Practices Make Perfect:
The Rôle of the Family Health Services Authority
Preface

The Audit Commission oversees the external audit of local authorities and the National Health Service (NHS) in England and Wales. As part of this function, the Commission is required to review the value for money provided, and to do so, undertakes studies and audits of selected topics each year.

The Commission has been responsible for the audits of family health services authorities (FHSAs) since their inception in 1990 with arrangements first audited in 1990/91. The preparatory work for the 1990/91 audits was undertaken by Mike Robinson and Anne Stuart. Some of the findings set out in this report are based on those first audits.

A more detailed review of the development of FHSAs then followed and this report sets out the findings of that review. It has been undertaken in parallel with a review of the commissioning rôle of district health authorities, published separately in a report entitled Their Health, Your Business (Ref.1). Taken together these two reports provide a summary of the introduction of commissioning to the NHS.

The more recent review was undertaken by Paul Durham (project manager), Anne Stuart and Geoffrey Jenkins under the direction of David Browning and supported by Mark Davenport and Patrick Graydon. Advice was provided by Professor Richard Hobbs (General Practitioner and Professor of General Practice at Birmingham), Dr. Donald Irvine (General Practitioner), Barbara Stilwell (Nurse Practitioner and Principal Lecturer at the Institute of Advanced Nursing Education, Royal College of Nursing) and June Huntingdon. A full list of the other advisers to the project is given at Appendix 1. The Audit Commission is very grateful for their help.
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CHANGING PRESSURES

The family health services provided by general medical practitioners (GPs) and practice nurses, dentists, pharmacists and opticians provide the main point of contact with the National Health Service (NHS) for most people. They cost £7 billion in 1991/92. General medical services accounted for nearly £5 billion (70%) of this expenditure including drugs and as a result, most of this report focuses on these important services. The rôle FHSAs play in managing the other services (dentists, pharmacists, opticians) is described separately (chapter 3).

UNDERMANAGED AND UNDER PRESSURE

In spite of this high expenditure, the structures for providing support and investment for general practices and for holding them to account have been weak. Many practitioners have used the freedom provided by these loose arrangements to develop excellent services including many innovative schemes. But the range and standards of service provided have varied widely with different referral rates to hospitals, uneven quality of care, and professional isolation for many GPs. Pressures have been mounting, with rising costs, increasing expectations, and changes in policy which place greater emphasis on primary care: community care policies in particular are increasing GP responsibilities for elderly people and people with disabilities and mental health problems.

NEW INITIATIVES

The medical profession itself has been taking initiatives to address some of these changes; and the Government has given a lead with:

— **New policies** introduced in a series of white papers, with supporting legislation provided by the NHS and Community Care Act 1990;

— **New ways of operating** with the introduction of the 1990 GP Contract, and GP fund-holding;

— **A new framework** with the introduction of family health services authorities (FHSAs) in 1990, reporting to regional health authorities (RHAs).

FAMILY HEALTH SERVICES AUTHORITIES

The agenda for change is large. The Government established FHSAs to promote change locally. FHSAs took over from family practitioner committees (FPCs) and their first rôle was to continue the former rôle of FPCs, acting as **providers** of common services making payments and providing administrative support. But they have also been extending this rôle to act as **development agencies** promoting good practice. Increasingly, if they are to give practices the support they need, they must start to act as **commissioners** of services, assessing need and developing policy. And they must undertake **performance review**.

Summary
GETTING STARTED
ADMINISTRATION AND SERVICE DEVELOPMENT

Internal Management

The FHSAs' first task was to introduce new management structures and arrangements. All have now done so, but further progress can still be achieved. FHSAs need to ensure that they:

— fully involve members by providing training where necessary, and by using their skills on specialist panels;
— promote efficiency by streamlining paperwork, using electronic data transfer wherever possible and improving the management information produced;
— co-ordinate and target the use of professional advisers to best effect.

The process could be helped if FHSAs could keep part of any administrative savings for reinvestment in patient services.

Promoting Practice Development

FHSAs have also been promoting practice development. They must address clinical issues through their professional advisers by:

— promoting good prescribing practice through better information and education;
— developing a health promotion strategy that encourages local initiative and choice;
— developing arrangements for managing chronic conditions;
— focusing support on practices that are struggling to achieve targets;
— promoting and monitoring the quality of minor surgery (with reports of incomplete excisions and undetected carcinomas);
— setting a framework for medical audit with agreed performance indicators.

Practices are employing more staff from a wider range of professional backgrounds. FHSAs should be taking steps to improve practice staffing arrangements by:

— providing advice on practice management and organisation;
— reviewing training needs and co-ordinating training schemes;
— promoting and supporting team working.

FHSAs should also be strengthening practices’ infrastructures by:

— developing an information strategy, providing a framework for the development of information technology in practices: currently, management information is poor and there is a plethora of different systems;
— surveying and improving the state of practice premises.

Finally FHSAs should be assisting practices who are preparing for fund-holding. And in future some degree of local influence over the distribution of funds may be necessary, with 40 fund-holders declaring savings in excess of £100,000 in 1991/92 with five in excess of £200,000.
MOVING ON:
COMMISSIONING SERVICES AND REVIEWING PERFORMANCE

General Medical Services

So far most FHSAs have been concentrating on the initial agenda opposite. Some are now building on this agenda, adjusting it to take account of local circumstances, acting as service commissioners. And they must monitor what they commission, with performance review increasing in importance.

— **Need assessment** provides a key starting point. Increasingly, practices can provide data on morbidity patterns because of computerisation; and they can provide comments and suggestions. District health authorities (DHAs) also collect data through their directors of public health; and local authorities have information on community care. National sources of data such as the General Household Survey can also be useful. FHSAs must collect and sifting this information in conjunction with these other agencies. They need to use it to shape their own strategies; and they should feed it back as 'practice profiles' to practices to enable them to compare themselves with others, and plan their services.

— **Priority setting** must then follow. The needs assessment process should reveal patterns of social deprivation and incidence of disease and risk. FHSAs should then establish strategic priorities, working with health and social services.

— **Implementation** of priorities requires FHSAs to ensure that practices adopt them. Here there can be difficulties. The powers of FHSAs are limited. They must rely on persuasion backed by modest incentives from the cash-limited part of their budget.

— **Performance review** must then follow. Quality assurance frameworks are required for the evaluation of practice activity. But here again, FHSAs' lack of powers can reduce their effectiveness; and there are major resource implications for FHSAs if they take performance review seriously.

— **RHAs** need to provide more extensive support to FHSAs based on comparative studies where appropriate.

Dental, Pharmaceutical and Ophthalmic Services

FHSAs also have a responsibility to develop and plan the services provided by dentists, community pharmacists and opticians. But they have even fewer powers and resources than they have for developing a local agenda for general medical services. They have little budgetary discretion, and little leverage. Many FHSAs have no advisers with relevant experience. But NHS expenditure on these services is about £2 billion and there is scope for FHSAs to promote and develop services. If they are to play a more significant rôle, their responsibilities and powers will need to be aligned.
**NEXT STEPS**

While there is much that FHSAs can improve within current arrangements, overall progress will also depend on a clarification of relationships with other key players - particularly DHAs and practices.

**Developing Local Initiatives**

Primary care is taking a more central and influential rôle within the NHS. Further improvements could be impeded by too rigid a framework. GPs should have greater say in the services they provide and greater flexibility through greater delegation; but such flexibility must be linked to strategic policy with increased accountability within clear terms of reference. A framework is needed that allows greater flexibility while ensuring that such flexibility aligns with strategic policy. It will not be possible to achieve this from the centre and FHSAs are the logical agencies to take the lead. They will not be able to do so working alone and must work with others - particularly DHAs. But current links are not adequate and require strengthening.

**Linking FHSAs and DHAs**

The current separation of responsibilities creates boundaries between primary and secondary care limiting the scope for adjustment, and it restricts management. Many FHSAs are working very closely with DHAs, sharing a single chief executive and other senior staff. Some aspects of close working are voluntary and are being adopted by some DHAs and FHSAs. All need to be encouraged to work jointly. Legislation is required to allow authorities to merge if they are to realise the full benefits of joint working, improving value for money.

**Linking Commissioning Authorities and Practices**

The relationship between commissioning authorities and practices then needs to be clarified. Strategies worked out by such authorities should include the national agenda but should also address local issues. And such strategies should be co-ordinated with practice activities through practice agreements. These agreements should set out objectives and targets and specify financial arrangements including payments, replacing some of the more inflexible aspects of the 1990 GP contract.

**The Audit Commission's Audits**

However, in the short term, improvements must continue within the current context. The Audit Commission, through its field auditors, is reviewing the way FHSAs are addressing the issues set out in this report. The outcome will be confidential reports to FHSAs, setting out agreed courses of action.
1. For most people, the family health services provided by general medical practitioners (GPs) and practice nurses, dentists, pharmacists and opticians provide the main point of contact with the National Health Service (NHS). On an average working day, 750,000 people visit their GP; about 1,500,000 prescriptions are presented at pharmacies; a further 300,000 visit their dentist and dental auxiliary staff; and 17,000 have their sight tested by an optician under the NHS. These important services are the front line of the NHS and together with the community health services (district nurses, health visitors and others) they make up the primary health care services. Since the start of the NHS in 1948 the family health services have been provided by independent, self-employed contractors and their staff: currently there are 30,000 GPs, 16,000 dentists, 10,500 pharmacists and 6,500 ophthalmic opticians in England and Wales. Community health services are provided by NHS trusts and district health authority directly-managed units.

2. The family health services cost £7 billion in England and Wales in 1991/92 (Exhibit 1). General medical services cost £2,383 million with pharmaceuticals prescribed by GPs costing a further £2,522 million. Pharmacists received £631 million for processing these prescriptions. Dental services cost the NHS £1,298 million and ophthalmic services £152 million. Expenditure has risen by a quarter since 1988/89 mainly due to increases in the general medical services, which when drugs are included, now account for £5 billion or 70% of total spending on the family health services.

Exhibit 1
NHS EXPENDITURE IN ENGLAND AND WALES ON FAMILY HEALTH SERVICES (1991/92).
The family health services cost £7 billion with general medical services accounting for £5 billion or 70% including drugs.

Source: Department of Health Departmental Report and Accounts of Welsh FHSAs.
3. General medical services are nearly all funded in full by the NHS, while the other services receive only a proportion of their income from the Government. GPs provide medical services directly and act as gate-keepers to the rest of the NHS - a system provided in few other countries. They provide over 90% of the contacts with people seeking assistance, yet cost less than 10% of the total NHS budget - around £100 per person per year (including drugs). Consequently most of this report focuses on general practice, although a separate chapter (Chapter 3) is included on the different though related problems of the other practitioners. The remainder of this introduction focuses mainly on general practice.

A CHANGING SERVICE

4. The network of general practitioners and practice nurses across the country is central to the NHS. Many people turn to their family doctor first in time of trouble, and the personal service that most receive is much valued. But there is a risk that these vital services are taken for granted. They must be supported and encouraged if they are to thrive, although support has been patchy over the years. They have been administered by executive councils (1948 to 1974) and family practitioner committees (1974 to 1990) whose main task has been to pay GPs according to national formulae. But structures for providing support on other matters have been weak. Many practitioners have used the freedom provided by these loose arrangements to develop excellent services, including many innovative schemes. But the range of services available and the standards of service provided have varied widely. And GPs have had only a limited influence over an NHS dominated by hospitals with a focus on treating rather than preventing illness.

5. Pressures have been mounting in recent years, from a variety of sources. The profession itself has been involved in developments aimed at raising standards. The Royal College of General Practitioners was established in 1952 (Royal Charter gained in 1963) with its associated academic standards. The Doctors' Charter was introduced in 1965. Compulsory vocational training followed in 1981 with more educational programmes for established GPs. The 1980s saw other innovations in general practice including comprehensive disease surveillance clinics and more health education and family planning, assisted by the appointment of practice nurses, practice managers and early computerisation. As a result, general practice changed significantly during the 1980s, with more doctors - especially female doctors - working in increasingly large partnerships, employing 100% more practice staff, with the largest increase among practice nurses (Exhibit 2).

6. Such improvements have been countered by difficulties. There has been increasing concern about the rising cost of GP prescribing, the inconsistency of standards of care across practices, and the substantial variation in referral rates to hospital (Ref. 2). Concern has also been expressed about the uneven quality of care available to chronically sick and socially disadvantaged patients, the poor quality of practice premises in deprived areas, and the continued professional isolation of significant numbers of GPs (Ref. 3).

7. External factors have also been raising the pressure. There have been increasing demands for community-based rather than hospital-based health care for many conditions such as diabetes and asthma. The Government's community care policies mean that many more elderly people will in future receive care in their own homes or in residential or nursing homes under their GP. The same policy is increasing the numbers of people with disabilities and significant mental health
Exhibit 2

THE CHANGING SHAPE OF GENERAL PRACTICE

General practice changed significantly during the 1980s...
...with more doctors, especially female doctors... ...working in increasingly large partnerships...

employing more practice staff... ...with the largest increase among practice nurses.

problems who require care in community settings. There have also been changes in expectations and attitude, with a greater awareness of the need to promote a healthy lifestyle, preventing premature illness. Demands for screening for the early signs of disease have been increasing as a result.

8. Many of these pressures raise fundamental questions about how practices and practitioners operate. The traditional rôle of family health services has been reactive - waiting for people to come forward for diagnosis and possible treatment, securing hospital placements and care services where necessary. Such a rôle is extremely important and will remain at the heart of primary care. But how should this rôle be discharged and supported? Should it be extended? What rôle should practitioners play in future? Questions such as these present practitioners with dilemmas (Exhibit 3, overleaf) for which there are no solutions - only compromises. The dilemmas are caused by finite NHS resources. The ensuing compromises must be debated and made overt if primary care is to play a consistent and effective rôle within the health and care services.
Exhibit 3
THE DOCTOR’S DILEMMA
...but what rôle should practitioners play in future?
9. Inevitably, practitioners themselves must judge how best to steer a way through these complex issues; but they are entitled to expect support and guidance. In particular, two key questions need to be addressed:
   — what role should family health services play in the future?
   — who is to shape this role?

NEW INITIATIVES

10. Recently the Government has taken the lead in tackling these questions with a number of initiatives:
   — the introduction of new policies in a series of white papers and the NHS and Community Care Act 1990;
   — the introduction of the 1990 GP Contract and GP fund-holding;
   — the establishment of a new framework with the introduction of family health services authorities (FHSAs) in 1990, reporting to RHAs.

NEW POLICIES

11. Over the last few years the Government has published a series of white papers, setting a new framework and direction for the NHS, including family health services:
   — 1987: Promoting Better Health (Ref. 4) laid out the Government's programme for primary care, with a new emphasis on health promotion.
   — 1989: Working for Patients (Ref. 5) proposed an increased role for the former family practitioner committees (FPC) to include the planning and management of family health services. It also introduced indicative prescribing amounts for GPs to contain prescribing costs; it proposed fund-holding, medical audit, and better information for patients.
   — 1989: Caring for People (Ref. 6) set out the Government's plans for care in the community, enabling people - mainly elderly and disabled people - to live in their own homes where possible.
   — 1992: The Health of the Nation (Ref. 7) outlined targets for health improvements in five key areas: heart disease and strokes, cancers, mental health, HIV/AIDS and sexual health, and accidents.
   — 1992: The Patient's Charter (Ref. 8) proposed clear standards of service. From April 1993 FHSAs have to set specific standards and targets for their own work and facilitate the development of (voluntary) charters in practices, providing information to consumers.

12. The policies in the first three white papers were confirmed in statute in the NHS and Community Care Act 1990 (Ref. 9). The NHS Management Executive published papers outlining how policy should be translated into practice. The report FHSAs ~ Today and Tomorrow's Priorities (Ref. 10) outlined the tasks and priorities for FHSAs, and proposed some possible alternative organisational arrangements. Integrating Primary and Secondary Health Care (Ref. 11) stressed the need for NHS agencies to co-operate and integrate their efforts. The Health of the Nation white paper was supported by First steps for the NHS (Ref. 12) and handbooks on the five key areas (Ref. 13).
NEW WAYS OF OPERATING

13. The Government has also changed the way GPs operate by introducing the 1990 GP Contract and GP fund-holding. Changes in the dental contract are described in Chapter 3.

14. The 1990 GP Contract (Ref. 14) set out changes to GPs' remuneration and conditions of service; it introduced new payments and allowances, and facilitated service development. Some new money was provided, diverted following the abolition of universal sight and dental checks; and the contract changed the make-up of GPs' incomes (Box A).

Box A
THE 1990 GP CONTRACT

The contract changed the makeup of GPs' incomes by introducing:
— an increase in the proportion of doctors' income determined by the numbers of people on their lists ('capitation' fees) with enhanced capitation payments for elderly people;
— payments for health promotion clinics of ten or more patients to increase emphasis on the promotion of health;
— payments for GPs reaching specified targets for the proportion of patients on their lists who are immunised or (for women) who have been screened for cancer of the cervix;
— payments for minor surgery and children;
— payments for GPs working in deprived areas;
— postgraduate allowances for GPs participating in continuing education;
— cash-limited funds for practice staff and premises.

15. GP fund-holding was introduced a year after the contract in April 1991 for larger GP practices with over 9000 patients to hold funds for the purchase of certain hospital services, including elective referrals to acute units up to a cumulative cost of £5000 per person per year, all outpatients visits (except antenatal and obstetrics), and diagnostic investigations from pathology laboratories. The funds also cover prescribing costs and a proportion of practice staff costs (including training), with a separate allowance for management and computing costs. From April 1993, the fund is to be extended to cover the purchase from NHS community units and trusts (but not direct employment) of health visiting and district nursing services, mental health and learning disability services, and other specialist services (Ref. 15 and 16).

16. In the first year, 306 'first wave' fund-holding practices were established with a further 285 following a year later in the second wave in April 1992. These first practices between them have almost seven million people on their lists or 14% of the population. They are not distributed evenly across the country (Exhibit 4). The size of practice qualifying for fund-holder status is being reduced from April 1993 to 7,000, patients bringing increasing numbers of people within reach of fund-holding. Where practices do not meet the list size criterion they may group together to become fund-holders. From April 1993, more than one in four of the population will be served by fund-holding practices (Ref. 17).
17. The budgets allocated to first wave fund-holders amounted to about £400 million, with £206 million for elective procedures, £162 million for prescribing and £29 million for staff. An average first wave fund-holding practice with a list of 12,600 received £574,000 for acute care, £504,000 for prescribing and £117,000 for staff (Ref. 18).

A NEW FRAMEWORK

18. The agenda for change described above is large. The Government has established family health services authorities (FHSAs) to promote the changes locally. The new authorities have taken over the administrative duties of the former FPCs and their management rôle has been strengthened and their tasks and duties extended.

19. The funds available to FHSAs for this process have been tightly constrained. Most of the expenditure in general medical services (around 90%) goes on payments to GPs for services to patients, capitation payments for GPs’ lists, and drugs prescribed by GPs, and is not controlled by FHSAs (although they make the payments). This expenditure is not cash limited - unlike hospital expenditure - although since April 1991 indicative prescribing amounts have been set for GPs to provide guide-lines for the range of expenditure expected, and mechanisms exist to recover monies where the total earned by GPs exceeds the planned expenditure. The balance of expenditure of around 10% is cash limited and can be used by FHSAs at their discretion within national guide-lines for practice staff, premises and other related areas such as computers (with virement allowed between these areas), giving FHSAs some leverage to promote new development (Exhibit 5, overleaf). Most of this money is already committed: much goes on ancillary staff in post before April 1990 with costs usually reviewed on a three year basis; and funding to support improvements to practice premises is generally committed for six to nine years.
THE COMMISSION'S STUDY

20. The Audit Commission has been reviewing progress in FHSAs with a first round of audits carried out in 1990/91, and a study started in parallel with the audits. The study involved detailed investigations at seven FHSAs and discussions with a wide range of interested parties. Analysis of data from these seven FHSAs has been underpinned by analysis of national level information and the results of other studies. During the course of the study, interviews were held with twenty GP practices, and a survey of practice nurses was carried out. Discussion groups were arranged with patients to identify patient concerns. Auditors are undertaking a new round of audits in 1992/3 which will review at the local level many of the issues raised in this report.

REPORT STRUCTURE

21. Implementation of the Government's new policies has inevitably dominated the agenda for FHSAs so far. Progress made on service development of general medical services is reported in Chapter 1. But to be fully effective, FHSAs must make local adjustments to these policies to fit them to local circumstances. Many are making a start, as reported in Chapter 2, although they face major difficulties because they lack authority to do so. These difficulties are even more significant for the other services – dentists, pharmacists and opticians (Chapter 3) – where FHSAs' powers are even weaker and practitioners are less reliant on the NHS for their income.

22. Some review of the rôle of FHSAs would seem appropriate, but only after further debate about the best way forward (Chapter 4). The Government has made a vigorous start to the process of reform: further progress will now depend on all interested parties helping to shape the future agenda for family health services and primary health care, with administrative arrangements then adjusted as necessary to deliver this agenda.

Exhibit 5
GENERAL MEDICAL SERVICES EXPENDITURE
Around 10% of expenditure is cash limited and can be spent at the FHSA's discretion on practice staff, premises and other related areas

23. FHSAs’ first task was to continue the former key rôle of FPCs, acting as providers of certain common services. They have also been extending this rôle to act as development agencies, implementing the Government’s initial agenda (Box B). These first two sets of tasks are considered in this chapter.

**Box B**

**THE INITIAL AGENDA FOR FAMILY HEALTH SERVICES**

The most immediate tasks for FHSAs involved:

- Improving FHSA management and administration
  - developing management structures
  - providing professional advice
- Addressing clinical issues
  - controlling prescribing costs
  - developing health promotion
  - implementing new target payments
  - establishing arrangements for minor surgery
  - introducing medical audit
- Improving practice staff arrangements
  - strengthening the staff establishment within practices
  - providing training
- Strengthening infrastructure
  - improving information management and the use of information technology
  - improving practice premises
- Introducing fund-holding

**IMPROVING MANAGEMENT AND ADMINISTRATION**

24. The family health services authority itself is made up of a board of members and a chief executive or general manager. Staff are usually organised into three groups: administrative staff who make payments, update lists and transfer medical records; professional advisers who provide
Staff are usually organised into three groups: clinical advice and monitor clinical issues; and management staff who provide support on staffing arrangements, premises, computers, and similar new developments (Exhibit 6). A typical FHSA serving half a million people has about 70 staff of whom four in five are administrative staff previously employed by the FPC with one in five undertaking the new roles of commissioning, development and monitoring. It is not untypical to find tensions between the administrative staff and the 'newcomers'.

FHSA MEMBERS

25. The FHSA itself provides strategic oversight. In England, it consists of a chairman appointed by the Secretary of State, nine non-executive members appointed by the RHA, and the general manager. In Wales, members are appointed by the Secretary of State for Wales. They are appointed for fixed terms of either two or four years. Four are professionals, drawn from general practice, nursing, dentistry and pharmacy (although not representing their professions); and five are 'lay' members who usually either have relevant health or social services experience or business, finance or other management skills. Some FHSAs have had difficulty in making best use of these skills.
26. To help improve members’ involvement, five of the seven FHSAs visited had organised training which included visits to practices, reading and information packs, seminars on FHSAs and on more general health topics such as fund-holding. They had also organised exchange visits with other authorities such as DHAs, local authorities, and other FHSAs. Cambridgeshire FHSA has set up specialist panels of members to focus on specific issues - for example finance and information, policy, and quality assurance. Routine but essential matters can be scrutinised in depth, without them taking up too much time at authority meetings. Such arrangements allow FHSAs to make full use of members’ skills and allow members to direct the authority more effectively.

GENERAL MANAGERS

27. General Managers were introduced in 1989; many brought experience from other parts of the NHS, public services and the private sector (Exhibit 7).

Exhibit 7

THE PREVIOUS EXPERIENCE OF GENERAL MANAGERS
Many brought experience from other parts of the NHS, public sector and the private sector

Source: Audit Commission: 1990/91 FHSA audits.

28. Most staff in FHSAs provide administrative support for general medical practices. They pay GP and staff costs, transfer medical records, maintain patient lists, respond to patient complaints and process applications for activities such as training and new clinics.

29. Administrative costs are subject to economies of scale: the largest FHSAs have costs less than half those of the smallest (Exhibit 8, overleaf). FHSAs vary in size by a factor of fifteen in terms of population served and by a factor of eight in terms of expenditure. Co-operation between neighbouring FHSAs could reduce costs: for example a reduction from 90 to 50 payments centres in England could potentially save about £7 million a year. The payment of dentists has been transferred from FHSAs to a single payment centre, the Dental Practice Board (DPB), with no reduction in accuracy or speed of response. But centralisation could reduce contact between
Each member of the FHSA's staff engaged on administration supports on average about five GPs - a high cost reflecting a considerable administrative ‘paper chase’. There is a corresponding administrative burden within practices. Paying practices by the number of activities undertaken (vaccination, cervical smears etc.) generates large amounts of paper (Exhibit 9). It also produces a lot of discontent amongst GPs. And yet all of this activity rarely generates management information in a form useful either to the FHSA or to practices.

Further savings could be realised by streamlining some of the paperwork. A number of practices visited made several sensible suggestions. A single form for each activity could be used for recording the details of several patients at once, instead of using one form per patient. The aggregation of claims in this way should not slow down payment as doctors are paid quarterly. Sometimes two different forms are needed for the same activity for the same patient for different parts of the FHSA. One form should do. Software should be used to match the FHSA's and the practice's versions of the practice lists - producing short lists of mismatches for checking rather than thick piles of printout. There are no doubt many other good ideas, and the ‘Unnecessary Bureaucracy Working Group’ in 1991 promoted various approaches. FHSA staff should always be on the look-out for them, discussing arrangements with GPs and particularly with practice managers. What is needed is sharper management within FHSA's of their own affairs.

Savings might also be realised by introducing electronic (rather than paper) transfer of data from practitioners to payments agencies. The Dental Practice Board is promoting electronic links with contractors to speed payments to dentists and reduce staff time. To date (March 1993) 15% of dental practices have been linked with a saving of sixty whole time equivalent staff posts; by the year 2000, the number linked is expected to have risen to 70% with a saving of over 300
Exhibit 9

THE PAPER CHASE

Paying practices by the number of activities undertaken generates large amounts of paper.
whole time equivalent staff posts at the DPB. Similar arrangements should be possible with GPs - especially as practices increasingly have computers. There are some initiatives under development, such as GP/FHSA Links project (Ref. 19) to promote and develop software. But a major obstacle is the wide range of (often incompatible) computers and software in use. The Dental Practice Board has overcome this difficulty for dentists by specifying that only systems certified by them may be used.

33. Much of the information collected by FHSA for administrative purposes could be used to provide management information, and monitor claims. There is an increasing emphasis on action by FHSA to ensure proper cost control and value for money (Ref. 20). Leicestershire FHSA carries out a series of systematic checks using software developed specifically for this purpose. Specific items of service are analysed every month to identify outliers; and quarterly checks are made on trends in payments, with prescribing rates (and costs) checked for fluctuations. However, at present the cost of such financial monitoring falls on the FHSA's cash limited administrative budget, while the benefits of any savings identified go to the Exchequer with no benefits to FHSA. FHSA should be encouraged to be more active - possibly through schemes that allow FHSA to keep part of any savings for investment in patient care or further development of primary health care teams to share the benefits with practices.

PROFESSIONAL ADVISERS

34. FHSA employ experienced professionals who provide both the FHSA and practitioners with professional advice. Most are medical, pharmaceutical and nursing advisers, although less commonly they can be dieticians or specialists engaged for specific purposes such as public health, health promotion, or the needs of homeless people or children.

35. At present, the cover provided is low - due in part to the difficulty of recruiting suitable people. They are also expensive: a medical adviser typically costs £50 – £60,000 per year. In England in February 1992, FHSA employed 47 full-time and 80 part-time medical advisers. The full-time advisers mainly had backgrounds in general practice, or less commonly in public health medicine (Ref. 21); the part-time advisers were usually practising GPs who typically worked as advisers for two or three sessions per week, and in general practice for the rest of the time. Most were originally introduced to promote better prescribing practice, but FHSA are increasingly engaging pharmaceutical advisers for this rôle: in England in February 1992, FHSA employed 72 part and full-time pharmaceutical advisers. There is wide variation in the numbers of advisers deployed in different FHSA (Exhibit 10). As a result, some practices rarely see an adviser.

36. FHSA must make the most effective use of advisers' time through specialisation and specific targeting. With the introduction of pharmaceutical advisers, medical advisers have been able to extend their rôle (although in some FHSA there can be overlap and duplication between the two types of adviser). They provide advice and approve arrangements for health promotion and minor surgery. They also support practices who are not achieving targets for immunisation and screening, and are sometimes involved in developing medical audit. The rôle is a developing and varied one, which is increasingly influential in shaping the FHSA's broader policies. Nursing advisers are also used to provide support to practice nurses – a potentially important rôle, given their growing numbers. They assess and arrange training, and offer advice on health promotion and support groups.
Exhibit 10
NUMBERS OF MEDICAL AND PHARMACEUTICAL ADVISERS IN SEVEN FHSAs
There is wide variation in the numbers of advisers deployed in different FHSAs

Source: Audit Commission Analysis.

37. Advice is also available to FHSAs from a range of other sources. Regional advisers in general practice play a vital rôle. University departments of general practice can help provide expertise, survey tools and access to existing research; and directors of public health in DHAs can provide much useful advice — so much so that they are sometimes jointly appointed and funded by the FHSA. There are benefits to be gained by co-ordinating these different sources of advice to produce as complete a picture as possible of the needs of practices: one FHSA organises its own advisers in a primary care unit to better co-ordinate their activities; and it has established links with the local medical school.

SERVICE DEVELOPMENT MANAGERS

38. The seven FHSAs visited had between four and seven (whole time equivalent) managers involved in service development, with a wide variation in the numbers of such staff to practices. The range of activities is broad, although they were grouped in different ways in different FHSAs according to local priorities and staff skills (Exhibit 11, overleaf).

ADDRESSING CLINICAL ISSUES

39. Professional advisers employed by FHSAs provide advice to practices on clinical issues. A number of areas singled out by the Government for particular attention are considered in turn below.

PRESCRIBING

40. Drugs prescribed by GPs in England and Wales in 1991/92 cost £2,522 million – over a third of all family health services expenditure, 6% of the entire expenditure of the NHS in England and Wales, and £50 for every person in the country: yet in the past controls on this huge expenditure have been modest. It has not been cash limited, being dependent on the number of
Exhibit 11

SERVICE DEVELOPMENT STAFF IN SEVEN FHSAs

There are wide variations in the numbers of management staff involved in service development

...and the range of activities is broad

Source: Audit Commission Analysis.

people consulting their practitioner, and on the practitioner's response: doctors jealously guard their clinical freedom to prescribe as they think fit. There have been no real incentives for non-fund-holding GPs to control their expenditure, since they have not been able to use any of the savings. And the relative professional isolation of many practices and practitioners has meant that they have lacked any basis on which to compare their own prescribing behaviour. In the past they have had little access to independent advice, depending instead on recommendations from the drug companies. Such loose controls on an open-ended budget have not surprisingly
led to waste. Various campaigns around the Country, which have encouraged people to bring in unwanted and unused drugs (known as ‘DUMP’ campaigns), have indicated the scale of this problem. The subject is of such importance that the Commission is carrying out a separate more-detailed study which will be reporting at a later date and which will lead to audits in 1993/94.

41. Prescribing costs per patient across FHSA vary by as much as 100% (Exhibit 12). It is unclear whether this variation is caused by different clinical needs, different patterns of patient demand, different referral patterns or different prescribing habits of GPs. In reality it is probably a mixture of all four compounded by other factors. There has often been poor communication between GPs and hospitals, exploited through differential pricing: hospital doctors with cash-limited budgets are charged a few pence for a drug which costs pounds when prescribed by a GP as part of a continuing programme of treatment following hospital discharge. Often there is a perfectly adequate alternative at lower cost. Hard-pressed hospital doctors have also sometimes engaged in ‘cost-dumping’ - discharging people with only a few days supply of drugs in order to transfer the cost of treatment from the cash-limited hospital to the open-ended GP prescribing budget. And the cost of drugs for patients with established conditions on repeat prescriptions accounts for 60% of the total expenditure and can be an area of much waste (Ref. 22) particularly where there are inadequate checks and controls. But perhaps more worrying than any variation in costs is the possible variation in quality of care - although without monitoring systems, no such variation can be demonstrated.

Exhibit 12
PRESCRIBING COSTS PER PATIENT IN EACH FHSA
Prescribing costs of GPs across FHSA vary by as much as 50%

Source: Department of Health, HSI DATA 1990/91.

42. All of this is now changing through a combination of guidance and advice, better budgeting and better information. Medical and pharmaceutical advisers are able to give practices advice, with all of seven FHSA visited as main sites having an adviser actively looking at prescribing. A prescribing and cost information system (PACT) is available to GPs comparing their own prescribing patterns with the average. As with all information systems, PACT must
be adequately supported with expert analysis and interpretation if it is to be useful and 'PACT line' provides an information system which helps with the interpretation of PACT. Indicative prescribing amounts (IPAs) introduced in April 1991 give guidance to practitioners on the amount they should be spending each year (without any cash limit being imposed). Limited lists have been introduced by the DoH to limit prescribing to drugs of proven worth. And GP fund-holders have the capacity to redeploy any savings to other services.

43. Many FHSAs are progressing well, producing imaginative ideas. *North Tyneside FHSA* has set up a systematic programme for reviewing prescribing practice (Case Study 1). *Leicestershire FHSA* circulates a short newsletter on prescribing practice for particular conditions (e.g. urinary tract infections) with one page of main points and one page of possible drugs with comparative costs. Others are developing protocols with hospital consultants for the management of conditions such as asthma, hypertension, and diabetes; and some are beginning to co-ordinate protocols and procedures for managing hospital discharge more effectively. Some are also beginning to involve the community pharmacist who makes up the prescription to provide a check for interactions and incompatibilities (Ref. 23). But effective prescribing practice is not just about controlling costs. It is also about improving quality. In some situations improvements may increase costs: low prescribing patterns may need to be corrected; and longer consultations may be required giving patients better quality care instead of just a prescription.

**Case Study 1**

**A FRAMEWORK FOR PRESCRIBING**

FHSAs can improve prescribing in a number of ways. In North Tyneside FHSA a framework has been established in which the medical and pharmaceutical advisers promote a positive and constructive dialogue with practitioners, with emphasis placed on good prescribing practice. The process involves a number of steps:

— the PACT data for the top twenty therapeutic groups of drugs (which cover three quarters of the cost) are analysed by cost and item.

— the pattern of prescribing for different groups of patients within a practice is reviewed (with, for example, a greater use of hormone replacement therapy expected in practices with high numbers of older female patients, and more use of cardiovascular drugs expected where there are more older patients of both sexes).

— practices are then classified into three groups to allow better targeting. First there are those whose prescribing practice is generally good, who are offered educational support and help to review and question their own behaviour - particularly repeat prescribing. Second there are those who acknowledge that they need advice in some areas. Third there are the few whose prescribing behaviour is generally considered poor. Advisers concentrate their efforts on these last two groups through a planned programme of visits targeted at specific aspects of prescribing practice.

— Advice is provided on the comparative costs of drugs to all practices, and a bimonthly prescribing bulletin provides other comparative data.

— practices are visited to give the FHSA a better understanding of their circumstances, with the information gained used to improve the monitoring process in the future.
HEALTH PROMOTION

44. One of the key objectives of the Government has been to change the emphasis within the NHS from the treatment of illness to the promotion of good health. The white paper *The Health of the Nation* (Ref. 7) has set out a framework, and new payments were introduced in 1990, with fees paid to practices for running health promotion clinics for ten or more people. They rapidly became a major source of income for GPs: over half of the GP practices visited had increased their health promotion activity substantially.

45. The increase in activity masked underlying concerns. There has been a wide variation in activity per head of population across FHSAs (Exhibit 13) and there have been many disputes about how best to promote health. From the start some questioned whether clinics were the best way of achieving results: there is evidence that they concentrate activity where it is needed least (Ref. 24). The majority of patients attending clinics reported them useful, however (Ref. 25). Opportunistic interventions during consultations in the surgery are preferred by many GPs, and there is some evidence that advice during consultation provides wider coverage at lower cost (Ref. 26). However there is also evidence that such advice is not always sufficiently comprehensive (Ref. 27). At the present time it is difficult to say which approach is better, and it may well be that each has its merits in different situations.

Exhibit 13
EXPENDITURE ON HEALTH PROMOTION CLINICS IN 1990/91
There is a wide variation in activity per head of population across FHSAs

Source: FHSA accounts 1990/91.

46. Evaluating health promotion is difficult with a long chain from initial intervention to ultimate effect. Health promotion should change behaviour and reduce risk, postponing the onset of morbidity and reducing premature death. However, the effects may not be apparent for many years. Evaluation can only focus on the first one or two links in this chain. The links between risk factors and health require long term research. Evaluating behaviour is difficult, since what people say they do often diverges from what they actually do. Even measuring the occurrence of
health promotion advice is difficult, because a quiet word from a GP to eat less or reduce smoking may not be recorded. Hence promoting health through a system of financial rewards to GPs is not straightforward; the link between finance and improved health is tenuous. But it is essential to try.

47. Payment arrangements can also create tensions within practices and primary health care teams. Some feel that it is nurses who do the work within clinics, and yet it is the doctors who get paid. And, in any case, there are some who consider it inappropriate for the onus on health promotion to fall on practices when potentially more effective initiatives outside practices using pharmacists or outreach workers remain underdeveloped. While the effects of a poor life style involving smoking, heavy drinking and a poor diet may be medical, resulting in illnesses such as heart disease and lung cancer, the causes may be rooted in social and cultural behaviour. GPs may not be best placed to change such deep-seated behaviour: wider initiatives in schools and work places may be more effective. Initiatives at the national level may also be appropriate. There is evidence linking ill health to poverty and social class (Ref. 28) and some people are calling for national intervention on food labelling and tobacco and alcohol taxation and advertising.

48. Given the many difficulties and complexities, a broader health promotion strategy makes better sense, allowing greater local initiative and choice. Consequently, the Department of Health is introducing new arrangements from July 1993 allowing greater local discretion (Ref. 29) within the overall framework set by Health of the Nation (Ref. 7). Finance is to be controlled year-on-year within an overall budget, and financial support is to be allowed for a wider range of approaches, with priority given to initiatives that are well researched and monitored.

49. Under the new arrangements, practices will draw up their own programmes to meet their own patients' needs within overall national priorities set out in Health of the Nation in England and Welsh Office guidance on priorities in Wales. They will also need to take account of local priorities defined by the FHSA in consultation with the local medical committee. Activities can include clinics, opportunistic counselling, questionnaires, etc. Practices will collate an increasing range of information about their patients on relevant indicators such as height, weight and blood pressure, which will then be used to help target initiatives to those most at risk. Initially, programmes will be aimed at reducing smoking, minimising the health risk to those with hypertension (high blood pressure) and preventing coronary heart disease and strokes - all of which have been thoroughly researched (Ref. 30). The intention is to include other priority conditions in due course as sound research results emerge. Current health promotion activity will be protected by transitional payments, which can be switched to new priorities in future. Practices will be allocated to one of three bands according to progress, and paid accordingly. As they make further progress, they will progress through the bands.

50. Approaches are to be agreed locally between practices and the FHSA, with activity reported in the practice annual report. Continuation of schemes will depend on practice performance, with FHSAs able to withdraw approval. There is considerable scope for FHSAs to give a lead on protocols, training and monitoring within the context of Health of the Nation targets, and to ensure that practices co-ordinate their activities with other local agencies. Indeed, FHSAs could become more directly involved in campaigns as part of an overall health promotion strategy, in association with DHAs in England, and with the Health Promotion Authority in Wales. Such
campaigns should aim to raise public awareness through the local media, through talks in schools and places of work, and through the provision of information in the form of leaflets and videos. FHSA links with pharmacies could be exploited, with space purchased for displays of such material. The Pharmacy Health Care Scheme currently provides an example of the involvement of pharmacists in health promotion, with literature circulated as part of wider campaigns. FHSA could also encourage and support self-help groups for people wanting to give up or reduce smoking or drinking or who want to lose weight. They need to develop an overall health promotion strategy that allows local initiative and choice.

MANAGEMENT OF CHRONIC CONDITIONS

51. The 1990 contract also encouraged the use of clinics for the management of certain conditions, such as asthma and diabetes. Clinics used for this purpose have been better received than health promotion clinics, with early findings indicating that the majority of patients find them useful (Ref. 25). But from the start, arrangements have been mixed up with those for health promotion, causing some confusion.

52. In future there are to be separate arrangements and funding - initially only for the management of diabetes and asthma - with protocols agreed between GPs and the FHSA before fixed payments are made to each GP separately. FHSA should play a major rôle facilitating the development of such arrangements with hospital specialists. Protocols should cover the whole range of activity, from diagnosis, referral, and management to monitoring (Ref. 31). And as with health promotion, activity in future will no longer be limited to clinics. There is much scope for professional advisers and the profession itself through medical audit to take these issues forward for other chronic and acute conditions with GPs and hospital consultants, focusing on local priorities. By working with practices in this way, FHSA could be at the forefront, raising clinical standards and promoting good practice.

TARGET PAYMENTS FOR IMMUNISATION AND SCREENING

53. Health care professionals have also been promoting better health by increasing the number of children immunised against disease and by raising the number of women screened for cervical cancer. In the past, these relatively straightforward ways of improving health have not always been adopted for a variety of reasons. Patients may not have understood the potential benefits. But poor take-up may also have been caused by inadequate practice premises, insufficient numbers of female GPs, low numbers of practice staff, poor record keeping and inadequate recall arrangements for advising women to attend for screening every three years. These are all factors that FHSA can do something about.

54. The 1990 contract introduced extra payments for practices where the proportion of eligible children on practice lists immunised reaches 70% or 90%, with higher payments for the higher target. Similarly, extra payments are made if the proportion of eligible women on practice lists screened in the last three years reaches 50% or 80%. The results have been dramatic. The proportion of GPs achieving targets for children on their list immunised increased from 81% to 90% between 1990 and 1991, with numbers achieving targets for pre-school ‘booster’ vaccinations rising from 73% to 85%. The proportion achieving targets for women on practice lists screened for cervical cancer has risen from 85% to 92% (Exhibit 14, overleaf). Target payments have now
Exhibit 14
CHANGES IN THE PROPORTION OF GPs ACHIEVING TARGETS - 1990 TO 1991
The proportion of GPs achieving targets has increased

Source: Department of Health: figures for England only.
become a major source of income, with GPs achieving all targets earning up to £8,000 extra per annum.

55. FHSAs for their part need to focus on practices which are not achieving targets; and they need to work out a common strategy with DHAs, who are also involved with immunisation and screening through commissioning community health staff. They need to improve the maintenance of accurate patient data, both for their own part and in practices, since low take-up can be the result of inadequate information handling and poor transfer of records. Where poor take-up is caused by inadequate arrangements, FHSAs can use their cash limited funds to make improvements. But FHSAs should not neglect to review arrangements in practices that are achieving targets, because there may still be problems with pockets of low take-up – from deprived housing estates for example - which could be tackled with the active support of the FHSA.

DEPRIVATION PAYMENTS

56. Deprived areas commonly have persistently low rates of immunisation and screening, possibly because of poor perceptions of such measures and because of above-average population movements. GPs in such areas may have reduced incomes because they do not achieve targets, often through no fault of their own; but the workload generated may be greater and more difficult than that of other areas. Not surprisingly, it can be difficult to attract good GPs to such areas given higher workloads for less pay.

57. In consequence, special 'deprivation payments' have been introduced to compensate for lower income and greater workload. Such payments are made according to an 'under privileged area score' (UPA) developed by Professor Jarman (Ref. 32). The score is based on eight weighted social factors (the numbers of people who are single parents, unemployed etc.). It indicates the expected increase in the workload from patients living in the area. Practices are paid in three bands, with those in the top band receiving £9.05 for each person on the list. The UPA scores are averaged over the whole ward area and do not take account of pockets of deprivation which can exist within non-deprived areas; and unlike target payments, deprivation payments are not linked to performance. As such they may not be well targeted; and they provide no encouragement for action. The Government needs to consider whether there may be scope for introducing a more flexible scheme which allows FHSAs to adjust deprivation payments, linking them more directly to the provision of specific services or facilities. FHSAs, for their part, could also take additional measures, possibly in association with DHAs. For example, they could deploy additional health visitors in difficult areas, to provide alternative services for those least likely to attend practice surgeries.

MINOR SURGERY

58. As well as shifting the balance from treatment to health promotion, the Government is also seeking to shift care from hospital to the community wherever it is sensible to do so - particularly if by so doing hospital waiting lists can be reduced. The 1990 GP contract provides payment to GPs who perform up to fifteen minor surgical procedures each quarter. Such an initiative makes sense. Many GPs have been performing minor surgical procedures for many years and some have had considerable recent experience as surgeons. Treatment in the practice is also
more convenient for many patients. But activity varies considerably: in 1990/91 the number of minor surgery sessions per GP per FHSA varied by a factor of twelve (Exhibit 15).

Exhibit 15
NUMBER OF MINOR SURGERY SESSIONS PER GP PER FHSA - 1990/91
The number of sessions varied by a factor of over thirty

Source: FHSA Accounts 1990/91.

59. Ensuring quality is difficult. FHSAs inspect to check whether there are appropriate facilities, and whether GPs are suitably qualified. But GPs operate in relative isolation, and may not have the benefit of colleagues and the support of histopathologists to hand. The maximum of fifteen procedures per quarter may militate against quality, since the more practice surgeons have, the better they become. There are reports of incomplete excisions and undetected carcinomas (Ref. 33 and 34); and some of those included in the Audit Commission's own survey of GPs questioned whether much of the work done is strictly necessary, and whether it is having any beneficial effect on patient care.

60. But there is much that FHSAs can do. They should be taking the lead in promoting quality, working alongside the profession. They must ensure that GPs have sufficient experience, training and equipment and should work with regional postgraduate organisations and their regional advisers in general practice to set up suitable training arrangements as necessary. They should also be developing suitable accreditation arrangements and should be in a position to monitor activity - numbers and types of procedure, and infection and complication rates, involving pathologists as appropriate. They should be working with GPs to develop suitable information systems where necessary, and asking patients for their perceptions. All such activities have considerable resource implications.

MEDICAL AUDIT

61. Medical audit involves peer review of the care given to patients in order to improve practice. It is mainly undertaken to identify educational opportunities rather than to police standards. It is the one area of the 1990 GP contract in which GPs have been given the lead rôle: consequently, they generally have a positive attitude toward it (with 17 out of 20 practices visited
viewing it favourably — a finding reflected in other surveys — Ref. 35). However, there is often some ambiguity about what it means in practice. The initial enthusiasm will only last if audit is supportive and positive. The results remain strictly confidential and are not available to the FHSA. But equally audit must be challenging enough to bring about some improvement in the quality of care.

62. The development of medical audit in each FHSA is overseen by a medical audit advisory group (MAAG) made up of local practitioners. All FHSAs visited had set up MAAGs, although the state of progress was mixed: some were into their second year of operation while others were only just starting. The rôle of the FHSA in the development of audit is somewhat equivocal. FHSAs provide the finance - £50,000 was a typical figure in 1991/92 - and promote the establishment of the MAAG. They have an interest in ensuring that the audit process is adopted widely and that it is effective: in two of the seven FHSAs visited, the medical adviser was a member of the MAAG and suggested topics based on common problems found on practice visits, but they are not involved in the audit process and do not have access to the results. Instead, FHSAs help set a framework (Case Study 2, overleaf); and they can promote the use of agreed performance indicators summarised in an annual report, including:

— input measures (how MAAG staff spend their time);
— activity measures (frequency of meetings, range of topics covered, number of practices visited and type - e.g. single handed);
— process measures (involvement of practice, community, and hospital staff, use of demonstration audits, and guidance manuals — Ref.31);
— outcome measures (patients views including complaints and views of results of treatment, extent of good practice, gains achieved by the audit process).

MAAGs for their part should be able to suggest where the FHSA should be providing increased support.

IMPROVING STAFFING ARRANGEMENTS

63. FHSAs should be helping practices expand the range of staff within the practice. In the past, GPs tended to work either alone or in small group practices supported by a sole receptionist. Today, practices are more elaborate. Since 1980, the number of practice staff per GP has increased by 80% in whole-time equivalents (Exhibit 2) and by significantly more in terms of numbers of people, as many practice staff are part-time. The trend has been encouraged by the Government: between 1965 and 1990, 70% of the cost of staff was reimbursed directly; from April 1990, FHSAs have had additional discretion to reimburse up to 100% using their cash-limited budgets.

64. Practices now include practice nurses and managers, and there are more receptionists and administrative staff to handle the paperwork. In some practices more specialised staff have been engaged. Practices also work closely with community health staff — often forming primary health care teams with district nurses, health visitors, midwives and the professions allied to medicine - occupational therapists, physiotherapists, and others. This increasing complexity reflects the shift in emphasis from hospital to community-based care. It also requires better co-ordination.
Case Study 2
MEDICAL AUDIT

Liverpool FHSA

In 1990, the Department of Health funded four FHSAs, including Liverpool, to act as pilot sites for the development of medical audit.

Open consultation

From the start in Liverpool, working GPs were fully involved. The local medical committee and department of general practice were represented on the medical audit advisory group (MAAG) with the MAAG itself operating independently from the FHSA. Visits were made to all practices to explain the audit process and the role of the MAAG, and a MAAG newsletter was published. Open meetings were held to explain the audit process and to seek GP views. Two thirds of practices were represented at the first meeting and half at the second. Confidentiality was stressed throughout, with the disclosure of audit results left entirely to practices' own discretion. All of these initiatives helped to establish a common philosophy and approach to audit, and increased awareness of the audit process in practices.

A thorough approach

During audits, other members of the primary health care team as well as GPs were involved. Professional facilitators provided support and medical students were used to carry out audit projects in practices. Records were kept of practice characteristics and audit involvement; and a database was assembled (with the express permission of practices) to provide an information exchange between practices of activity and areas of interest.

On-going developments and benefits

More recently, more specialised audit groups have been formed. A single-handed practice audit group was established to represent the interests of the 40% of practices in Liverpool with GPs working alone; and following local requests, locality-based audit groups have formed for practices in particular neighbourhoods. Other areas of development have included shared audits with hospitals and patient satisfaction surveys. There has been an increase in contact between practices, and a great deal of interest has been generated. Audit activity has been increasing steadily: two thirds of all practices and two in five single-handed practices were covered during the first year. The range of audit topics has been expanding, with increasing numbers of support groups and training courses, and increasing exchange of information.

PRACTICE NURSES

65. Practice nurses are one group that has been developing particularly rapidly, with numbers doubling between 1988 and 1990 (Exhibit 2). But development has often been unco-ordinated: numbers of practice nurses and district nurses often do not correspond (Exhibit 16). There can be overlaps in their tasks: over half of practice nurses in one region carry out home visits to people aged over 75 - a task also carried out by district nurses. The confusion is compounded where community health staff relate to a geographical area and practice staff relate to people on the
66. The way practice nurses spend their time varies considerably between practices (Exhibit 17, overleaf). GPs can delegate any task (in theory at least), although practice nurses must ensure that they have the necessary training, education, knowledge and skills, as they are accountable for their practice under the UKCC's Scope of Professional Practice (Ref. 37). But one study found that while three quarters of practice nurses take cervical smears, less than a quarter receive any formal preparation for the task (Ref. 38). Given the rapid development of practice nursing, and the pressures on staff, they need the support of a framework setting out training requirements and standards.

67. Practice nurses have an evolving rôle (Exhibit 18, overleaf) which is extending the range of tasks they undertake. Nurses in fund-holding practices are more likely to work with other practice nurses, to feel a part of the primary health care team and to work with computers. They are less likely to carry out home visits and undertake reception duties - indicating that there may be a clearer definition of roles in such practices.

68. FHSAs need to start reviewing how staff resources are allocated and used. At present they have limited control, as the cash limited budget largely supports commitments made before FHSAs were established. However, this is changing and they have increasing leverage to alter financial allocations for staff appointed after April 1990 and for those employed in practices before 1990 as circumstances change. They need better information on the numbers of practice and community nurses and their activities, to help them identify where the numbers do not correspond (Exhibits 16 and 17). Such information should help them review priorities when faced with rival bids from different practices. Four of the seven FHSAs visited have policies for allocating new staff. These policies take into account such factors as the ratio of practice staff to patients, and the proposed rôle and significance of additional staff in practice development plans. Often FHSAs...
Exhibit 17

THE ROLE OF THE PRACTICE NURSE

The way practice nurses spend their time varies considerably

give priority to meeting minimum standards - one nurse per practice for example. They also need to ensure that appropriate support and training is available (Ref. 39).

Exhibit 18
THE CHANGING RÔLE OF THE PRACTICE NURSE
Practice nurses have an evolving rôle

The Commission questioned practice nurses in FHSAs in the West Midlands RHA in the summer of 1992, comparing their responses to a similar survey conducted in 1987 (Ref. 39), and found that practice nurses:
- are mostly aged 35-44
- are increasingly working full-time (15% compared to 9% in 1987)
- are increasingly working in single-handed practices (16% compared to 6% in 1987), although the majority (84%) work in group practices
- many (29%) are the only practice nurse employed, with possible problems of professional isolation
- are becoming more highly graded (and paid) with 35% paid at G grade, comparing favourably with district nurses and health visitors
- are increasingly involved in home visiting (53% compared to 35% in 1987), especially for patients aged over 75, with potential overlaps with community health service staff
- are increasingly involved in areas requiring expert skills, such as psychological examinations for early signs of depression (28% compared to 13%)
- are not regularly involved in duties such as reception work (22%)
- mostly do not feel themselves part of a primary health care team (only 44% believed they were members)
- a significant proportion have been visited by a health promotion facilitator (66%) or by a practice nurse adviser (44%)

PRACTICE MANAGERS

69. Practice managers are relative newcomers to GP practices and play a key rôle in strengthening practice organisation and management. They need to be skilled in staff management, finance and information technology. Although many came to the job with some of these skills already to hand, some are having to acquire them for themselves without agreed standards or guide-lines. Here again, FHSAs can provide support by giving advice on good practice, and co-ordinating access to courses.

70. At present there is great variation in the level of education, qualifications, experience, and expertise of this fast-growing group, which until very recently was not seen as part of NHS management. As recruitment processes in the majority of practices are primitive and as many GPs are both ambivalent about the need for management and confused about who and what will be managed, they may be disappointed by the result, and blame the appointee. The future capacity of general practice to meet the expectations being placed upon it will in large part be determined by the clarity and competence brought to the management function by both GPs and practice managers.
TERMS AND CONDITIONS OF SERVICE

71. Many practices may not be using satisfactory contracts for employing staff that take full account of employment law. They can get into difficulties as a result. FHSAs can help by providing guidance and advice on the terms and conditions of service for practice staff. Two of the FHSAs visited provide model job descriptions to practices; three monitor and advise on rates of pay; and two provide advice and assistance on recruitment procedures.

TRAINING

72. FHSAs can help review training needs in practices. Three of the seven visited actively did so (Case Study 3). They can also co-ordinate external training resources, often in conjunction with the RHA, by forming links with local colleges and departments of general practice, building up a 'library' of approved courses.

Case Study 3

Developing Practice Staff Training - Liverpool FHSA

Liverpool FHSA recognised the need for training generated by the 1990 GP contract. While acknowledging that responsibility for staff training remained with practices, it undertook to support, encourage and monitor the take-up and effectiveness of training schemes. Practice staff members were sent a questionnaire about their training needs. Four areas were reported to need attention: medical audit, business planning, general management and fund-holding. The FHSA also wanted to encourage multidisciplinary team working and so provided a course in the training programme. Other courses covered immunisation, vaccination, and cervical cytology, recruitment and selection of staff, the rôle of the practice manager, the rôle of the receptionist, and the functioning of primary health care teams. Courses focused on practical skills development and application. Three quarters were oversubscribed. They were evaluated by participants immediately after completion and again after six months to check their relevance and applicability in the workplace.

73. GPs undertake a minimum of five days training a year over a five year period to qualify for a post-graduate education allowance. FHSAs' medical advisers, working with regional advisers in general practice, can provide advice on the content and design of courses, supporting and monitoring the take-up of the allowance. They also visit practices regularly and can identify training needs. GPs themselves need to be involved in the design and selection of courses if they are to be relevant to their needs.

74. FHSAs also need to promote teamworking among primary health care teams. Problems with teamwork are common. A recent study found active collaboration between only a quarter of GPs and district nurses and one in ten GPs and health visitors with patients in common (Ref. 40). Team working can increase participation and mutual understanding which in turn should lead to more co-ordinated services for patients and higher job satisfaction. It can also increase the capacity of the team to deal with a wider range of conditions, reducing the need for secondary services. FHSAs and DHAs need to be committed to team working and willing to fund joint training. Gwynedd and Leicestershire FHSAs have primary health care team facilitators to promote team working. One is a joint appointment with the DHA. A particular focus for facilitators in
future is likely to be the development of a team's patient's charters to improve the services provided to patients, with standards specifying quicker or better co-ordinated treatment.

STRENGTHENING INFRASTRUCTURE

75. Management support staff are employed by FHSAs to help practices develop an appropriate infrastructure, with sound information and good premises.

INFORMATION MANAGEMENT

76. If FHSAs are to develop and plan patient services, they need relevant information. All seven visited considered the 'Exeter' system, currently used to process payments to practitioners, to be of limited use for generating management information - with six developing their own approaches as a result.

77. But they face major problems. There are few standards for hardware, software and data capture either for FHSAs' own systems or for practice computing. The choice is bewildering with up to 109 different software systems available to practices in 1991 (Ref. 41). One FHSA visited was facing 56 of them. As a result, support and information exchange is difficult to provide. The seven most common systems account for three quarters of all systems sold, but they use four different operating systems (Ref. 41). Practices for their part are equally confused, and need help and advice on finance, training and choice of system. A survey by the Chartered Institute of Certified Accountants in 1991 (Ref. 42) found two thirds of GPs experiencing problems with hardware and software, without adequate support. Some FHSAs are not well placed to assist.

78. Many FHSAs are, however, giving a lead. They are developing an information strategy setting out in precise terms the information required by themselves and by practices. Given the national agenda, the issues described in this chapter are likely to be included. One FHSA has developed a 'practice profile' as the framework for collecting information, returning it with each practice's figures set out alongside the FHSA averages (Case Study 4).

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**Case Study 4**

**PRACTICE PROFILE**

Hereford and Worcester FHSA has developed a 'practice profile' as the framework for collecting and returning information.

The profile encompasses:

**WORKFORCE:** Numbers of GPs, practice nurses, receptionists, managers and other staff per 1000 patients.

**HOURS:** Times of surgeries, clinics, and availability of doctors.

**POPULATION:** Composition by sex and age - particularly numbers of elderly people.

**ACTIVITY:** Immunisations, screening, minor surgery sessions and health promotion clinics per 1000 patients; and prescribing costs and use of generic items.

**DISTRIBUTION:** Demographic data on patients across the practice area.
79. Only after such an information strategy has been established can information technology requirements be clearly identified. However, the computerisation of general practice has already been proceeding apace: there has been an increase in the proportion with a computer from under one in ten of practices in 1987 to nearly two thirds by 1991 (Exhibit 19). A higher proportion of larger practices are computerised.

**Exhibit 19**
**PRACTICE COMPUTERISATION**
The computerisation of general practice has been proceeding apace...

...with a higher proportion of larger practices computerised.

80. This expansion has been encouraged by funds from the FHSA cash-limited budget for both non-fund-holders (up to 50% of costs) and fund-holders (up to 75% of hardware costs and 100% of software costs). In 1990/91, the expenditure on practice computer equipment totalled £35 million and averaged £10,000 per practice, varying from around £5000 for a single-handed practitioner to about £20,000 for a group practice with six or more partners. Maintenance costs averaged £1300 per year.

81. Some FHSAs have tried to establish standards to promote compatibility, but they have often met opposition from both practices and suppliers. In contrast, there has been a set of standards for GP computing throughout Wales since 1991 - specifying coding systems for recording clinical information, report generators and adequate support systems. The DoH is moving toward national standards from April 1994.

82. FHSAs also need to provide training, advice and guidance to practices. Here FHSAs' information officers can be useful. But the numbers available vary considerably (Exhibit 20), and they can vary in ability and seniority. FHSAs need to ensure that they can provide good advice, as patterns of use vary considerably between practices (Exhibit 21, overleaf). They need to take account of such variation when evaluating bids for new equipment, and advising practices on how to make better use of existing systems. They need to explain the benefits and disadvantages of alternative systems: some have computer 'laboratories' for demonstrating different packages. They also need to keep in touch with colleagues in other FHSAs to keep up to date with new developments.

Exhibit 20
INFORMATION OFFICERS
Numbers per practice vary considerably

Source: Audit Commission analysis.

PREMISES

83. Inadequate premises can adversely effect quality of care. Some have inadequate space, heating and lighting. Patients often lack privacy and staff may lack a room of their own. Nationally, 7% of premises were judged below standard in 1990/91; more recently, the figure for
inner London was put at 46% (Ref. 43), where property prices and planning permission difficulties often act as barriers to new partners joining existing practices, or new practices setting up for the first time. Particular problems occur in health centres, owned and managed by DHAs, who rarely give priority to premises occupied by family health services staff.

84. FHSAs allocate funds to GPs for building or altering premises. They need clear criteria. They should be recording the current state of practice premises (the availability of toilets for patients, the number of consulting rooms available, etc.) and giving priority to meeting minimum standards. London FHSAs will also have to co-ordinate their activities with practices in the proposed London Enterprise Zones, being set up to tackle the particular problems of primary care in London.

INTRODUCING FUND-HOLDING

85. One of the major new initiatives in family health services is the introduction of GP fund-holding. Fund-holders are accountable directly to RHAs who determine their budgets and oversee arrangements; but in many cases, RHAs are delegating activities to FHSAs. This sensible development needs to be supported by legislative change if it is to be extended to allow fund-holding budgets to be determined locally. Much needs to be done to prepare practices for the scheme. FHSAs may also need to provide support to established fund-holders, allowing them the freedom and flexibility envisaged when the scheme was first introduced, while ensuring that they remain viable.

86. Funding was initially set centrally based on historical levels of expenditure. But because costing within the NHS is so rudimentary, estimates of expenditure on hospital services have proved inaccurate. Amounts allocated to fund-holders have varied between £52 and £176 for each patient, with hospital service budgets varying between £30 and £104, prescribing budgets
between £12 and £67 and staff budgets between £3 and £20 per patient (Ref. 44). Similar funding
arrangements based on previous expenditure patterns apply to community nursing services from
April 1993. It is not clear how much these variations reflect real differences in need between
practice populations, in clinical practice between GPs, in hospital costs, or simply in the
difficulties of performing the calculations. The savings achieved in some practices (well in excess
of £100,000 in the first year) would seem to indicate that this last explanation certainly applies
in some situations. Auditors reported 40 fund-holders declaring savings in excess of £100,000 in
1991/92, with five in excess of £200,000. In 27 cases, auditors commented on unrealistic budget
setting and/or changes in referral patterns. As information improves, there will no doubt be
continued refinement in the way finance is allocated between fund-holders, and for 1993/4, the
Department of Health has already issued guidance to RHAs on the allocation of funds for
prescribing and for hospital and community health services which take account of the numbers
of patients on doctors' lists (Ref. 45). In future some degree of local influence or control will be
appropriate if this refinement is to reflect local need and the FHSA should therefore be involved.

87. Good practice advice and support will still be needed after practices become fund-
holders. If anything, their need for advice on good management and improved information
technology is all the greater because they have to manage their budgets effectively. Indeed,
advance Government payments to help potential fund-holders prepare are a recognition of the
scale of the problem. Yet practices remain relatively isolated and self contained. The key rôle
that FHSA s play as development agencies should continue for fund-holders and non-fund-holders
alike.

88. Leicestershire FHSA employs a fund-holding co-ordinator funded by the RHA. He
recruits practices to the scheme, and reviews whether they are sufficiently well managed to
succeed. In the preparatory year, he helps to train practice staff in planning, contracting,
negotiating and financial management. He ensures practices collect the correct information, and
he provides advice and support on information technology where necessary. He also helps
interview and recruit staff for practices if requested, ensuring that skills needed to run a
fund-holding practice are in place. As such, he bridges the gap between central health service
management and GPs by getting to know fund-holders, helping them meet their individual
requirements.

CONCLUSION

89. The initial agenda set by central government has given FHSA s plenty to do; and progress
has been made in nearly all areas. But progress is uneven. FHSA s should continue to develop
their activities in support of the new initiatives; but they also need to start taking the initiative
themselves, as described in the next chapter.
SUMMARY OF RECOMMENDATIONS

FHSAs need to:

• fully involve members through training and specialist panels;
• consider the possibility of inter-FHSA co-operation on some administrative activities;
• examine ways of streamlining the paperwork, possibly using electronic data transfer, and improving the management information produced;
• ensure that they have sufficient and appropriate professional advisers and service development staff and that all are used effectively;
• have in place a systematic approach reviewing prescribing practice;
• develop a health promotion strategy that allows local initiative and choice;
• promote the development of protocols for managing chronic conditions;
• focus on practices not achieving targets for immunisation and screening, producing a common strategy with DHAs, and using funds to make improvements where appropriate;
• support practices in deprived areas by deploying additional resources such as health visitors, possibly in conjunction with DHAs;
• take the lead in promoting quality in minor surgery - particularly in view of possible incomplete excisions and undetected carcinomas;
• set a framework for medical audit, with agreed indicators of performance;
• monitor the use of practice nurses, practice managers and other staff to ensure duplication does not occur, information is to hand to help decide priorities and appropriate support and training are available;
• provide advice to practices on practice organisation and management;
• facilitate access to training courses for practice managers;
• advise on terms and conditions of service for practice staff;
• co-ordinate training resources, reviewing the training needs of practices and promoting teamworking among primary health care teams;
• develop an information strategy, and encourage the introduction of compatible information technology, adequately supported;
• develop clear criteria for allocating funds for improvements to premises;
• be increasingly active in promoting and preparing practices for fund-holding, advising them on good practice.

Central Government should consider whether there may be scope for introducing schemes which allow FHSAs to keep part of any administrative savings for reinvestment in patient services, and to adjust deprivation payments, linking them more directly to performance.
2. Moving On: Commissioning and Performance Review

90. Initially, most FHSAs concentrated on introducing the immediate agenda set out in the 1990 GP Contract and Working for Patients, acting as development agencies. Many are now beginning to act as commissioners of services to meet the objectives of Promoting Better Health (Ref. 4): to make services more responsive to the needs of the consumer, to raise standards, to promote health and prevent illness, to give patients the widest range of choice in obtaining high quality primary care services, to improve value for money, and to enable clearer priorities to be set for family practitioner services in relation to the rest of the health service. They must also promote the Government's health strategy set out in Health of the Nation (Ref. 7).

91. The FHSAs' role has been expanded to include assessment of local needs for family health services, and the planning and development of services to meet these needs' (Ref. 11). Indeed, 'needs assessment is at the heart of the Working for Patients reforms' (Ref. 5). Progress with needs assessment is reviewed in the first section of this chapter.

92. FHSAs must then sift through the information obtained, and set local priorities alongside the national ones. Here they must take account of the views of others. In particular, they must balance the priorities of users, practitioners, DHAs who commission community health services, and local authorities who are taking the lead in co-ordinating community care (Ref. 11). Progress with priority setting and interagency planning is described in the second section of this chapter.

93. As regards implementation, FHSAs' direct powers are limited, as described in the third section of this chapter. They must always rely on persuasion to negotiate and promote their policies; but in many situations, they may face difficulties if these are the only powers they have. They have some discretion over the cash limited part of their budget (some 10% of the whole), providing some leverage, but much of this is already committed at any one time. As a result, in many situations, their involvement is limited to the provision of 'mere advice'. This state of affairs is likely to be further exacerbated as GP fund holders gain greater discretion over their own affairs, unless FHSAs start to take a more proactive approach.

94. FHSAs must also start to undertake performance review which is described in the fourth section of this chapter but here again their lack of direct powers undermines their ability to enforce any shortfalls found. Their overall role will be strengthened if RHAs provide active support as described in the fifth section - but with one or two exceptions RHAs are not yet giving a strong lead.
ASSESSING NEED

95. FHSAs can still boost their influence by making the most of their rôle, co-ordinating the assessment of need and negotiating priorities with others to set a context within which practitioners can themselves start to shape their own priorities. And they can use their cash-limited budgets to tackle some of the anomalies found. In the past, FPCs had no remit and limited information and resources to assess need. As a result, resource distribution was determined by historic patterns based on demand rather than need. Practices with GPs who have been articulate and proactive attracted a relatively higher proportion of resources, possibly at the expense of the less articulate.

96. As a result, current patterns of provision appear not to match measures of need. The measure of need for primary health care developed by Professor Jarman (Ref. 32), based on factors affecting GPs' workload, correlates strongly with death rates in FHSAs (Exhibit 22) after adjustment for differences in the age and sex of their populations. Perhaps, more significantly, it also correlates with causes of death amenable to treatment by general practitioners (Ref. 46). But the number of GPs in each FHSA shows no correlation with the Jarman Index (Exhibit 23) – indicating a poor relationship to need. And the number of practice nurses in each FHSA shows a similar poor relationship (Exhibit 24). There is also evidence that provision of activities such as health promotion does not match need within an FHSA across different practices (Ref. 24).

PROBLEMS OF MEASUREMENT

97. However, neither the Jarman score nor mortality rates are necessarily sufficient measures of need for planning FHSA priorities and were not designed to be so. The Jarman score concentrates on social factors rather than the incidence of clinical conditions, although the two may be linked (Ref. 28); and mortality rates give little insight into the vast majority of conditions dealt with by GPs which are not life-threatening: they are used because they are readily available and unambiguous (although cause of death recorded is often oversimplified).

98. Measures of need should reflect morbidity (illness) rather than mortality – but morbidity is much harder to define precisely, and data on it much harder to collect. Even a relatively simple condition such as hypertension (high blood pressure) does not have a single clear definition.

SETTING A FRAMEWORK FOR ASSESSING NEED

99. Some authorities are developing a range of measures from a variety of sources which complement each other and build to give a more complete picture (Exhibit 25, page 44). Increasing computerisation means that practices ought to be able to supply information (with

Exhibit 22
JARMAN INDEX AGAINST STANDARDISED MORTALITY RATE
The index correlates strongly with death rates

Source: HSI 1990-1991 (line of best fit: $r^2 = 0.68$).
that is of direct use. The practice profile already described in Chapter 1 can be extended to include local health data - possibly combined with DHA and national data - allowing practices to set their own priorities. From July 1993 they will need such information to plan and secure resources for health promotion. **North Tyneside FHSA**, together with the coterminous DHA and local authority has produced a health profile for its area and the twenty wards within it. It sets out population characteristics such as mortality, migration, deprivation and other social factors and numbers of new babies with a low birth weight. It also shows how the area compares with others (there are low numbers of practice nurses for example, although high numbers of community nurses in compensation); and it sets out the local provision of family health services and acute

### Exhibit 23

**JARMAN INDEX AGAINST THE DISTRIBUTION OF GPs**
The number of GPs in each FHSA shows no correlation with the Jarman Index

![Graph](image1)


### Exhibit 24

**JARMAN INDEX AGAINST PRACTICE NURSES**
The number of practice nurses in each FHSA shows a similar poor relationship

![Graph](image2)


100. It is important that this type of exercise translates into meaningful action. Practitioners will not supply information if they do not think it worthwhile. Their cooperation can best be secured if they positively gain from the process, receiving information back confidentiality suitably safeguarded) on the incidence of morbidity, given suitable definitions; and practitioners can advise FHSAs about problems and areas requiring improvement. DHAs also collect information on health problems, with specialists in public health medicine on hand to interpret it. It is then published in an annual report, and FHSAs should be involved in the report's preparation. There is much useful information produced at the national level, particularly by the census; and the General Household Survey provides information on the incidence of drinking, smoking, leisure and immigration. Some research workers are developing more sophisticated measures which take account of years of life gained and quality of life achieved, such as the QUALY (quality adjusted life years); and Jarman UPA scores and mortality statistics have their place in any needs assessment framework.
services in each ward. This profile has helped to highlight some local health concerns, such as a high incidence of lung cancer, a high level of peri-natal mortality and exceptionally high levels of GP prescribing. Northumberland FHSA has also started a system for collating and returning information in this way (Case Study 5).

101. Of the other FHSAs visited, none had an overall strategy but many had some of the components. Two of the seven had collected morbidity data from practices; three had canvassed practice staff on their views of services; three had contacted other agencies (mainly DHAs); four were collating other data on health needs from other sources; and three had started systematic feedback of information to practices.
Case Study 5

ASSESSING NEED IN GENERAL PRACTICE:
NORTHUMBERLAND FHSA MEDICS

Northumberland FHSA, working with local practices and the DHA, has introduced an information system called MEDICS (morbidity and epidemiology data interchange and comparison scheme). Practices collect and send morbidity information on summary sheets to the FHSA for analysis. It is then returned, with each practice compared with others (anonymised to preserve confidentiality). Information is collected on the prevalence of:

- seven chronic conditions - asthma, cancers, diabetes, hypertension, ischaemic heart disease, hypothyroidism, and cerebrovascular disease;
- five health markers - blood pressure, cholesterol, smoking, weight and alcohol consumption;
- disability

The above data set was agreed over six months by a project board of seven, of whom five were medically qualified including one specialising in public health medicine. Its practical application was then tested in trials by thirty GPs, before being piloted on the three most common computer systems in use by Northumberland practices.

The scheme is voluntary and practices taking part receive a quarterly payment of eleven pence for each person on the practice list to cover costs. By July 1992, thirty two out of fifty practices, serving two thirds of Northumberland's population, had joined the scheme. The first quarter's data identified topics for action (more consultations to tackle hypertension and more clinics to lower the incidence of heart disease) and topics requiring further investigation (a low incidence of asthma - implying low detection rates). One side effect has been an improvement in the use of computers within practices.

The data base produced is useful for planning medical audit; and the FHSA also combines it with prescribing and referral data, building a more complete picture of practices - improving the dialogue between the two. In the longer term, as the quality of data improves, it may be possible to use the scheme to help plan the allocation of resources and the setting of priorities for health promotion, for example.

SETTING OBJECTIVES

102. Taking the various indicators of need as a starting point, FHSAs should then start the difficult process of setting priorities. Such indicators should reveal patterns of social deprivation, above-average incidence of disease, high levels of risk and particular local peculiarities, possibly linked to local industry. They should also take into account the (sometimes conflicting) priorities of others, including patients, practitioners, DHAs and local authorities; and they should reconcile local priorities with national priorities.

PATIENTS

103. Patients should be involved when deciding priorities. Surveys have indicated that patients and professionals often have different priorities (Ref. 47). However, there are difficulties. Patients are not often in a position to judge whether advice or treatment is appropriate. They usually assume practitioner competence. People are often grateful for help - especially after
successful treatment. As a result user views may give little guidance on clinical issues, and are often difficult to collect. But some people are becoming increasingly critical of services (Ref. 48). It is essential to try to gauge their views as patients’ different perspectives can help identify shortfalls in quality and gaps in services, requiring adjustments to priorities.

104. A number of techniques are available. FHSAs can carry out surveys directly or they can tap community groups, community health councils and other representative bodies. They can analyse the complaints received from patients to identify weaknesses. And national surveys can reveal general trends. As part of this study, the Audit Commission used ‘patient focus groups’ to identify users’ concerns (Box C). Such activity often demonstrates that users have a diverse range of different concerns, often shaped by local circumstances such as the ethnic makeup of the population or the existence of deprivation. Such variation is best addressed by providing choice and a diverse range of services.

105. By and large, users recorded a high level of satisfaction with practitioners, although there can be differences between different patient groups depending on class and health status (Ref. 48). Concerns tended to focus on services, communications, access and continuity of care, with less attention given to clinical matters. People want more time with their doctor (as do doctors with their patients) and do not want to be dismissed with a prescription. They are concerned with time spent waiting and with the convenience of surgery hours. Other studies have reported that patients tend to be more interested in the quality of traditional GP services, and are less concerned to see additional options (Ref. 47), possibly because they lack knowledge of the possible benefits.

106. Such general findings are based on large samples, but practice-specific issues also need to be identified. The introduction of the Patients’ Charter has formalised the need to identity such issues, requiring a greater attention to patients’ rights and an increased sensitivity to the views of patients. Practice-based surveys provide information of direct relevance to practitioners — but the skills available to interpret them are often limited. However, FHSAs can provide survey ‘packs’ for use in practices (Ref. 49), and can supply the expertise to carry out any analyses. They can also support other initiatives such as patient participation groups.

PRACTITIONERS

107. Practitioners’ concerns inevitably differ from those of their patients. As part of this study, with a number of GPs were interviewed (Box D, page 50). They expressed concern about a range of issues: they lack comparative information about other practices; they need guidance on health promotion activity, on how to co-ordinate their activity with community health staff; and on appropriate training for their staff. Other surveys have indicated that GPs give priority to keeping up to date with medical knowledge; they value pleasant surroundings at the surgery, and recognise the need to balance treatment with preventative advice, giving high priority to spending as much time as possible with patients (Ref. 47).

108. Virtually all practitioners visited – and all FHSAs – expressed concern about the 1990 contract. FHSAs have had to promote the implementation of the contract, and have invested much effort to overcome practitioners’ initial reticence in order to involve them in the development of strategies for improving patient services. In practice many FHSAs have had to start work
on their own; but they must find ways to involve practitioners if the resulting strategies are to be implemented successfully.

DISTRICT HEALTH AUTHORITIES

109. DHAs provide a third perspective. They have responsibility for commissioning hospital services. Where they supervise directly-managed units they must ensure that such units are used effectively. They therefore have an interest in ensuring that appropriate referrals take place, and that proper arrangements are made for discharging people from hospital. They have a financial interest in seeing the development of initiatives that enable care to be provided efficiently and effectively in practices saving referrals and the use of scarce and expensive hospital services. DHAs may use FHSAs to sound out practices' views of secondary and other services and to check referral behaviour. DHAs also commission community health services which form part of primary health care teams and here, in particular, there can be conflicts. Members of teams may serve different populations, and priorities may vary: community health staff report to senior staff in community units with objectives set separately by the DHA.

110. Achieving joint activity is seldom straightforward. In authorities that do not share common boundaries, much time can be spent on joint working — often to little effect. Some FHSAs must relate to six or even seven DHAs and up to three local social services authorities. Some are trying to overcome such difficulties by operating as one agency or 'consortium' although it is not possible for DHAs and FHSAs to merge at present. Such arrangements help the coordination of primary and secondary services. Others are making the locality the focus for joint activity, planning and commissioning services which take into account a wide range of local patient views of health needs. Locality purchasing must be reconciled with fund-holding which puts the practice, and practitioners, at the centre. In Gwynedd FHSA (which shares common boundaries with one DHA and County Council), services are being reorganised around twenty centres of population which all have their own GP and community health services. Overall co-ordination is provided by the Primary Care Liaison Group with representatives from the FHSA, the DHA, community unit, community health council, local authority social services and the county organiser of voluntary services. At the operational level primary health care teams provide the focus, with a facilitator jointly employed by the FHSA and DHA. The FHSA reimburses practice staff for time spent in team meetings and supports bids for extensions to practice premises to accommodate team members. Joint working locally can overcome many of the difficulties encountered at the strategic level.

LOCAL AUTHORITIES

111. Local authorities are taking the lead in arranging community care for elderly people, people with disabilities and those with long term mental health problems. But their priorities may differ from those of practices. Local authorities may give priority to the most severely disabled, while practice staff may wish to see support for people who are at risk but not yet at a point of collapse. Here FHSAs must represent practices at the strategic level when needs are addressed and priorities set as part of the community care planning process. Indeed, FHSAs should be sharing their information on needs (while safeguarding confidentiality) as part of this process.
As part of the study the Commission used patient focus groups to review patient views of GP services. The groups included elderly people, women, mothers with children, people with disabilities and members of ethnic minorities in three locations: London, Sheffield and South Wales. In total 37 discussion groups met and involved over 300 members of the public. Many of the issues raised concerned communication, access and continuity of care. There was less concern with clinical aspects of GP services. The work was carried out by Dr Andrew Thompson of the Cardiff Business School in collaboration with the Health Policy Advisory Unit based in Sheffield.

**Range of Services**
- Patients liked and wanted more screening and preventative work.
- Well woman clinics were strongly supported but were not felt to be thorough enough.
- Interest was expressed in alternative therapies and exercise facilities at surgeries.
- Health vans offering screening services would help widen access.
- Mothers would like additional facilities for children, such as:
  - play area/childminding in the waiting area
  - a specialist GP sensitive to children's needs and routines.
- In London, people regarded hospitals as an alternative to their GP and were just as likely to seek help there.
- People within the discussion groups learnt a lot from each other about the range of services available, including nursing services.

**Information and Communication**
- Patients thought surgeries should have information on eligibility for benefits generally and, not just for health services.
- More information was needed on the availability of respite care for carers and counselling and psychiatric services.
- Language was a barrier to members of ethnic minorities (with translations often pitched at too high a level, and interpreters present in consultations causing stress due to lack of privacy).
- Videos were seen as a good alternative where verbal and written communication was difficult.
- Wider use of the Sympathetic Hearing Scheme and provision of information in Braille would help sensory disabled people.
- Information on drugs and their expected side effects was felt to be poor.
PATIENT VIEWS OF GP SERVICES

• Some were unsure how to change their GP, yet many had changed GPs several times during the last year, particularly in London.

• Few people knew where to complain about their GP.

Access

• Physical access into and inside buildings for wheelchairs, prams, pushchairs etc. often presented problems.

• Multilingual signs would be helpful.

• The condition of buildings caused little comment in the discussion groups (probably seen as less relevant compared to services and staff).

• Opening hours were too limited particularly in rural areas, and favourable comments were expressed for GPs offering a seven day service.

• Access was always worst on Mondays because of the backlog built up over the weekend and services weren’t changed to cope.

  • GPs didn’t have enough time to listen (regarded by patients as very important in the care process) although elderly people were content with the time spent with them.

Staff

• Name badges would be useful to identify staff, especially for people with hearing problems and on home visits.

• GPs often sounded resentful of being called out of hours.

• In London, particularly, the locum service was disliked due to lack of understanding of individuals’ needs and continuity of care.

• Also in London, there was strong support among young women and members of ethnic minorities for access to a female GP.

• It was felt that GPs failed to co-ordinate properly with health visitor and midwifery services.

• Receptionists often showed a poor attitude and were not good at communicating.

• Both GPs and staff lacked an understanding of the effects of disabilities.

Clinical Issues

• Disabled people questioned the competence of GPs to diagnose deafness properly or understand its consequences.

• Concern was expressed over conflicting advice given by different health professionals.

• People, particularly older people, did not want to be met with a prescription as a mechanistic response.
**Box D**

**THE CONCERNS AND PROBLEMS OF GENERAL PRACTICE**

As part of the study visits were made to twenty general practices to get an understanding of the concerns of GPs and the problems they face. There was much opposition to the 1990 GP Contract. The visits took place between September 1991 and January 1992. GPs particularly mentioned (the frequency is given in brackets):

- lack of comparative information about other practices (7)
- not asked opinions about performance of hospitals on referrals (3)
- a lack of guidance on the evaluation of health promotion and disease management clinics (4), and a scepticism about the medical value of health promotion activity by clinics (10)
- insufficient time to provide acute and emergency treatment to patients (3)
- no choice over community health service staff (7) or no control over their tasks and priorities (5), and no contact with CHS managers (3)
- poor access to dieticians, physiotherapists, etc. (2)
- a need to make GP postgraduate training relevant to GP’s (5)
- concern over inappropriate courses for practice staff (4)
- a need for advice on the purchase of information technology, database design and data handling (3)
- planning blight due to funds only known for one year ahead (3)
- limited by current premises and need to move (3)
- need to rationalise forms (4)
- need to move to the electronic transfer of data (4)
- lack of dealing with the same people (3)
- lack of GP involvement with the activities of the FHSA (3)
- currently GPs have too much to do (6)
Community care is increasingly important to practices. It is inextricably linked with both primary and secondary care - and failure to co-ordinate community care policies with GPs and the NHS in general could rapidly result in health services overloaded with people who require long-term care. In particular, community health services will need to be linked to the day and domiciliary services provided by social services. Similarly, community mental health services and services for those with a learning disability will need to be co-ordinated with plans to close long stay hospitals. Under the Government’s proposals, some local authorities are introducing care managers with delegated budgets who can therefore purchase services for individuals in a way similar to GP fund-holders. In some experimental schemes, care managers are being located in GP practices enhancing the prospect of active co-ordination between GPs and social services. A shared activity is the assessment of people for services. While local authority staff take the lead, GPs and other health staff will often need to contribute, and recent guidelines have been issued to help them do so (Ref. 50). The need to co-ordinate and integrate activity in this way argues for ever closer working between health and social services.

BALANCING CONFLICTING DEMANDS

All of these different interests must be weighed and balanced, with the FHSA often acting as intermediary. There may be a further tension between national and local priorities. There is no easy way to resolve conflict although most FHSA have made a start. Five out of seven visited have produced annual reports or other strategic documents outlining priorities, which bring together national and local issues (Exhibit 26).

Exhibit 26
SETTING HEALTH PRIORITIES
FHSA have produced annual reports outlining priorities, which bring together national and local issues (Health of the Nation key issues are marked (+))

<table>
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<th>Priorities</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
</tr>
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<td>Heart Disease and Stroke (+)</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
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<td>✔</td>
<td>✔</td>
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<td>✔</td>
<td>✔</td>
<td>✔</td>
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<tr>
<td>Respiratory Diseases (+)</td>
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<td>Care of Elderly</td>
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<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Prescribing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reducing Waiting Lists</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Audit Commission analysis.
114. Sometimes local circumstances require special local initiatives with greater flexibility. The Tomlinson Report (Ref. 43) highlighted the need for flexibility for inner London where primary care is underdeveloped and faces high deprivation, overcrowding, high death rates and multiracial populations (Ref. 51) in common with some areas of provincial cities. Current GP services have poor accommodation, high numbers of elderly practitioners and single-handed practices, large list sizes and few practice staff. The Department of Health has published Making London Better (Ref. 52), and has set up a special London Enterprise Zone. Extra funding is being provided for the development of primary care services, with an emphasis on innovative schemes including more accessible premises, expanded roles for nurses, pharmacists and other professionals, and services for special needs groups such as the homeless. In Liverpool, an initiative is underway to tackle similar problems (Case Study 6).

### Case Study 6

**LIVERPOOL FHSA – DEPRIVED AREA STRATEGY**

The city of Liverpool has a declining and ageing population of 470,000 with a high unemployment rate and much urban deprivation. In 1989 two in five households were in poverty (defined as being unable to afford three or more socially perceived necessities) and one in six were in intense poverty (unable to afford seven or more necessities). Unemployment and deprivation were particularly high in eight electoral wards, with unemployment rates of one in three. The area also has one of the country's highest death rates from heart disease, lung cancer and other lung diseases such as bronchitis with an associated high hospitalisation rate for these diseases. In response, the FHSA has designed an approach for targeting this area within the overall framework of the World Health Organisation's Healthy Cities Programme, working with a total of fourteen partner agencies (including the DHA, local authority, Community Health Council, police and voluntary groups). Priority was given to bids for resources from practices in the deprived areas. A public health report was commissioned on the health problems of one particular ward. The report was followed by a series of public meetings involving local community groups to define local requirements for health service. Working groups were formed of equal numbers of residents and professionals to identify priorities and gaps and to produce an agenda for action.

### IMPLEMENTING PRIORITIES

115. Lists of priorities are meaningless unless practices adopt them. But the powers FHSAs have to direct their adoption are few (Exhibit 27). The national priorities are backed by financial incentives: health promotion, screening and immunisation all carry financial benefits for those who meet the targets and these incentives have been very effective. The incentives available for promoting local priorities are limited. FHSAs can start to correct the uneven distribution of practice nurses (Exhibit 24) - but they have no direct powers to tackle the uneven distribution of GPs although they do have some influence through the Medical Practices Committee (Exhibit 23).

116. FHSAs must instead rely on persuasion backed by modest incentives from the cash-limited part of their budget. But persuasion by professional advisers is necessary for promoting priorities whatever other incentives are available. To be truly effective, priorities must be
accepted by practices and made their own. Different practices face different priorities: inner-city practices are unlikely to face the same needs as suburban or rural practices; and fundholding practices have greater autonomy and different concerns.

Exhibit 27

FHSA POWERS
The powers of FHSA over self-employed medical contractors are few

<table>
<thead>
<tr>
<th>FHSA Powers</th>
<th>FHSA Influence</th>
<th>Authority Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structure of Contract</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Choice of Contractors</td>
<td>Selection of single-handed practitioners</td>
<td>Limited</td>
</tr>
<tr>
<td>Distribution of Contractors</td>
<td>None</td>
<td>Limited</td>
</tr>
<tr>
<td>Professional Misconduct</td>
<td>None</td>
<td>Limited</td>
</tr>
<tr>
<td>Terms of Service</td>
<td>Limited</td>
<td>Limited</td>
</tr>
<tr>
<td>Non-cash limited Budget GMS (90% of the total)</td>
<td>Limited</td>
<td>Some influence on health promotion and prescribing</td>
</tr>
<tr>
<td>Cash limited GMS Budget (10% of the total)</td>
<td>Yes</td>
<td>Extensive discretion (although not for staff in post prior to April 1990)</td>
</tr>
</tbody>
</table>

117. Priority-setting is not yet widespread. Most FHSA have had more than enough to do promoting the national agenda, but it is becoming increasingly necessary to promote greater local flexibility if the Government’s objectives for primary care are to be met in full.

PERFORMANCE REVIEW

118. FHSA are required to help review progress in practices and promote quality. Quality assurance frameworks are required for evaluating the process and outcomes from practice activities, and some of the components of such frameworks are already in place. A wide variety of staff—especially professional advisers—pay routine visits to practices, and during these visits they assess arrangements. Practices must also produce an annual report.

119. FHSA must build on these beginnings. They have recently taken on responsibility for promoting the use of patients’ charters within practices. Henceforth practices will need to set explicit targets for performance, specifying maximum acceptable waiting times for appointments and diagnostic tests for example. They should be promoting the use of procedures to handle comments, suggestions and complaints from patients. They should also be providing guidance on ways of contacting doctors or nurses out of hours, and be promoting the development of
specialist services, either for people with particular needs, or for people from ethnic or minority groups.

120. Hereford and Worcester FHSA has introduced a series of systematic monitoring visits - establishing a baseline of information for comparative purposes (although respecting confidentiality). Practices that are out of line are targeted for more frequent visits. Visits are made by the service development director and medical adviser to ensure a broad approach across all aspects of practice activity; and the visits are informed by practice profiles in which each is compared with the FHSA average. PACT prescribing information and the annual report are also used. Practices are notified in advance of visits and can prepare background material where appropriate. Check-lists of issues to be covered during every visit are compiled, and short (two page) reports are prepared and agreed with the practice. Emphasis is always placed on a positive approach, although where outstanding issues are identified, they are subsequently monitored and progress evaluated.

121. FHSAs are also well placed to identify and spread good practice - using funds to ‘pump prime’ innovative projects (complete with evaluation of outcomes). Examples encountered include the deployment of specialist services such as dieticians, chiropodists and occupational therapists and the integration of the management of nurses. Others include a business planning approach for practices, a health promotion campaign, a scheme to evaluate health screening in practices, a scheme for the development of outcome measures for the management of diabetes, and an interpretation service for an ethnic minority. Practice-based activities such as family therapy and swimming therapy for children with arthritis have also been promoted. No doubt there are many more, and there are clear advantages to sharing good ideas developed in one practice with others, although most have costs attached and value for money must always be taken into account. There are major resource implications if FHSAs take performance review seriously.

OVERSIGHT OF FHSAs

122. The position of the FHSAs can be strengthened by active oversight. Since April 1991, FHSAs have been accountable to RHAs. Each RHA oversees a number of FHSAs as well as DHAs and GP fund-holders, and is therefore well placed to provide a strategic perspective on both the national agenda and local issues. Their rôle is currently under review, and may change: but some form of inter-authority co-ordination may be beneficial whatever the administrative framework.

123. There should be a consistent approach to the way funds are distributed between FHSAs for cash-limited general medical services and FHSA administration. Initially some adjustment may be needed to bring funds more into line with overall population numbers, perhaps weighted for age and sex differences. Eventually, adjustments could start to take account of morbidity and mortality differences and to promote a shift from secondary care to primary care in accordance with government policy - by encouraging closer working between DHAs and FHSAs and by diverting funds at source. There is also a need to make sure that scarce NHS management skills are used to best effect, and that the provision, assessment and accreditation of courses for GPs and practice staff are well co-ordinated across FHSAs.
124. One or two RHAs have already started to give a strong lead, but others are less proactive, often lacking sufficient staff with experience of primary care. Priority is still all too often given to the traditionally dominant hospital sector, even though a re-balancing between primary and secondary care is required. All should ensure that they have sufficient expertise and that they make full use of it; and they need to grasp the full extent of the FHSAs' new and changing management responsibilities and adapt accordingly. Some are actively promoting the integration of FHSAs and DHAs into joint organisations which build on the strengths of each to develop local health strategies and commission health care in its entirety.

**SUMMARY OF RECOMMENDATIONS**

FHSAs need to:

- develop a framework for assessing health needs which uses a range of measures including morbidity information from practices;
- set priorities which reconcile local and national issues;
- involve patients and practitioners as much as possible when setting priorities;
- work with DHAs and local authorities identifying issues of common concern, and co-ordinating responses;

Ways of providing FHSAs with incentives for promoting local priorities amongst practitioners should be considered (and the new initiatives on health promotion described in Chapter 1 point the way).

FHSAs should also:

- promote the development of quality assurance frameworks;
- ensure that the principles of the Patient's Charter are applied to the FHSA's own work; and that patient's charter initiatives are promoted in practice.

Oversight is needed to:

- promote a consistent approach to the way funds are distributed between FHSAs, taking account of population differences and in due course morbidity and mortality differences and the need to shift from secondary to primary care;
- encourage closer working between DHAs and FHSAs making best use of scarce NHS management skills.
3. Dental, Pharmaceutical and Ophthalmic Services

125. FHSAs also have a responsibility to develop and plan the services provided by dentists, community pharmacists and opticians. But they have even less leverage than they have for developing a local agenda for general medical services (Exhibit 28). They have little budgetary discretion to influence developments, and their influence is further reduced where practitioners receive some of their income privately. Many FHSAs also have little expertise, especially where they do not employ professional advisers. Such funds as there are must be diverted from FHSAs’ administrative budgets which are otherwise used to process routine tasks. In spite of these difficulties, FHSAs must try to develop these important services which cost the NHS over £2 billion a year.

Exhibit 28
FHSAs’ CURRENT POWERS WITH REGARD TO DENTISTS, COMMUNITY PHARMACISTS AND OPTICIANS
FHSAs have even less leverage than they have for developing a local agenda for general medical services

<table>
<thead>
<tr>
<th></th>
<th>Pharmacists</th>
<th>Dentists</th>
<th>Opticians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Structure of Contract</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Choice of Contractors</td>
<td>None</td>
<td>Limited</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(salaried only)</td>
<td></td>
</tr>
<tr>
<td>Distribution of</td>
<td>Yes</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Contractors</td>
<td>(new only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional Misconduct</td>
<td>Limited</td>
<td>Limited</td>
<td>Limited</td>
</tr>
<tr>
<td>Terms of Service</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>(NHS work only)</td>
<td>(NHS work only)</td>
<td>(NHS work only)</td>
</tr>
<tr>
<td>Non-cash Ltd Budget</td>
<td>Limited</td>
<td>Limited</td>
<td>Limited</td>
</tr>
<tr>
<td></td>
<td>(unless fraudulent)</td>
<td>(unless fraudulent)</td>
<td>(unless fraudulent)</td>
</tr>
<tr>
<td>Cash Ltd Budget</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

DENTISTS

126. Nearly all dental services within the community are provided by self-employed contractors, who are part of the General Dental Service (GDS) overseen by FHSAs. There are approximately 16,000 GDS dentists in England and Wales, operating either on their own or in group practices. The 1990 dental contract, negotiated at the national level between representatives of the dental profession and the Department of Health, has significantly changed the way dentists operate. The proportion adults pay has been increased to 80% of all costs up to an upper limit; and dentists are also paid an annual fee by the NHS for each person registered with
them. Most children's treatment is covered by an annual 'capitation' fee from the NHS, although dentists receive an additional payment if they treat two or more teeth. Dentists are also required to provide emergency 24 hour cover. They must provide practice leaflets and make them publicly available, and inform patients of the basis for charges within a treatment plan. They must make good any treatment that fails within one year free of charge to the patient; and they are paid an allowance to cover two sessions of post-graduate education each year. Traditionally, dentists have always had a large measure of independence, and 'Promoting Better Health' (Ref. 4) confirmed the GDS as the main provider of dental care for both adults and children.

127. In addition, the **Community Dental Service** (CDS) administered by DHAs also provides valuable dental services. It was originally set up to provide a service of inspection and treatment for children in schools. While this service remains significant in many areas, in others its treatment rôle is increasingly restricted to providing a 'safety-net' service for people with disabilities (Ref. 53). There is sometimes very little contact between GDS and CDS dentists.

128. Since April 1991, dentists have been paid by the **Dental Practice Board (DPB)** in Eastbourne. The DPB approves and authorises all payments for dental care and treatment (with prior approval being required for some of the more complex and costly treatments); and it collates activity data summaries which are returned to practices. After some initial problems, most dentists interviewed felt the speed of turnaround and accuracy of the DPB compared favourably with the payment service provided previously by FPCs.

129. The fragmentation between these organisations has meant that there has been little co-ordinated oversight of dental services. Responsibility for assessing need notionally rests with the FHSA, but expertise resides within the Community Dental Service and information is collated by the Dental Practices Board. The DPB records information by FHSA on the type of treatment and can show practice location in relation to overall population, but cannot yet map the distribution of patients throughout the population, to allow the identification of gaps in provision. Most practice data that would give more precise information about take-up and need are not collated.

130. The rôle of the FHSA can be strengthened by the appointment of dental advisers. **Norfolk FHSA** employs a dental public health adviser to carry out surveys on the incidence of dental disease among children. It also confers with dentists about how best to provide orthodontic services where there is a shortfall in hospital provision (with some dentists training to provide a service in the community as a result); and carries out surveys of groups who drop out of regular attendance at GDS dentists - young adults aged 18-24 for example.

131. But even where FHSAs are proactive and identify outstanding needs, their response is limited by their lack of powers. They can, together with the Community Dental Service, provide health education and promotional material, visiting schools and places of work - particularly in areas where attendance is poor. **Norfolk FHSA** has mounted a health promotion campaign in an area where only three in five adults are registered for continuing care. Working with the local dental committee, they designed a campaign to increase registration by advertising on the radio and in the newspapers; and they set up a dedicated telephone line for people wanting to know how to register with a dentist. A 'road show' was used to spread health promotion advice with a copy of the campaign literature sent to every dental practice in the area. Evaluation showed an
increase in registrations over the period of the campaign. But such initiatives need careful evaluation to make sure they represent good value for money, and provide guidance as to ways of improving future campaigns.

132. FHSAs have little direct control over the quality of clinical work. Suspected unnecessary work, either proposed or completed, and the quality of the work done is investigated by the Dental Practice Board's dental reference service (DRS) who employ dentists to carry out inspections on a sample of GDS patients. However, FHSAs can request practice inspections by the DRS. Peer review, seen as a precursor of clinical audit, has been introduced as a pilot scheme funded jointly by the Department of Health and the profession, although it is still unclear how it will develop and what rôle, if any, the FHSA will play. Self-assessment manuals and standards are prepared by the Faculty of Dental Surgery at the Royal College of Surgeons and funded by the Department of Health in order to help the establishment of standards, but there has been little extra funding to introduce reviews into practices.

133. FHSAs are seen by the Department of Health to be the lead authority for developing and co-ordinating the delivery of primary dental care (Ref. 53); although they hold dentists' contracts, they cannot control numbers of dentists entering the FHSA dental list, since anyone with the necessary professional qualifications can set up practice. They cannot control the location of premises, although they can fund 20% of capital costs up to a maximum of £50,000 for new or expanded premises through an incentive scheme to encourage new dentists to start practising in areas of shortfall. They cannot influence the numbers of practice staff, or type of equipment used. Fees received from the NHS automatically include contributions toward these items. Computing is beginning to be introduced but financial payments of £900 are available from the Dental Practice Board, to practices who link with the DPB's scheme for electronic transfer of information, and not from the FHSA. By March 1993, 15% of dentists in England were linked to the DPB with about a further 50 linking each week.

134. This lack of influence means that they are in no position to respond when difficulties arise. The dental profession claim a long term deterioration in their income which, taken together with the pressures of the new dental contract and a fee cut of 7% in July 1992, led to a recent dispute. Some dentists have withdrawn from the NHS, either partially or entirely - reducing the provision of NHS services in some areas. A survey by the Department of Health before the recent dispute (September 1991) found only three quarters of dentists were accepting all NHS patients, with 22% being selective over whom to accept for NHS treatment, and 2% accepting no NHS patients at all. One in five were refusing to accept adults eligible to pay their own charges; and one in six were refusing NHS treatment to children and adults exempt from charges.

135. The situation is most marked in high cost areas such as the South East, as the national payment mechanism makes no allowance for differences in cost. It aims is to provide an average target income for an average volume of care and treatment. In 1991 in London and the home counties fewer than 70% of dentists were accepting all NHS patients, while in the North, the Midlands and East Anglia, the figure was much higher at 90% (Exhibit 29, overleaf and Ref. 54). More recent surveys (Ref. 55) suggest that this situation has since deteriorated.

136. To counter shortfalls, FHSAs can, with Department of Health approval, employ salaried dentists. They can also use the incentive schemes funded by the Department of Health.
encourage dentists to practice in poorly served areas. FHSAs can deploy mobile surgeries using dentists, although such schemes do not provide either the continuity of care or the 24 hour cover of established practices. FHSAs visited have found such measures to be largely ineffectual – particularly as there are few dentists prepared to work on a salaried basis.

137. FHSAs also calculate and make a number of minor payments to GDS dentists, funding early retirement payments, vocational training, maternity benefits, long-term sickness, post-graduate education and drug costs. They must also maintain dental lists, ensure that dentists provide an emergency service and produce a practice leaflet. They must invite patients of a retiring dentist to register with another dentist, and must produce a public directory of NHS dental services, providing information in response to enquiries about dental services. They must also deal with patient complaints and inspect premises; and they must arrange an emergency dental service for non-registered patients. This limited list of marginal activities means that the FHSA’s rôle in the development of local dental services has changed little since the days of FPCs.

138. But some FHSAs still manage to play a more proactive rôle, by employing a dental adviser. Without such an adviser, FHSAs have no expertise available apart from the one member on the authority with dental experience and the local dental committee. The Department of Health funded the appointment of dental advisers in a number of FHSAs in a pilot scheme in 1991/92 (Ref. 56). This funding was transferred to RHAs in 1992/93 as part of the general allocation of administrative expenditure and there is therefore no guarantee that it will continue to be used as originally intended. But where FHSAs have dental advisers, they can have an impact. Norfolk FHSA employ a practice adviser for one day a week to visit practices. He advises on health and safety issues, premises, computing and complaints procedures; and talks over issues of general concern with GDS dentists such as the balance in the provision between NHS and

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**Exhibit 29**

**PROPORTION OF DENTISTS ACCEPTING ALL NHS PATIENTS (SEPTEMBER 1991, ENGLAND AND WALES)**

In London and the South East fewer than 70% of dentists were accepting all NHS patients

![Graph showing the proportion of dentists accepting different NHS patient categories in various regions of England and Wales.](image-url)
private services. The adviser also provide guidance to the FHSA on technical issues (e.g. complaints), and to patients on the FHSA's behalf.

139. In conclusion, the rôle of the FHSA is mainly limited to providing advice and a few administrative services. They can make the most of this rôle by employing dental advisers, but if they are to do more to make up shortfalls in provision and to target specific needs, their powers will need to be enhanced. The Bloomfield Report (Ref. 57) proposed several options for more local management of dental services, focusing on need, health gain, priority setting and the introduction of financial incentives to encourage practitioners to meet the needs of priority groups. If FHSAs are to develop and coordinate primary dental care, then some adjustments will be needed to match their authority with their responsibilities.

COMMUNITY PHARMACISTS

140. There are about 10,500 community pharmacists in England and Wales, dispensing NHS prescriptions in return for a fee. Most operate as single-handed practices and combine dispensing with the retailing of other pharmaceutical products and toiletries (Ref. 58). In 1991/92 in England and Wales they dispensed 450 million prescriptions at a cost to the NHS of £2,522 million for which they were paid £631 million in professional fees.

141. Traditionally, pharmacists have provided a check against prescription errors, and advise patients on the safe and effective use of medicines dispensed. Many operate a patient medication records scheme for elderly and confused patients on multiple medication. But the context within which they practice is changing (Ref. 22). Today, there is an increasingly wide range of more powerful, complex and effective medicines. More are supplied pre-prepared by manufacturers, and there are new delivery systems available which make the pharmacist's manipulative skills less important.

142. They also play a key rôle as a source of advice in their own right. People consult them on ways of treating common ailments; and they often provide advice on health promotion. The ageing of the population is producing changes to disease patterns and the resulting demands on the service, and people are seeking more information and greater involvement. Pharmacies are well placed to respond, being among the most accessible of health services, although they are often isolated from other primary care workers. They can provide information in the form of leaflets, displays and videos. However, a recent survey has raised doubts about the overall standards of advice offered by pharmacists to patients with common health problems such as indigestion, coughs, diarrhoea, and piles (Ref. 59). Although the majority of advice given was correct, they failed to question the patient's own diagnosis. If advice is to be encouraged, training will be required.

143. The two key functions of FHSAs in relation to community pharmacists are to make payments (as authorised by the Prescriptions Pricing Authority) to pharmacists, and to operate the entry controls for new NHS pharmacy contractors. Such controls are operated to ensure that the local population has reasonable access to the full range of NHS pharmaceutical services and to provide stability in the number and distribution of pharmacies. In designated rural areas (called 'controlled localities') the FHSA, when dealing with an application for a new pharmacy, has first to decide whether it would undermine existing general medical or pharmaceutical services in the
area: many doctors in controlled localities dispense medicines for patients who live more than one mile from a pharmacy. FHSAs also operate the essential small pharmacy scheme, subsidising pharmacies which dispense less than 16,000 prescriptions per annum, and which are more than two kilometres from the next pharmacy, in order to provide reasonable access for all patients. Some FHSAs are now developing pharmacy strategies, identifying gaps and over-provision.

144. FHSAs maintain and publicise a list of community pharmacists, and most organise an 'out of hours' dispensing rota. And while they have no powers of inspection, they may liaise with the Royal Pharmaceutical Society's Inspectorate, who are involved in an extensive programme of visits. Some operate voluntary inspection schemes by agreement with the local pharmaceutical committee. Some also organise the collection of hazardous waste from pharmacies and co-ordinate a syringe exchange scheme; and use pharmacies for the sale of 'prescription season tickets' for patients who require a considerable number of prescriptions but who are not exempt from charges. As with the other family health services, FHSAs handle complaints about community pharmacists and deal with any breaches of terms of services.

145. Generally speaking, the priority and resources allocated to the oversight of community pharmacy activities reflect the limited range of functions currently exercised by FHSAs. Over the years, the Department of Health has expressed a wish to see an enhanced rôle for community pharmacists. In 1992, a joint working party, set up by the Department of Health, made a series of recommendations for extending their rôle (Ref. 22), and discussions about implementation are currently taking place. The pharmacy contract is also under review. But as with dentists, if the FHSA's rôle in relation to pharmacies is to change, the Government must ensure that they have sufficient authority to discharge their responsibilities.

OPHTHALMIC SERVICES

146. Ophthalmic services are provided by about 10,000 opticians in the UK, two-thirds of whom are ophthalmic opticians with contracts with the FHSA. The market is growing, with an expenditure of around £900 million in 1992. Of this, £152 million was funded by the NHS. The increasing numbers of elderly people are major customers with 97% of those aged over 65 wearing spectacles. Most services are bought privately, and in 1992, 55% (about 7 million) eye tests were paid for privately at an average cost of £14.56. 56% (1.7 million) of all pairs of glasses were paid for privately at an average cost of £80.89, and an estimated one in twenty of the population bought ready-made reading glasses in 1992 (Ref. 60). NHS services are therefore in the minority, but are still a significant element of the total service.

147. The market has undergone considerable deregulation over the past ten years. In 1984, the opticians' monopoly of the supply of glasses was ended. In 1985, NHS glasses were restricted to people fulfilling certain criteria. In 1986, a voucher scheme was introduced, providing financial assistance for the purchase of spectacles or contact lenses for people meeting the criteria. In 1989, reading glasses were first sold 'over the counter' without the need for a sight test for the first time. From April 1989 free sight tests were restricted to certain eligible groups only – resulting in an initial fall of over 30% in the total number of sight tests between 1987/88 and 1989/90. Numbers have since increased again although not to the original level.
148. The FHSA’s rôle is largely restricted to payment for NHS treatment and a few regulatory functions. FHSAs must keep lists of approved NHS ophthalmic opticians, handle complaints about NHS services and reimburse opticians for vouchers and exemptions claimed by patients. They have powers of inspection but rarely use them, and cannot influence the location or numbers of ophthalmic opticians. Since 1990 there have been no representatives on the FHSA with any ophthalmic knowledge. Many FHSAs have difficulty establishing contact with the profession and few take any initiatives, regarding optical services as a low priority. As part of their health promotion duties they can promote the importance of eye tests. And they can help to promote links between ophthalmic opticians and medical services for the referral and monitoring of conditions such as diabetes and glaucoma (with around half a million such referrals occurring each year). Such initiatives have been proposed in a recent review of the service (Ref. 61). But on the whole, FHSA’s rôle is marginal.

CONCLUSION
149. FHSAs’ new management rôle introduced to co-ordinate primary care services does not extend in practice to dentists, pharmacists and opticians to any significant degree. Their rôle continues to be much the same as that of the old family practitioner committee providing administrative support only, unless they engage in the occasional exercise in service development. Where they engage a professional adviser they can have more of an effect; but by and large they provide a minimal service and dentists, pharmacists and opticians remain on the margins of FHSA activity.

SUMMARY OF RECOMMENDATIONS
The rôle of FHSAs with dentists, pharmacists and opticians needs to be clarified. If they are to undertake a more proactive commissioning rôle, their current powers will need to be extensively reviewed. At present they can do little more than undertake a limited range of administrative tasks similar to those provided by FPCs before them. For those wishing to undertake a more proactive rôle within current arrangements, the appointment of professional advisers is key. They must then try to influence provision by:

for Dentists
- assessing need and identifying shortfalls
- helping to co-ordinate the general and community dental services
- facilitating health promotion campaigns

for Pharmacists
- promoting a reasonable distribution of pharmacies
- engaging pharmacies in health promotion campaigns

for Opticians
- promoting eye tests
- developing protocols for co-ordinating medical and optical services for detecting glaucoma and diabetes.
4. Next Steps

150. Since their introduction in 1990, FHSAs have been busy consolidating their position and tackling the initial agenda for action set by the Government. Their key tasks (Exhibit 30) have included service development and the provision of administrative support (stages 2 and 4 - Chapter 1) and commissioning and performance review (stages 1 and 3 - Chapter 2). The Government has taken the lead in setting objectives with FHSAs putting most effort into service development and the provision of administrative support in the early years. However, as matters progress, this balance of effort is shifting. Ways of underpinning this shift are the subject of this chapter.

Exhibit 30

KEY TASKS
The Government has taken the lead in setting objectives with FHSAs putting most effort into service development (2) and the provision of administrative support (4)

151. Inevitably, with so many radical changes in progress all at once within the NHS, a number of tensions are emerging, requiring adjustment as the reforms progress. Those already identified in this report include:

— increasing frustration within practices with the limitations of the 1990 GP contract;

— increasing overlap between DHA and FHSA responsibilities as FHSAs increase their involvement with commissioning, with both engaged in the assessment of need and the setting of priorities;

— increasing frustration within FHSAs as they try to co-ordinate policy but lack authority to do so.

Any adjustments must address these issues, and should start from the perspective of the patient and the practice.

152. General practices are evolving as the hub of health care in the NHS. Looking immediately ahead, patients will find that their practice combines personal and continuing care
with a much expanded range of services. When referral to hospital becomes necessary, the practice will retain a vital influence on the quality of that care through the the contracting process, directly in the case of services which fund-holders purchase, and indirectly for all practices through the commissioning strategies of DHAs. The modern practice will also make full use of the registered practice list and information technology to obtain good quality data describing the health status of the practice population and patterns of services use. These data will be invaluable in delivering preventive care, in planning and costing future health care, and in underpinning the quality assuring and quality improving activities of the practice itself.

153. Practices with this capacity and capability are likely to see a 'tight-loose' relationship with the FHSA as the most acceptable and productive in future. They should retain maximum flexibility in the means by which services are actually delivered because it is they — and not the health authorities — which are best placed to fine-tune care to the needs of individual patients. The FHSA, acting for the community, should be able to ensure proper accountability by specifying the services required and by selective monitoring.

DEVELOPING LOCAL INITIATIVES

154. Further improvements in practices could be impeded by too rigid a framework. Innovation in general practice will require local flexibility. A number of examples of situations that should benefit from such flexibility and experimentation have already been identified in this report. Alternative strategies for health promotion could be beneficial including one-to-one counselling, and wider health education. New arrangements are being introduced to allow such flexibility. Target payments for immunisation and screening may need to be more flexible in areas of high deprivation where take-up is low. Deprivation payments should be linked to improvements in the care delivered. Minor surgery could be improved if some GPs are allowed to specialise and undertake more than fifteen procedures a quarter. Disease management could improve with local incentives, encouraging the development of protocols with hospital consultants for diagnosis, referral and management. And the distribution of GPs could be matched more effectively to need if FHSAs have more say in partnership with the Medical Practices Committee, adjusting the local distribution of practitioners to fit local circumstances more precisely.

155. GP fund-holding provides flexibility, which is not available to non-fund-holders, but is limited to a prescribed range of activities and procedures. Further flexibility cannot easily be developed within the present centrally determined 1990 GP contract. The contract has certainly had a positive impact on practices as described in Chapter 1, but interviews with GPs have revealed that many practitioners feel shut out of the debate about where primary care is going; they report that while they agree with many of the principles, the practicalities have restricted them to working in ways that they do not always consider to be the most effective. What is perhaps now needed is a dialogue that will secure the progress made in health promotion, immunisation etc. but which will stimulate new initiatives.

156. However, any increase to the range of activities and choices made within both fund-holding and non-fund-holding practices must be aligned with strategic policies if the Government's national health strategy is to be realised. Some framework is needed that allows this. It will not be possible to achieve this balance from the centre, and FHSAs are the logical agencies to take the lead.
157. But they will not be able to do so working alone. FHSAs are already required to develop local strategies working in conjunction with DHAs, local authorities and others. If practices are to have more influence over secondary care and the primary/secondary relationship, they will also need to be involved. But the relationships between DHAs, FHSAs and GPs are relatively loose at present (Exhibit 31). FHSAs have only modest scope to co-ordinate the way general practice is evolving (Chapter 2); and DHAs have no formal links with practices at all (although some have formed good informal networks).

Exhibit 31
REPORTING LINES
The relationships between DHAs, FHSAs and GPs are relatively loose.

158. These links will need to be co-ordinated more clearly if progress with primary care is to continue and to keep in step with the rest of the NHS. First, new links will be needed between DHAs and FHSAs; and second the relationship between practices and health authorities will need to be clarified. These two points are considered in turn.

LINKING FHSAs AND DHAs
159. Almost as soon as FHSAs were set up, speculation started about whether they should continue as separate organisations, with a report published in January 1991 by the NHS Management Executive setting out possible alternatives (Ref. 10).

160. The current division of responsibility between FHSAs and DHAs creates boundaries, limits any re-balancing of responsibility between DHAs and practices, and restricts management. To counter these problems, many FHSAs are working very closely with DHAs, with increasing...
numbers sharing a single chief executive and other senior staff. Such close working removes internal boundaries within the NHS apart from the intentional one between commissioners and providers. Financial adjustment between secondary and primary care can be realised with commissioning strategies shifting some activities into community-based settings (possibly with safeguards - internal ‘ring fencing’ – to prevent leakage of funds the other way if necessary).

161. As well as promoting the co-ordination of care, such arrangements could also provide efficiency gains – with a single management replacing parallel structures engaged on activities such as needs assessment, health promotion and contracting. Such streamlining should also improve effectiveness, making best use of commissioning skills within the NHS which at present are all too scarce. Joint working is evolving steadily with a significant proportion of FHSAs actively working towards links of this sort. But some aspects of close working are voluntary at present, and therefore some are not doing it. All need to be encouraged to do so. And legislation is needed to allow authorities to merge to reap the full benefits of joint working, improving value for money.

LINKING COMMISSIONING AUTHORITIES AND PRACTICES

162. The relationship between commissioning authorities and practices then needs clarification. Strategies should be based on the national agenda but should also address local issues of concern to practices. And they should be co-ordinated with practice activities through practice agreements. These agreements should set out objectives and targets and specify financial arrangements including any payments to practitioners that may be negotiated. They could start to replace some of the more inflexible aspects of the 1990 GP contract; and they could help to provide a framework within which fund-holding and non-fund holding practices work with commissioning authorities to set purchasing plans.

163. Such close working would not be easy. It could only succeed if local practitioners were to be fully involved in the process from the start, and if commissioning authorities could bring sufficient expertise to bear. Management should be strengthened with an emphasis on partnership between authorities and practices. A cautious approach might be prudent initially. FHSAs are developing at different speeds and their links with DHAs vary. These links need to be strengthened first. Some of the more forward-looking could well be in a position to accept additional responsibilities now, perhaps as pilot projects initially, but some may not be ready to take on an extended role for a while. A phased programme with different authorities progressing at different rates would seem the most practical arrangement.

164. Different approaches would be required for fund-holders and non-fund-holders. For fund-holding GPs, the practice agreement could be set annually as an extension of the annual fund-setting process. Such an extended process should continue to include fund-setting, monitoring of financial management and quality of care, and use of savings. But it could also be extended somewhat to allow commissioning authorities to take a wide view of practice performance, raising the level of accountability of fund-holders; and it would in return allow fund-holders to discuss authority policies and strategies for secondary care and other issues. In this way commissioning and local action by practices would be brought into a closer relationship. The delegation of responsibility for setting GP fund-holding budgets to commissioning authorities would be a natural extension of this relationship, but would require legislative change. As
authorities become increasingly involved with fund-holders, some strengthening of expertise and skills would also be necessary.

165. For non-fund-holding GPs (the majority at present) central commissioning will continue to secure all services. It is already prudent for commissioning authorities to discuss arrangements with GPs in order to ensure that contracts with secondary care are in line with GP referral patterns (see the Audit Commission’s report *Their Health, Your Business* Ref. 1). Greater flexibility could result in local agreements with GPs to purchase some services on behalf of the commissioning authority (through delegated budgets) to promote greater choice. If so, local agreements between commissioning authorities and GPs could start to blur the distinction between fund-holding and non-fund-holding status, while ensuring that the activities of GPs are consistent with overall policy, and that commissioning authorities are providing what GPs need. Given the increasingly multi-disciplinary nature of practices it may be more appropriate for agreements to be arranged with practices rather than with GP practitioners allowing other professionals to become involved. And agreements would need to be tailored to the needs and abilities of each practice.

166. If commissioning authorities are to maintain the support and respect of GPs, they would need to manage agreements with a light touch - allowing maximum delegation and only seeking to direct activity when there is broad agreement that some re-balancing is appropriate. The most appropriate compromise could involve authorities encouraging and enabling a bottom-up approach while checking that the sum total of individual decisions makes sense within broad policy objectives - with the emphasis firmly placed on local decision making. The result could be a gradual shift away from large ‘block’ contracts in favour of a network of more flexible local agreements. To help this process, ‘locality’ planning and purchasing should help. Specialist or innovative services would be purchased centrally, with increasing numbers of more routine services be purchased locally within practices or localities within broad guide-lines. Careful balancing would be needed.

167. For example, the commissioning of support services for people with mental health problems may need adjusting. GPs see large numbers of people with minor mental health problems, but only the occasional new person suffering from schizophrenia — whom they promptly refer on for secondary care. After stabilisation in hospital, most people with schizophrenia are discharged to be managed in the community. From the practice perspective, community health resources may be pre-empted by people with lesser conditions, who present in larger numbers. From the strategic perspective, it is very important to provide sufficient resources to manage people with the more serious conditions. There are many who consider that resources have shifted to support people with minor conditions at the expense of those with chronic serious conditions. The balance may need to be readjusted, with central commissioning of scarce community mental health services for those with serious conditions.

168. Local agreements could also be used to tackle the wide variation in practice standards. Guide-lines and protocols describing good practice would help to raise standards overall, but would need to be agreed with the professions to be credible. The Welsh Office has already developed explicit standards for health promotion, for example (Case Study 10). It would be helpful if such standards could be more widely developed.
169. Standards are particularly important as people take on new tasks. The shift from secondary to primary care has led to a shift in roles (Exhibit 32). GPs are taking over tasks formerly performed in secondary care settings; and protocols developed jointly between GPs and hospital consultants are needed to ensure that appropriate care is given. Practice nurses now play a more central rôle as providers of patient care and must ensure that they have sufficient skills to do so. This shift in responsibility needs to be underpinned by appropriate training, and accreditation arrangements; and it must be backed by the results of research to ensure that the quality of care given remains high. The Government should play a key rôle in promoting and supporting such arrangements.

Exhibit 32
CHANGING RÔLES
The shift from secondary to primary care has led to a shift in rôles

170. These proposals are based on the experiences of some of the most progressive authorities. Much progress is being made already within current arrangements (Case Studies 10 & 11). The aim should be to make it easier to achieve the greater integration produced, by removing administrative obstacles, and making the level of progress described the norm for everybody.

DENTAL, PHARMACEUTICAL AND OPHTHALMIC SERVICES
171. To complete the simplification of present arrangements, it would be helpful if commissioning authority relations with dental, pharmaceutical and ophthalmic services could be brought into line with general medical services - or at least clarified. FHSAs have been given responsibility to develop these services but do not have the authority to match. Either responsibilities need to be reduced, or authority (and control of finances) needs to be enhanced.
WALES: GWENT HEALTH COMMISSIONING ORGANISATION

The Gwent Health Commissioning organisation is a joint commissioning body set up by Gwent DHA and FHSA, who both serve the same population of 446,000. The area is served by an acute unit and a community unit which achieved trust status in April 1993. A further acute unit is seeking to become a trust in April 1994. The joint health organisation is housed on a single site and has a joint chief executive, joint directors of planning and primary care. The planning directorate and communications department are common. Focus groups are reviewing the rest of the management structure of the two authorities. There is a joint commissioning team of seven members from the DHA and FHSA which meets every month. In theory the two budgets of the authorities are combined.

The authorities are working within the framework set by the Welsh Offices's Strategic Intent and Direction (Ref. 62) adopted throughout Wales (and which the Health of the Nation is following in England), to match health services more closely with local needs. To do this services must increase health gain, and provide care in a people-centred and cost-effective way. Ten key health areas have been identified as making the biggest contributions to health gain for the people of Wales. There are also Welsh Office Protocols which help to identify ways of improving local health and achieving health gain across a wide range of services. For instance, for cardiovascular disease, the protocol proposes that each frontline ambulance for rural areas should carry a paramedic with extended training, that GPs should screen patients at high risk of heart disease, and that response times by GPs to calls from high risk patients should be within 30 minutes.

This overall strategy then translates into local strategies and health plans, which are incorporated into the local contracting process. FHSAs, DHAs and GP fund-holders are included in the strategic framework of the local strategy. In recognition of the closer working of FHSAs and DHAs within Wales, there is a joint annual review process for both authorities.

In delivering the Local Strategy for Gwent there has been an explicit ranking of options and services with a commitment to explore a shift up to 15% of expenditure from secondary services to primary care by 1997/8. Part of this shift will be achieved by moving 10% of consultations from hospitals into the community during 1993/4 by designing appropriate treatment guidelines and by identifying and using GPs with special skills - for example, in dermatology and surgery. British Thoracic Society guide-lines on asthma will be implemented by hospitals and supported by GPs to promote shared care. A confidential enquiry will follow each death from asthma.

The planning of services will be refined by developing approaches in five local neighbourhoods attuned to local needs. Public consultation exercises and user panels are feeding back information on local needs.
Case Study 11

ENGLAND: DORSET HEALTH COMMISSION

The Dorset Health Commission was formed in 1992 by integrating the management structures of Dorset FHSA and Dorset DHA. The two authorities retain their statutory accountabilities, while the Commission acts as the main focus for recommending the purchasing and investment intentions of both authorities. The Commission comprises the Chairman who is also Chairman of the FHSA, the Chairman of the DHA, the Chief Executive, and five non-executive members from each authority. Its overall intention is to integrate primary and secondary care services to secure the best possible organisation of health services within the resources available. Staff work from one building under one Chief Executive.

The Commission has produced a Health Strategy and pools the resources of both authorities to achieve its aims. Its Contract for Action with Wessex RHA ensures accountability for their delivery. The Commission serves a population of 665,000 and is wholly committed to developing primary care as the principal focus for health.

It is achieving this through a major primary care development programme designed to extend the capacity of practices to offer a broader range of services, some of which were previously offered in the hospital setting. It has encouraged general practitioners to put forward development proposals, and has funded these if practices can demonstrate expected health gain and benefit to their practice population. Each practice is required to produce a highly developed health plan which demonstrates that the practice's intentions as both purchaser and provider take account of national, regional, and local health targets, and that it has the organisational capacity to deliver these. Some schemes involve practice-based management of extended primary health care teams, and provision of high priority GP support services such as counselling, physiotherapy, and audiology. Those practices participating in the development programme are offered organisation development consultancy designed to ensure that they are able not only to produce a plan but to implement it. The plan provides the Commission and the practice with a focus for subsequent review.

Recognising GPs as major customers of provider Trusts, the Commission has also supported the development of both fund-holder and non-fund-holder support groups.

From its inception the Commission developed a strong collaborative relationship with fund-holding practices. The former Director of Finance in the FHSA who had entered the NHS from the private sector was given full-time responsibility for exploring expressions of interest, developing practices' capacity to proceed, and monitoring their financial arrangements.

Shortly after formation of the Commission in 1992, as practices produced their plans, copies were supplied to each member of the senior management team which collectively reviewed and evaluated them. This enabled former FHSA and DHA staff to learn about each other's perspectives on the commissioning of both secondary and primary care.

A Fund-holding Unit has now been created, managed by the Head of Primary Care Contracts who was formerly both a GP and a Director of Public Health. The GP fund-holding group meets once a month, and these meetings are always attended by unit
managers as are monthly meetings of practice fund managers. A Commission manager also joins in Regional Review meetings with the practices.

GP fund-holder purchasing intentions, shared with the Commission, enable it to ensure that these further the Dorset Health Strategy. They also supply a GP view of providers. While the Commission has developed its own system of provider quality monitoring, its information is sometimes questioned by GP fund-holders whose patients discuss their experience of particular providers with their GP. When fund-holders contact the Director of Quality at the Commission to express concern about a particular provider, they usually supply specific examples that she is able to follow up in detail. Such examples can be potent instruments for achieving change. It is not that one type of information is richer or poor than the other, but that they are different. Together, they provide the Commission with a more rounded picture of provider performance and a drive to improve quality.

The Commission, derived as it is from both an FHSA and a DHA, knows these fund-holding practices well as both providers and purchasers. Its primary care development programme which extends to fund-holders as well as non-fund-holders provides a rich picture of practice structure, dynamics, and performance. Similarly, because the DHA used to manage the trusts as DMUs, it knows their strengths and vulnerabilities, and can if necessary adopt a facilitative rôle if relations between a trust and fund-holder reach stalemate. In such a situation it would adopt the course of action judged to be in the best interests of the health of its population.

Neither GP fund-holders nor the Commission perceive themselves to be in competition with each other as purchasers, and the Commission both respects and supports fund-holder independence. Both are committed to using the leverage available to them to meet more effectively the needs of the local population. From April 1993 Wessex FHSA will delegate the majority of its fund-holding management functions in Dorset to the Commission providing an opportunity to demonstrate that this new phase in its relationship with fund-holders will enhance its capacity to make primary care the principal focus for health.

THE AUDIT COMMISSION’S AUDITS

172. In the short term, however, improvements must continue within the current context. The Audit Commission, through its field auditors, is reviewing the way FHSA s are managed. The audit concentrates mainly on general medical services, as this is the area of greatest change and greatest expenditure. Where time permits, a short review of activity relating to the other services may be included as part of the audit; and a further study is underway focusing on GP prescribing and scheduled to lead to a report and audit in 1993/94.

173. The audit focuses on management and organisation, health needs assessment, community care planning and the service delivery issues described in Chapter 1. It starts with a short overview of the FHSA, to determine the focus for the rest of the audit. The main part of the audit involves a review of arrangements with FHSA staff, supplemented by data analysis and GP interviews (Exhibit 33, overleaf). The outcome of each audit will be a confidential report to each FHSA, with an agreed plan of action.

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STRUCTURE OF THE AUDITS
The main part of the audit involves a review of arrangements with FHSA staff, supplemented by data analysis and GP interviews.
LIST OF ADVISORS AND SITES VISITED
The project team was advised by a numbers of advisors. The project advisory group was:
Dr Stuart Carne OBE, past President of the Royal College of General Practitioners
Brenda O'Driscoll, Director of Primary Care, North Western Regional Health Authority
Heather Gwynn, Department of Health
Sarah Harvey, Patients' Association
Paul Kind, Researcher, Centre for Health Economics, University of York
Clive Parr, General Manager, Hereford and Worcester FHSA
Joe Rich, British Dental Association
Tony Ruffell, General Manager, Nottinghamshire FHSA
Barbara Stilwell, Nurse Practitioner and Principal Lecturer at the Institute of Advanced Nursing
Education, Royal College of Nursing
Dr Heather Wood, Isle of Wight Community Health Council
Other individuals who assisted with the study included:
Dr Rosemary Beardow, Consultant in Public Health Medicine, North West Thames Regional Health Authority
Dr Jennifer Dixon, Consultant in Public Health Medicine, North West Thames Regional Health Authority
Dr Steve Gillam, Consultant in Public Health Medicine, North West Thames Regional Health Authority
Ms Sue Osborne and Ms Sue Williams, Joint Chief Executives, Lambeth, Southwark and Lewisham FHSA

THE MAIN STUDY SITES WERE:
Cambridgeshire FHSA
Gwynedd FHSA
Hereford and Worcester FHSA
Lambeth, Southwark and Lewisham FHSA
Leicestershire FHSA
Liverpool FHSA
SHORT VISITS WERE MADE TO:

Norfolk FHSA
Northumberland FHSA
Oxfordshire FHSA
Rochdale FHSA
Trafford FHSA
Stockport FHSA
East Anglian RHA
North West Thames RHA

ADDITIONAL CONSULTANCY WORK WAS CARRIED OUT BY:

Health Policy Advisory Unit, Sheffield, which under the direction of Dr Andrew Thompson (Cardiff Business School), carried out patient focus discussion groups.
### References


48. Institute of Medical Care, User Surveys of General Practice, 1989.