles and practice, London: Tavistock, 1983.

Howie, J.G.R., Hannay, D.R. and Stevenson, J.S.K. The Mackenzie Report: General practice in the medical schools of the UK: Edinburgh, 1986.

Jarman, B. 'Underprivileged areas: validation and distribution of scores', *British Medical Journal*, 289, pp. 1587-1592, 1984.

King's College School of Medicine & Dentistry, Department of General Practice Studies, Annual Report: London, 1988.

King's College School of Medicine & Dentistry/ Camberwell District Health Authority, *From birth to death in Camberwell 1981-1985*, Department of Commuity Medicine, occasional paper 1: London, 1987.

Morley, V., Evans, T., Higgs, R. 'Danger in the dustbins', *The Health Service Journal*, May 1988.

Morley, V., Evans, T., Higgs, R. 'Developing primary health care premises in inner London', *The Health Service Journal*, September 1988.

Morrell, D., Courtenay, M. and Wyn Owen, J. *A Survey of General Practice*, Department of General Practice, United Medical Schools, St. Thomas Street, London SE1, c1980.

Noble, A. *Final progress report to King Edward's Hospital Fund for London*, May 1984.

Pepper, L. *Final Report of the Speke Collaboration Project*, February 1988.

Pettigrew, A., McKee, L. and Ferlie, E. 'Understanding Change in the NHS', *Public Administration*, 66, pp. 297-318, 1988.

Reedy, B.L.G.C. 'Discrepancies in the perceptions of a structural relationship for team work', Occasional paper 1, *Nursing Times*, 77, pp. 93-95, 1981.

Rees, H. *Interviews with Women's Groups*, Department of General Practice Studies, King's College School of Medicine & Dentistry: London, April 1984.

Stocking, B. *Initiative and Inertia: Case studies in the National Health Service*, Nuffield Provincial Hospital Trust, 1985.

Tudor-Hart, J. 'Measurement of omission', *British Medical Journal*, 249, pp. 1686-9, 1982.

UK Central Council for Nursing, Midwifery and Health Visiting, Project 2000: *A new preparation for practice*, UKCC: London, 1986.

Whitehouse, C.R. 'Conflict and co-operation between doctors and nurses in primary health care', *Nursing Practice*, 1, pp. 242-245, 1986.


020000 048572

a case study IN DEVELOPING primary care

General practice and community health services are uneven in quality and quantity, yet they are seen as the key to effective health care in the future. This book is about developing these primary care services.

Virginia Morley and her colleagues describe the work of the Camberwell Primary Care Development Project: its focus on practical service development, its skill in bringing together statutory agencies, its strength from local knowledge and networks, its base in a department of general practice with a clear view about how services could improve locally. The authors analyse some of the obstacles to change — poor communication between GPs and hospitals, mistrust between health visitors and GPs, inadequate premises — and describe the steps they took to overcome them and the reasons for success and failure.

The Camberwell Report *is a case study in developing primary care. It is also about innovation and change in the NHS. Why does it happen in one place and not another? Judith Allsop provides an outside assessment and commentary which puts the work in a wider context and helps draw out the lessons about initiating and sustaining improvements in health care.*

£12.95

ISBN 1-85717-006-7