King's Fund

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Executive summary

This report presents the findings from a two-year research project comprising six case studies of how primary care groups and trusts (primary care organisations, PCOs) are carrying out their health improvement role. It analyses:

(a) the approach taken by the six sites to health improvement, and the development of relevant strategies and processes

(b) the context, national, local and internal, in which PCOs are working.

Methods

Data were gathered primarily by means of 107 face-to-face semi-structured interviews with key personnel from each PCO and its partner organisations, conducted in 2000 and 2001. Those interviewed included chairs; chief officers or health improvement managers; nurse, lay and social services board members; public health specialists. Site selection was designed to capture the range and diversity of PCOs. Criteria included: population size; primary care group (PCG) level and early primary care trust (PCT) status aspiration; inclusion in a Health Action Zone (HAZ); urban and rural location.

Three semi-structured interviews involving eight civil servants working for the Department of Health gathered further information on the meaning of health improvement.

Findings

Most respondents had a complex understanding of the phrase 'health improvement', including a number of distinct though overlapping concepts such as NHS core activity, a broader definition of health, the root causes of ill health and individual well-being. A consensus definition did not emerge.

Choice of health improvement priorities was heavily influenced by local Health Improvement Programmes, into which the embryonic PCGs felt that they had had relatively little input. Most had consulted local professionals and/or community organisations about what local priorities should be.

Health improvement objectives and reported activity fell into the overlapping categories listed below.

- *Primary care development:* implementing guidelines; setting up or improving chronic disease registers; auditing existing practice; health needs assessment; providing new or extended services.
- *Commissioning:* improving existing services; developing new services; assessing need for service developments.
- *Health promotion:* smoking cessation; teenage contraception and advice; physical exercise for older people.
- *Community development:* linking with other community activity; supporting bids for Healthy Living Centres; health advocacy.
- *Public involvement:* links with neighbourhood forums, voluntary sector organisations and local panels; focus groups and patient participation groups.
- *Inequalities in health care:* withdrawing or widening access to fundholding services; addressing deficits in access to care; personal medical services (PMS) contracts in under-resourced areas.

Most sites have initiated work on primary care development, commissioning and public involvement. Evidence of work on the remainder was less consistent, although progress in smoking cessation services was reported at most sites.

The following factors are reported to have influenced progress towards health improvement objectives.

- PCOs found it difficult to prioritise health improvement among the multiplicity of national and local priorities. The sheer number of requirements was seen as unhelpful, and even enthusiasts for current policies felt that the pace of change was too fast for work to be done adequately.
- In the first year, some PCOs delayed employing management staff due to resource constraints, including prescribing overspends. Management teams are now in place, but still struggle to achieve their many tasks.
- Two sites reported significant development money from various sources, but elsewhere lack of development money has limited new work. Bidding for funding can be very time-consuming and frustrating.

- PCOs which collaborate avoid duplicated effort, free up their own capacity and enhance their influence in the local economy.
- Some NHS trusts were slow to recognise PCTs' independence and status, and continued to expect a disproportionate share of resources.
- Service re-configurations were widespread, bringing with them periods of 'planning blight' and the breaking of links between organisations.
- Health authorities were variously seen as wise and supporting at one extreme, and hide-bound and controlling at the other, with most somewhere in between. There were concerns about their limited sharing of resources (expertise, IT, budgets) with PCOs.
- Performance management was a mixture of informal knowledge by a health authority of its partner PCOs and a formal tick-box exercise: the latter was not generally seen as a process which supported development or strategy.
- Some progress in partnerships with social services departments at strategic or operational level were reported, but relationships with other departments were weak. Where there was two-tier local government, district councils were regarded as useful partners with a grasp of local issues.
- There was evidence of sustained attempts to establish relationships with the voluntary sector and the public, although progress was slow.
- In only one site had the achievements of a previous primary care organisation (a total purchasing pilot) provided a solid foundation for PCO work.
- Three PCOs in the first year identified weaknesses in the organisation's leadership, although these were all resolved by the second year. PCO boards which had won local esteem were praised for their inclusiveness, fairness and sensible decision-making.
- Board members have worked hard to engage GPs throughout the PCOs, with some success, although progress was slow. GPs engaged more readily in clinical governance and NSF-related work than in other aspects of health improvement. In the first year, some felt that the end of fundholding had reduced rather than improved the services they could offer patients.
- The transition to PCT status was a large organisational burden which tended to overshadow other activities. New PCTs experienced uncertainties about the roles

of the board and the executive committee, and some non-executives needed considerable support from officers in learning about the NHS and how it works.

- At three sites, there was clear leadership of the health improvement agenda at board level. Elsewhere, there were some committed 'product champions' for health improvement initiatives, typically not GPs: they included district council officers, health promotion personnel, lay board members, nurses, professions allied to medicine. However, without commitment at board level, such champions felt isolated. The existence of a health improvement sub-group was not clearly associated with corporate commitment.

Three key factors are associated with sites which show commitment to a broad health improvement agenda:

- a corporate recognition of local socio-economic inequalities
- support for and leadership of the broader health improvement agenda at senior level within the board
- development money for health improvement projects.

Messages for PCOs

Health improvement must be seen as at the centre, not at the periphery, of PCOs' work. Only executive/board-level determination can ensure that it is the health improvement strategy which guides and underpins the whole range of PCO activity. Such determination should be strengthened by the introduction of a board-level health improvement lead. PCOs should also consider whether public health training or experience should be an essential qualification for chief executives and chairs, or required professional development for postholders.

Clinical staff will need leadership and support if they are to have the motivation and the capacity to work beyond their clinical priorities and contribute more broadly and fully to health improvement.

PCOs, which in future will have public health teams, need to achieve with public health professionals a mutual understanding of what public health expertise is and what it can deliver.

PCOs gain credibility and influence by working together. They can divide between themselves some of their key priorities, thus reducing the strain on their own infrastructure, and freeing capacity for other activity, which may include health improvement work.

How can PCOs be supported in their health improvement work?

The tasks and priorities which flow from health improvement do not yet appear to be clear to some PCOs. Department of Health clarification would be helpful on a number of questions:

- what specifically are the ways in which health improvement goes beyond commissioning and primary care development as traditionally understood, and how should PCOs be tackling these?
- what should PCOs be doing about health inequalities as a priority, beyond promoting equity in its commissioning and primary care development strategies?
- what needs assessment and demographic data are required to support PCOs in working to achieve better health and well-being and reduced inequalities in health for their population?
- which members of the primary health care team should include broader health improvement work among their priorities, and what should this work entail?

We suggest that PCOs, strategic health authorities, managed public health networks, local government and regional government offices be encouraged or required to work together to draw up deprivation profiles/equity audits of each PCO population. These would draw on data about socio-economic factors (census and local authority data) as well as data about health status and access to health care. In some cases, this work will already be well advanced as a result of work on regeneration and neighbourhood renewal, Health Action Zones, etc. In order to ensure a truly local focus, PCOs should take a leading role in co-ordinating such an exercise.

Alliances with non-NHS agencies, such as local government, are central to the broader health improvement agenda. Local strategic partnerships, currently being established, should further promote broader understandings of the causes of health and illness, and make PCOs more aware of local government's power to promote

economic, social and environmental well-being. A further means of encouraging PCOs to consider in detail local government policies which address the root causes of ill health would be to give PCOs a statutory role in the drawing up of community plans by local government. Such a role might include health impact assessment of proposed policies, and an ongoing scrutiny role.

Performance management is another way of supporting and steering PCO health improvement activity. Much of what already exists (high-level performance indicators, NSF standards) relates directly to health improvement. More broadly, given that a successful health improvement approach is likely to involve partnership working, it may well be partnerships, rather than PCOs, which should be accountable for aspects of health improvement which are not the responsibility of PCOs alone, such as health promotion, community development, and work to reduce socio-economic inequalities.

Strategic health authorities need to develop a method of performance managing PCOs which is 'joined up' with policy and strategy development work, so that the performance management process helps PCOs to become strategic health care organisations, rather than a checklist of relatively superficial process indicators.

1. Introduction to this report

This report presents the findings of a two-year research project comprising six case studies of how primary care groups and trusts are carrying out their health improvement role. Specifically, its purpose is to record:

(a) the approach taken by the six sites to health improvement, and the development of relevant strategies and processes

(b) the context, national, local and internal, in which these organisations are working.

2. Aims and methods of the research

2.1 Aims

The aim of the research is to explore how six primary care organisations (PCOs) each carry out their health improvement role, addressing the following research questions:

- how is the concept of health improvement understood by stakeholders in the six PCOs?
- what health improvement priorities has each site chosen, and why?
- to what extent do these priorities address population health and health inequalities?
- how are the PCOs pursuing those objectives?
- what factors help, hinder or otherwise influence progress?
- what are the intended and unintended outcomes of the work, and how are these monitored?

2.2 Assumptions

This research is informed by our belief that good practice in health improvement includes not only core NHS activity (providing or commissioning clinical treatment) but also:

- recognition of the need for perspectives other than those of the NHS
- partnership working with a wide range of local agencies
- attention to the socio-economic determinants of health and to inequalities in the health of the local population (inequalities in morbidity and mortality as well as in access to services)
- the involvement of local communities in the development and implementation of health improvement strategies.

This list is not intended to prescribe what PCOs should do, but to indicate the range of perspectives and approaches which are likely to be evident in a comprehensive health improvement strategy.

The research is also grounded in a number of hypotheses deriving from previous work on primary care organisations (Mays *et al.,* 1998). These are:

- that the processes whereby health improvement priorities are determined will vary
- that the range of health improvement activity undertaken by PCOs will be diverse
- that progress towards the successful fulfilment of objectives will depend on a large number of factors relating to the local health system and, more broadly, to the public and voluntary sectors: the history of stakeholder organisations, their strengths, weaknesses, state of organisational development, and the nature and development of relationships between them.

2.3 *Theoretical basis*

The challenges of monitoring, evaluating and explaining the progress made by new and complex organisations working in a changing environment are considerable. Pawson and Tilley (1997) have suggested a widely admired model for 'realistic evaluation', based on a triad:

context – mechanism – outcome

This model poses two problems for a study of PCOs and health improvement.

First, the 'mechanisms' for health improvement are not distinct interventions, but complex, prolonged and iterative processes. As new organisations, PCOs have had to devise structures and processes for making strategic choices about which activities they should undertake, and which should be prioritised, before they then devise structures and processes for implementing those choices. Together, these constitute an iterative process in which:

- reflection leads to decision
- decision leads to action

- action leads to consequences
- decisions, actions and consequences separately and together all lead to further reflection, which in turn leads to further decisions, actions and consequences.

The term 'mechanism' does not reflect adequately this complex process.

The term 'outcome' is also problematic in this context. Given that this is a study of health improvement, 'outcomes' should include population health outcomes which can only be achieved and recognised over long time periods. For that reason, *Saving Lives: Our Healthier Nation* (Secretary of State for Health, 1999) sets targets to be achieved over a decade. This research project has a life of two years. Although a variety of 'proxy outcomes' could be used (for example, the national high-level performance indicators), fluctuations in such measurements in small populations over only two years would not have statistical significance, nor could they be reliably attributed to specific efforts of PCOs.

We therefore used another model, borrowed from Pettigrew, Ferlie and McKee (1992, pp. 6–9), and previously used in evaluating new primary care organisations (Mays *et al.*, 1998). This model offers the following triad:

content – context – process

'Content' ('the "what" of change') replaces Pawson and Tilley's 'mechanism', and refers to 'the particular area or areas of transformation under study', i.e. health improvement. It includes not only the mechanisms but also the strategies and structures put in place to achieve such transformations.

'Context' is used in broadly the same sense by Pawson and Tilley, although Pettigrew *et al.* distinguish between 'inner' and 'outer' contexts for change. In this report, inner contextual factors are those relating to the strategy, structure, resources, culture, and management of the PCO itself. Outer contextual factors are those relating to the local NHS (health authority, trusts, other PCOs or PCTs), and other agencies (local government, voluntary and community organisations), as well as the national economic, political and social context.

'Process' ('the "how" of change') refers to 'the actions, reactions and interactions of the various interested parties as they negotiate around proposals for change', and is therefore concerned with development and change over time.

The analytic framework, therefore, is:

content – context (inner and outer) – process

2.4 Methods

The chief method of gathering data was two rounds of face-to-face interviews with key personnel from each PCO and its partner organisations, conducted between February and June 2000, and January and June 2001. Those interviewed included a core of key players, as follows.

In both rounds:

- the chair of the PCG board, PCT executive committee, or PCT locality group
- the chief officer, or the health improvement manager
- the social services board member
- a health authority officer liaising with the PCG (and also, where this person was not a member of the public health department, a public health specialist).

In the second year, additionally:

- a nurse board member/representative
- a lay board member/representative
- someone who, either because of their position, their recent arrival, or their known independence of views, was likely not to hold the consensus attitudes at the heart of the PCO board/executive.

These interviewees were asked to suggest additional personnel who were involved in the PCO's health improvement strategy (e.g. district council officers, community development workers, health promotion officers, etc.). A maximum of ten people per site were interviewed each year.

The interviews were semi-structured, and included the following questions, although these were adapted to some extent depending on the role, profession and employing organisation of the interviewee, and, in the second year, whether the person had previously been interviewed:

1. What do you understand by the phrase 'health improvement'?
2. How were this PCO's health improvement priorities decided? (first year only)
3. How is health improvement being tackled?
4. What external and internal factors are helping or hindering your health improvement activity?
5. What actions is the PCO taking to address inequalities in health, and how do these relate to other local activity?

A number of prompts were included; the complete schedules appear in Appendix 1.

In order to be able to confirm and clarify interview data, relevant documentation was obtained from the sites (e.g. the local health authority Health Improvement Programme, the PCO's Primary Care Investment Programme or its own health improvement plan, the annual accountability agreement with the health authority), and, in the second year, one public meeting of each of five of the PCOs was attended.

During the course of analysing the first year's interviews, it became apparent that there was a wide range of understandings and definitions of health improvement both among respondents and in the different pieces of central policy guidance for PCOs. For this reason it was decided to conduct a small series of interviews with central policy-makers at the Department of Health. The aim was to clarify the meanings of health improvement held by those directly involved in formulating and implementing policy at the centre, as related to PCO function.

A total of eight civil servants were interviewed in three different interviews held between November 2000 and July 2001. The informants were selected by a purposive snowball sampling method. Interviewees included civil servants working in the Primary Care Directorate on PCO policy and implementation, on public health and on

HAZs. Interviews were semi-structured and lasted approximately one hour. They were taped and the verbatim transcripts were examined using thematic analysis.

2.5 The choice of sites

This research project is allied to *The National Tracker Survey of Primary Care Groups and Trusts* (Wilkin *et al.,* 2000), and the sites have been chosen from those participating in that study. The timeframe for the health improvement case studies meant that the sites had to be chosen before the collection and analysis of all Tracker Survey data were complete, and it was therefore not possible to carry out our original intention of using evidence of progress in health improvement as a selection criterion.

We chose sites according to criteria designed to capture some of the range and diversity of PCOs:

- size (i.e. patient population): we could expect from earlier research (Mays *et al.,* 1998) that size might influence the speed of organisational development
- level of PCO and aspiration to early PCT status
- inclusion in a Health Action Zone (HAZ) (using the HAZ as a proxy for poverty: there are substantial differences in health issues in affluent and deprived areas (Secretary of State for Health, 1999))
- both urban and rural PCOs.

We also aimed at a geographical range. This does not guarantee variety of PCO in itself, but does ensure that the findings will not be deemed non-transferable by people across the country, as might be the case were the sites close together. For the same reason, we set out to identify a wide range of health improvement activity.

Table 1 summarises some of the key features of the sites: a more detailed description of the six sites appears in Appendix 2.

Table 1: Key features of sites

Site	*Population size*	*Type of community*	*Socio-economic composition*	*In an HAZ?*	*PCG status, April 1999*	*PCO status, April 2001*
1	90,000	London	no deprivation reported	no	level 2	locality of PCT, April 2001
2	129,000	coast and country	mainly affluent, some very deprived wards	no	level 2, preparing for PCT	PCT, April 2000
3	94,000	London	very affluent, a few moderately deprived wards	no	level 2, preparing for PCT	locality of PCT, April 2000
4	120,000	urban	very affluent, a few very deprived wards	yes	level 2	PCT, April 2001
5	91,000	urban	mixed	yes	level 2	PCT, October 2000
6	43,000	rural	little deprivation reported	no	level 1	merged with 4 other PCGs, April 2001

2.6 *Data analysis*

Most of the data have been analysed as set out in Table 2, both comparatively over time (first and second years) and between sites. Answers to the first question (What do you understand by the phrase 'health improvement'?) have not been analysed using this framework: the method used is explained in detail below (Section 3.3).

Table 2: Framework for analysis

Area of investigation	Analytic themes
Meaning of health improvement (Question 1)	The range of concepts included in informants' explanations of the term
Objectives/priorities (Questions 2,3,5)	***Content:*** Nature and typology of objectives/priorities ***Outer context:*** Influence of national and district priorities and targets ***Inner context:*** Influence of local needs (including health and socio-economic inequalities), and existing services and initiatives (including local regeneration and community development) ***Process:*** The evolution of national and local policy, roles of key individuals and stakeholders
Helps and hindrances to success (Questions 4, 5)	***Content:*** Implementation processes ***Outer context:*** National and local policy and funding; inter-agency relationships and histories; other local activity ***Inner context:*** Organisational effectiveness (structures, resources, cohesion) ***Process:*** The evolution of national and local policy, roles of key individuals and stakeholders; unexpected events and changes

3. Findings

Structure of this section

The structure of this section is as follows:

- who was interviewed? (3.1)
- what is meant by 'health improvement'? (3.2)
- how were health improvement priorities decided? (3.3)
- how is health improvement being tackled? (3.4)
- primary care organisations and their context (3.5)
- the process of improving health (3.6).

Quotations are attributed by role rather than by site, in order to protect anonymity.

3.1 Who was interviewed?

One-hundred-and-seven interviews were carried out with 74 different PCO and associated personnel, as illustrated in Appendix 3. Interviews were conducted in each case with the chair of the PCG board or PCT executive committee, a PCO officer (typically the chief officer or health improvement manager), the social services board member, a public health specialist, and, in the second year, the nurse and lay members of the board. This was achieved in every case except one: site 3 initially had no consistent representation from social services on the PCO board, and the social services representative interviewed in 2000 was a member of the health improvement sub-group but not of the board.

3.2 What is meant by health improvement?

The original guidance on primary care groups (DoH, 1998a) sets out three core functions for these new organisations: developing primary care, commissioning health care, and health improvement. It explains that the health improvement function is to 'improve the health of, and address inequalities in, their community'. In explicitly

distinguishing this from the two other functions, the circular suggests that health improvement is health-related activity which is neither provided nor commissioned, and therefore additional to and beyond the scope of NHS activity as usually understood.

However, *The New NHS. Modern, Dependable* (Secretary of State for Health, 1997) had previously offered some rather different understandings of the term 'health improvement'. For example, in defining the content of the Health Improvement Programmes (HImPs) which health authorities were to draw up, the White Paper offered a definition of the concept 'health improvement' which *includes* core NHS activity, itemised thus:

- the most important health needs for the local population
- the main health care requirements of local people
- the range, location and investment required in local health services to meet the needs of local people.

The change of vocabulary during 2001, whereby Health Improvement Programmes have become Health Improvement and Modernisation Programmes, confirms a definition which centres on health care as much as or more than on health.

Elsewhere again, the White Paper lends the phrase to the title of the new Commission of Health Improvement, which is primarily concerned with improving standards of health care.

Anticipating a variety of understandings of health improvement among our interviewees, we asked every respondent: 'What do you understand by the phrase "health improvement"?' This was the first question of the interview, to ensure that the interviewee was not in any way influenced by attitudes implicit in the topic guide.

The transcribed data were coded according to a large number of emerging categories, which were then aggregated into eight key concepts. Concepts were counted only once for each informant. These concepts are, in descending order of the frequency with which they were mentioned:

- **NHS** core activity: primary care, commissioning, improving quality, improving access, strategy and prioritisation
- **root causes** of ill health: income, employment, housing, education, environment, transport, community development, social exclusion; inequalities in health and health care; social model of health
- a **broad definition** of health ('health in its broadest sense, a holistic view of health')
- **health promotion** and health education: lifestyle advice; individuals' responsibility for their own health
- a **population health** approach
- individual **well-being**: wellness; quality of life; emotional, spiritual, psychological and social well-being
- **partnership** working
- health outcome **targets**: *Saving Lives: Our Healthier Nation* targets, reductions in morbidity and mortality.

There was little consensus in the replies, and most informants did not take a simple view of health improvement, but used two or three of these concepts to explain the term. However, there was no consensus about how these different components should be linked into a coherent set of meanings. Informants thus seemed to show, in the same way as do government documents, an uncertainty about how different meanings could be combined to create a single working definition.

We looked to see if there were clear similarities in how personnel associated with each PCO understood the term, and whether these differed from other PCOs. Two sites appeared to have a consensus view which was also reflected in the PCO's activity. Site 1 PCO interviewees were more likely to mention the NHS, a population-based perspective and health outcomes targets than they were to mention other concepts, suggesting a concentration on the NHS and *Saving Lives: Our Healthier Nation*; this reflects the fact that the PCO chose a disease focus, building on existing health authority work on clinical effectiveness. Site 2 PCO interviewees were more likely to mention health promotion and the broader definition of health than other concepts, and this was the only site where fewer than half of those interviewed

mentioned NHS activity; this reflects the focus on community development and health promotion chosen by this site. In the other sites, there was less consensus among PCO personnel about what health improvement meant.

There was evidence that a lack of consensus within a health economy could be unhelpful. At one site, a widely held view at PCO level was that the district HImP was unhelpful in being too 'upstream'. By embodying a vision of how health is determined primarily by socio-economic and environmental factors, it had failed to engage, and had even alienated, clinicians whose expertise lay elsewhere. This example illustrates how different interpretations may reduce co-operation for the health improvement agenda.

As already explained, the question of what health improvement means was also addressed in interviews with people working in the Department of Health. Data thus obtained mirrored quite closely that yielded by the interviews with PCO personnel. There was broad agreement as to the range of activities and approaches included in health improvement, from the clinical to the non-clinical and from the individual to the community:

> *It's mainly to ensure that they improve the health of their population, and included in that is reducing inequalities in health and in access to services. And it's a full range of activities which go from activities that address the wider determinants through to how they can affect health through their other functions of commissioning and providing care and developing primary care.* (civil servant)

However, there was also acknowledgement that there was imprecision in the term:

> *The Department and all its manifestations use the phrase 'health improvement' to mean a number of different things for different people at different times, because it is such a useful phrase and it sounds meaningful.* (civil servant)

Whilst some felt that the guidance from the centre had been sufficient, others acknowledged that further work was needed to gain a joint understanding of what was involved.

For some, the prime PCO health improvement function is in partnership working:

> *My vision of PCTs is that they are a smallish discreet organisation which is fundamentally about how they address the health of their population in the community. And to be successful they have to work in partnership with a multitude of other organisations and agencies. But they can't do the agenda all themselves.* (civil servant)

Some thought that more specific guidance was needed on this area:

> *There needs to be a methodology for doing that, rather than, 'Oh, go work in partnerships or set up a network.' People need to really understand how you actually do that, and how that new kind of commissioning takes place there.* (civil servant)

3.3 How were health improvement priorities decided?

This question was asked in first year interviews only. All the sites described a very similar content, context and process for deciding health improvement priorities.

As regards content, the 'what' of deciding priorities, PCOs established their priorities by selecting from the district HImP priorities in the light of what was already known about local needs.

The outer context was the priorities set by central government, both those outlined in *Saving Lives: Our Healthier Nation* and other NHS priorities such as waiting lists and emergency services. Locally, these priorities had been embodied by most health authorities in their Health Improvement Programmes (Abbott and Gillam, 2000), which were universally regarded as very powerful contextual factors. The inner

context was that, while health authority HImPs were being drawn up, PCOs existed only in shadow form, and were therefore pre-organisations with no infrastructure. Overall, most informants held the view that there had been little opportunity to make local priorities genuinely local, because the number of national priorities was already so large that there was little chance of including priorities of local concern which did not reflect the existing national 'must-dos':

> *It doesn't necessarily feel like there's a particularly good balance between the county-wide HImP which as I say is all national priorities ... and what we have actually been able to feed in locally.* (chief officer)

There was general recognition of common process factors: the fact that health authorities had had to undertake the new work of drawing up HImPs too quickly for thorough consultation. Some PCOs nevertheless regretted how little input they had had. Shadow PCOs, meanwhile, were having to work hard to develop organisational structures and processes and were therefore unable to contribute significantly to the development of HImPs. The impression given by four sites was that the choice of a small number of local priorities out of a large number of district ones had had to be made too quickly, and indeed, the original choices had been changed during the first year in two cases. In most cases, the PCOs consulted local health professionals and voluntary/community organisations as part of the process of deciding local priorities.

It was also acknowledged that expertise in public consultation was lacking in PCOs, and that much of such activity had been *ad hoc* rather than underpinned by a public consultation strategy.

3.4 How is health improvement being tackled?

This section outlines the activities which sites are undertaking or planning to undertake to pursue health improvement: in other words, content factors, the 'what' of change.

We present here data as reported by our informants, and these may not be exhaustive. Where information from one interview appears inconsistent with that from several others, it has been omitted, unless documentary evidence could provide clarification (e.g. Primary Care Investment Plans, or the health improvement plans of PCOs). Minority and dissenting views are identified as such where they appear.

It is important to note that PCOs have sometimes built on existing activity; initiatives which pre-date the formation of PCOs are included if the PCO actively participates in such work, but inclusion does not necessarily reflect PCO innovation or leadership.

The health improvement objectives and activity reported by sites can be categorised as follows, although there are many cases where items could be included in more than one category:

- primary care development
- commissioning
- health promotion
- community development
- public involvement
- inequalities in health care.

In each of those categories, a range of activities and/or plans were reported by the sites as a whole, and these are summarised in Boxes 1 to 6.

'Community development' is a term without an agreed and clear definition. In order to avoid overlap with other categories, we here use it to mean exclusively those activities by PCOs designed to support or enable individuals or groups within local communities to undertake public or community health action.

Public involvement is not intrinsically a mechanism for health improvement; consultation may be more to do with achieving local consensus and support for policies than with inviting the public to shape those policies. There are two reasons for including it here. First, many of our informants saw public involvement as part of health improvement. Second, public involvement had enabled PCOs to enhance their

awareness of how their communities perceived their health needs and health-related non-NHS factors, thus contributing to health needs assessment and the overall health improvement process.

'Health inequalities' is a term which has multiple meanings: inequalities in the nature and amount of health care available, and in access to that care; and inequalities in socio-economic status, which create inequalities in people's health and well-being. We have chosen to name the category 'inequalities in health care' in order to reflect more accurately the nature of reported activity. Sites which included areas of socio-economic deprivation were normally addressing these by work here categorised as 'community development'.

Box 1: Primary care development

- *health needs assessment* (e.g. collecting data on falls among older people; numbers of smokers in practices; carers' needs)
- *auditing existing practice* (e.g. spirometry equipment and skills; nature of 75+ checks; primary health care team (PHCT) learning needs in mental health)
- *implementing guidelines* (e.g. stable angina, atrial fibrillation, coronary heart disease (CHD) prevention, chronic obstructive pulmonary disease (COPD))
- *setting up or improving chronic disease registers* (e.g. atrial fibrillation, ischaemic heart disease, stroke, asthma, diabetes; people with severe and enduring mental illness)
- *improving quality and consistency of primary care electronic data* (e.g. across practices, or between primary care and community health services)
- *providing new or extended primary care services* (e.g. nicotine replacement therapy, a falls prevention programme; appropriate primary care to nursing home residents; cardiac rehabilitation; spirometers; specialist clinics)
- *improving access to primary care by changing appointment arrangements*
- *improving quality by protected learning sessions, and by particular quality initiatives* (e.g. Investors in People, the RCGP's Quality Team Development Project)

Box 2: Commissioning

- *improving access to existing services* (e.g. optimising use of community hospitals; practice management of hospital waiting lists; integrated care pathway for stroke; improved drugs misuse services; clear referral criteria for physiotherapy; a protocol for opticians to refer cataracts direct to hospital)
- *developing new services* (e.g. intermediate care; chest pain clinic; outreach clinics in health centres; voluntary sector handyman and gardening schemes for older people living alone)
- *assessing need for service developments* (e.g. collecting data on falls; exploring needs and options for cardiac rehabilitation, specialist nursing, twilight palliative care)
- *strategic planning across the health economy to ensure the balance of acute and non-acute services*

Box 3: Health promotion

- *Sure Start*
- *advice services, general and sexual, to young people in schools and in deprived areas*
- *supporting opportunities for teenagers to play football*
- *Surviving Teenagers* (support to parents)
- *smoking cessation clinics* (run by practices, trusts, or community pharmacists)
- *exercise on prescription*
- *improving breast cancer screening uptake*
- *health impact assessment of domestic violence*
- *a healthy workplace scheme*
- *supporting carers to identify their needs*
- *welfare benefits advice*
- *falls prevention programmes, physical exercise for older people*
- *identifying and supporting older patients at risk in the winter*

Box 4: Community development

- *employing community development staff to build links with local people*
- *health advocacy service for Asian women*
- *supporting bids for Healthy Living Centres* (financial, managerial or moral support to the bidding process)
- *linking with other community activity and networks* (e.g. Councils for Voluntary Service (CVS), transport initiatives)

Box 5: Public involvement

- *links with neighbourhood panels*
- *participation in community festivals*
- *visiting community groups* (rather than expecting them to attend PCO meetings)
- *a public panel, which discusses PCO board meeting agendas*
- *proactively encouraging participation in public board meetings*
- *members of the public sitting on some working groups*
- *chief officer's 'surgery' for the public*
- *a MORI poll on health issues*
- *developing a public involvement and information strategy*
- *focus groups and patient participation groups at practice level*
- *professional public relations support*

Box 6: Inequalities in health care

- *withdrawing or widening access to fundholding services* (e.g. physiotherapy, counselling, chiropody, dietetics, benefits advice, ultrasound, phlebotomy, outreach clinics)
- *addressing deficits in access to care* (e.g. improving access to rehabilitation and mental health out-patient services in one part of the PCO, providing more GP specialist clinics)
- *using third-wave PMS contracts to attract funding to under-resourced areas*

Commissioning, primary care development and public involvement were reported more commonly than health promotion, community development and inequalities in health care. There are some fairly clear differences between the approaches which different sites have taken to health improvement. For example, site 1 is using clinical effectiveness and disease management as its driver for health improvement; sites 2 and 4 are emphasising the importance of community development work in deprived areas; sites 2 and 5 are emphasising improved access to services. Sites 3 and 6 have found it harder to establish an identifiable health improvement strategy. Table 3 records the activity being undertaken by each site.

Table 3: Aspects of health improvement activity, by site

✓✓= evidence of corporate commitment
✓ = evidence of commitment at sub-group or individual level only

Site	*Primary care development*	*Commissioning*	*Health promotion* *	*Community development*	*Public involvement*	*Inequalities in health care*
1	✓✓	✓✓	✓		✓	
2	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓
3	✓	✓✓	✓		✓✓	✓
4	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓
5	✓✓	✓✓	✓✓	✓✓	✓✓	✓✓
6			✓	✓	✓	✓

* Smoking cessation services are not considered here, as a dedicated funding stream ensured that such services were provided in every PCO.

3.5 *Primary care organisations and their context*

In accordance with the analytic framework outlined above (Section 2.6), this section is divided into the outer context (i.e. the national and local factors external to the PCO: Section 3.5.1) and the inner context (factors which arise from within the PCO itself: Section 3.5.2). Factors which support or reduce *PCO effectiveness in general* are included here as aspects of the context for health improvement work. Factors which support or reduce *health improvement activity in particular* are included in the section on the process of health improvement work.

'Progress' is taken to mean reported significant development and/or implementation (partial or complete) of plans made.

Many of the factors recorded below have already been identified by other research as being of relevance to PCO progress in general (Smith *et al.,* 2000; Wilkin *et al.,* 2000): limited management and financial resources; non-board GPs' engagement; the nature and quantity of health authority support; the pace of change, particularly regarding mergers and progress to PCT status. Our research confirms those findings.

3.5.1 The outer context

Outer contextual factors are reported as follows:

- the size of the national agenda
- the local NHS (including: financial issues; collaborative work between PCOs; relationships with trusts; relationships with health authorities; performance management)
- other local relationships (including: local government; the voluntary sector; and the public).

3.5.1.1 The size of the national agenda

There was virtual unanimity in emphasising that the new primary care organisations face a very taxing agenda, the size of which represents a brake on the speed of early progress (although it is likely that this will not be so in the medium and long term).

Generally, this agenda is accepted as non-negotiable, although there were small signs of resistance: for example, one site refused to comment formally on the draft of the NHS Plan, regarding the size of the task and the time allowed to be unreasonable.

Informants did not feel able to progress so much work adequately:

> *we're just putting together vestigial responses to keep people off our backs.* (chief officer)

In particular, one chair spoke of the pressure on GPs in an under-doctored area, and the PCT's reluctance to increase such pressure:

> *'It's in the NSF, it's got to be done.' How can it get done? How do you police it to say that it does get done? Would I want to police it, knowing how much they're struggling?* (chair)

In any case, though:

> *we might be able to put a bureaucracy in place ... but we can't actually make anybody at the coalface follow it. We have not time to, first of all, persuade them that it's worth doing, and then, to monitor it.* (chair)

Several chairs and chief officers agreed that deciding which top-down injunctions to disregard was important:

> *We've had several longish sessions discussing how not to do work ... giving people permission* not *to do something.* (chair)

In the second year, views were mixed as to whether the top-down burden was increasing. One chair thought that the 'must-dos' were:

> *getting very specific; whether they're getting more realistic is another matter.* (chair)

Others thought that the various policies and requirements were beginning to make more sense as a whole. Though there was considerable agreement that the NHS Plan was about health care rather than health, the NSFs were seen as positive and helpful in promoting specific aspects of health improvement work.

The pace of change expected by government was regarded as unhelpful:

> *you really have to let people have some time when things can settle down.* (non-executive board PCT member)

> *we must allow the process to mature ... all the time they keep tweaking us, they're also tweaking public confidence.* (lay member)

One enthusiastic supporter of current NHS policy summed up a majority view by saying, as if to the Department of Health:

> *The direction of travel is fine; but please take your foot off the accelerator.* (chair)

The need to tackle such a demanding agenda has made it harder to pursue a single set of objectives such as those relating to health improvement:

> *All of the public health agenda, all of the primary care development agenda, all of the community development side of the business is being, or likely to get, more and more side-lined ... an enormous amount of PCO time and energy are at risk of being drawn in to managing the traditional machine [i.e. acute hospitals].* (chief officer)

One particular 'must-do' likely to be of increasing importance in the future drew particular criticism: the planned increase in the proportion of GPs holding personal medical services (PMS) contracts (i.e. contracts for a GP service as a whole to a specified population) instead of general medical services (GMS) contracts (which aggregate a range of different payment methods for different activities). In site 4, practices were adamant that PMS represented an unacceptable alternative to their very successful businesses under GMS:

> *The benefit is not clear, and therefore, why do it?* (chair)

Another chair thought that PMS would be a powerful mechanism across the whole PCT but that:

> *piecemeal is hopeless.*

PMS was regarded as an inappropriate criterion for 'green light status' for local health economies, either because the PCO had limited ability to insist on practices adopting PMS, or because it was inappropriate to judge an organisation by an as yet unproven mechanism rather than by evidence-based activity or by outcomes.

3.5.1.2 The local NHS

Financial issues

The financial state of the local health economy was an important contextual factor affecting all aspects of how PCOs functioned. Two sites had had to work to reduce a large hospital deficit in the first year of the PCG, and sites 4 and 6 lacked growth money at district level; only site 5 reported that its health economy was expanding significantly. In site 1, there was anxiety that the new district general hospital would absorb too great a share of district funding, and so strategic plans for primary and community care were being developed to protect resources.

Site 2 receives less than its target allocation on a weighted capitation basis, and is gradually receiving a larger share of the district budget to correct this. Site 4, on the other hand, receives more than target, and will therefore receive little growth money for the foreseeable future. Site 5 benefited directly from the city's HAZ, receiving money and a share of human resources employed by the HAZ. This was not the case in site 4, where the HAZ's priority areas were all in other PCOs, although there were some benefits from the HAZ's city-wide activity.

Section 3.6 below considers the effect of financial issues on health improvement work in particular.

Collaborative work between PCOs

Three sites were actively collaborating with neighbouring PCOs, and/or planning to become PCTs at the same time as neighbours. Such collaborations were seen to empower PCOs and to minimise disruption to and fragmentation in the local health system. Site 4 in particular worked closely with its neighbours on all aspects of commissioning, and together they had impressed trusts and the health authority by their solidarity. Furthermore, such collaboration avoided duplication of effort in the local health economy, and made the very large workload more manageable. This co-operation reflected the PCG's perception of strategic advantage rather than of shared problems, as its predominantly prosperous population had little in common with the much more deprived population in the city as a whole. The urban sites in our sample were collaborating with neighbours more than the two rural sites. This was perhaps

because the former were only *part* of an entity (a city), whereas the latter, which saw themselves as umbrellas for many communities (small towns and villages), believed that health authorities and county councils did not understand their local needs, and wished to stress how their interests differed from rather than resembled those of their neighbours.

Relationships with trusts

Some acute services managers were regarded as intransigent, expecting levels of funding which PCOs thought inappropriate, and which they therefore had to devote time to challenging. Two sites reported good inter-clinician relationships in the local NHS. One PCT felt that the acute trust did not as yet recognise the PCT's independence and status. Service re-configurations (for example, plans for a new district general hospital, the re-configuration of mental health services, a long-resisted merger between two acute trusts, the attenuation of community trusts with the advent of PCTs) caused 'planning blight':

> *If you have a transient organisation, it's difficult for other organisations to work out how they are going to relate or even if they are going to bother relating to an organisation that might not be around.* (chief officer)

Relationships with health authorities

Reports of relationships with health authorities varied considerably. One chief officer spoke warmly of the wisdom which senior health authority personnel imparted, and praised the way in which their 'leading from behind' empowered and educated young PCOs. Perhaps significantly, this health authority had delegated budgets to PCGs in their first year. At another site, there was a consensus that, although a few individuals were helpful, the health authority in general was hide-bound, defensive, controlling, ill-informed about primary care and pre-occupied with the acute sector. Both before and after the announcement in 2001 that health authorities would merge, there was clear evidence of confusion among most PCO and health authority informants about the role of health authorities in the new NHS.

There were concerns that health authorities were not making their expertise sufficiently available to PCOs (e.g. information technology support, the education and

training budget, health promotion resources); in some cases, this was seen as caused by staff shortages and lack of capacity, in others, as an unwillingness to 'let go'. In site 3, the relationship between the health authority and the PCT was clear, and many of the functions of the former had been devolved to the latter using Service Level Agreements. In site 2, however, the PCT saw a similar devolution of health authority responsibilities happening less formally, and without adequate resources following; resisting extra unfunded work of this nature was itself an extra task for the PCT to tackle.

Performance management

Performance management of the PCO by the health authority was a source of unease or scepticism in many cases. In five cases, the process was seen as 'light touch'. Some saw this as desirable: formal performance arrangements (the Annual Accountability Agreement) need not be time-consuming since health authorities worked closely with PCOs on a whole range of issues, and were therefore very aware of PCOs' progress and performance. Others found the tick-box exercise meaningless or irritating, too perfunctory and shallow to be an adequate mirror of actual performance:

> *It's quite easy to answer their questions, to make it sound good. And they probably know that. So what's the point?* (chair)

In one site, however, the Annual Accountability Agreements had nearly 200 performance measures, which felt to the PCO both oppressive in number and unhelpful insofar as they reflected specified processes rather than real progress towards successful outcomes. One informant at this site believed that a problem-solving and supportive approach would be preferable, but observed that the performance management and policy development arms of the health authority appeared to work in isolation from each other.

Interviews with Department of Health personnel also highlighted concerns about performance managing health improvement:

> *It's not something which you necessarily see the results for many years in some instances. Performance management in the NHS traditionally has been*

about crunching numbers, about the sort of hard data. And where's the hard data on improving health? We need to be far smarter about our performance management in the NHS in future. (civil servant)

3.5.1.3 Other local relationships

Local government

Reports of relationships with local government were very varied, and this partly reflected a high degree of organisational instability. In all cases, PCOs' own rapid development was paralleled by changes in local authorities, which in all cases had either recently moved to a more streamlined 'cabinet' style of council working, or were planning to do so in the near future. There was evidence in five sites of recent, current or impending structural change in multiple organisations:

I have never known so many statutory organisations all going through major re-configuration at the same time: the trusts, PCGs, local authority, all the key agencies. (social services representative)

This was perceived as disruptive in most though not all cases; a common complaint was that:

nobody stays in office long enough, so we lose continuity. (GP)

In four cases, financial deficits or lopped budgets in local government funding were emphasised as a preoccupation and there was great variation in the degree to which community planning by local government was advanced: whereas at site 2, a community plan existed, work on the plan was only just beginning at site 3.

In two sites, with unitary local authorities, health authority and social services informants spoke of senior level discussions with social services to co-ordinate strategies; but there was little mention of visible progress at the operational level by PCO informants. In both cases, the social services departments were undergoing major re-structuring. In the other two sites with unitary local government, PCO informants referred to good operational co-operation with social services, even though

one department was also undergoing re-structuring. In both these cases, the social services department had redrawn service boundaries for a number of client groups to mirror PCO boundaries.

Both in the two cases of unitary authorities and the two London sites, links between PCOs and the other local government departments were reported to be weak or non-existent. In the case of sites 1 and 3, the weak links may be associated with the lack of attention given by the PCOs to the socio-economic determinants of ill health; this lack of attention in turn may in part be due to the prosperity of their populations.

Two had regular links with local neighbourhood groups organised by the council, although these were not thought particularly useful, because they were unrepresentative, because they were preoccupied with other topics, and because of lack of co-terminosity. For these reasons, one PCO did not maintain links with such groups.

Where there was two-tier local government (sites 2 and 6), county councils were perceived as rather distant, and unresponsive to local issues, although individual officers had been of great value to the PCO board. There were closer links with district councils, who were serving roughly the same populations. At site 2, this was at board level, but at site 6, the links were with the somewhat marginalised health improvement sub-group. At one site, relationships with parish councils were important, as some of these provided lunch clubs for older people. However, one district council officer saw a need to move beyond meetings, if partnership was truly to add value:

> *It's the things that are in the gaps between the silos that you should be focusing on, and you can't easily deal with those in a sort of committee framework. You need some free-thinking-type sessions.* (district council officer)

The voluntary sector and the public

Some PCOs had established good working links with local voluntary sector organisations. A number of problems were acknowledged: the difficulty of relating to so many organisations where umbrella organisations such as Councils for Voluntary Service did not exist; duplication among voluntary organisations; the difficulty some organisations had in understanding the nature and purpose of PCOs; the fact that such organisations are not representative of their communities, and that some (particularly those which provide services) are not necessarily local, and therefore may not reflect local needs and views.

Affluent and articulate middle-class lobbying groups needed to be handled with considerable sophistication if PCOs were to get local support for addressing health inequalities. As one chief officer joked:

> *if the BMW drivers decided we ought to be providing a golf injuries service, they could make themselves felt in a big way.*

However, one public health director had been well received when explaining to a public meeting in an affluent area the justification for targeting future district development money on poorer areas in other PCOs. In the same area, regular public panels met monthly to consider the agenda of the local PCOs, and contributed to public board meetings: their contribution was widely regarded as valuable.

Observations of board meetings held in public revealed a diversity of approaches to the presence of the public, a potential partner in the meeting. At one site, the public were cordoned off from the board table, and some members sat with their backs to the public; no papers were provided, and no questions invited from the floor. Elsewhere, questions and discussions were invited either at the end, or after each agenda item; some papers were provided, and, in two cases, refreshment was offered to board and public alike. At all the meetings attended, board members had name labels, meeting rooms were accessible to the disabled; one had an induction loop. There was a tendency for board members to use jargon and abbreviations; some lay members saw it as part of their role to ask for clarification when this happened. The numbers of

members of the public (excluding the researcher) ranged from 0 to 18. Three sites reported regular attendances of more than a dozen members of the public.

Overall, there was quite widespread acknowledgement of the learning that partnership working facilitated: learning about local services and communities, and about organisational structures, cultures and contacts.

3.5.2 The inner context

Inner contextual factors are reported as follows:

- previous primary care organisations
- PCO boards
- non-board GPs
- management and financial resources
- workforce issues
- mergers and moving to PCT status
- being a PCT.

Previous primary care organisations

Little history of primary care collaborations across localities was reported in any of the sites. In one, there had previously been a county-wide commissioning forum through which interested GPs had felt able to exert some influence; arrangements for PCOs to discuss commissioning with the health authority seemed to informants to be weaker. This was because the forum now had to discuss the whole commissioning agenda, whereas previously GPs had been able to focus on particular areas of concern and make small but significant changes.

All but one site included practices which had previously been fundholders, and were therefore faced with the problem of finding an equitable way of dealing with the differential services which had resulted from fundholding. The pace of progress varied: one had moved slowly, wary of risking the hostility of fundholding GPs and their patients; another had made the issue a priority, with the result that there was some dissatisfaction among those whose experience of PCOs was of fewer services:

> *One or two practices ... have been encouraging their patients to have a bit of a moan, and that's led to a flurry of letters to MPs and things like that.* (chief officer)

Three sites included former total purchasing sites. In one case, all the key personnel from the pilot had major roles in the PCO, and maintained the existing energy, expertise and strategic approach thus acquired. A local Promoting Action on Clinical Effectiveness network, which predated the PCO, had proved helpful in 'hitting the ground running' on clinical governance and clinical effectiveness work. In another, the PCG chair had led the total purchasing pilot, and saw a consistency in his own strategic aims in the two organisations; but the PCO's work did not appear to 'pick up the baton' from total purchasing in the same way as in site 5, perhaps because the pilot had been smaller. In the third, there was much less continuity between the leads of the pilot and of the PCO board; this appeared to be due to a mixture of personal decisions by pilot personnel and some local politics among the GP electorate.

PCO boards

Some boards were reported to have won general esteem locally, and this was attributed to the qualities of leadership shown by the chair and/or the chief officer. Factors often mentioned in this context were fairness, inclusivity, openness, drive, the ability to change hearts and minds, and sensible decision-making. One board had valued a series of organisational development sessions provided by a public health consultant.

There were leadership issues within three boards in the first year. In all of these cases, there was a change of chief officer or chair which was judged to be a substantial improvement. In one case, a board previously described as dysfunctional was regarded as effective and focused in the second year, as a result of the new chief officer's management skills.

Non-board GPs

Generally, it was thought that most non-board member GPs were not yet fully engaged with the PCOs and their work:

> *The problem area is engaging with the broader PCO base, and getting commitment and enthusiasm below board level.* (chief officer)

Partly, this was because the practices within a PCO did not necessarily see themselves as being similar. Specifically, all of the sites had:

> *the classic problem of the pockets of deprivation in an overall average OK.* (director of public health)

Even in site 6, where areas of deprivation were small, geographical factors prevented cohesion:

> *The area is very vast, and the communities are all very different.* (voluntary services co-ordinator)

However, most sites reported a slow increase in GP participation. A number of mechanisms had been used to achieve this:

- inclusion of personnel from all practices in PCO sub-groups
- GP advisory groups and forums, open to all GPs
- open meetings open to PCG staff, the public, the voluntary sector, other professionals
- a system linking practices with a named GP on the executive committee in one case, or a non-executive PCT board member in another
- the appointment of a primary care manager to make and sustain customised links with each practice
- support for clinical governance and prescribing
- the provision of detailed comparative data (anonymised) about practice behaviour (referrals, prescribing, etc.), which had encouraged GPs to see themselves as part of a greater whole, and to review their own performance
- protected learning sessions (at one site, these were also open to, and attended by, administrative and clerical staff)
- a formal bidding procedure for practice development money, which has increased a sense of fairness and equity between practices

- quality initiatives (Investors in People and others).

It was widely reported that major efforts were needed to improve the quality and comparability of primary care data across practices. It was also noted that GPs are engaging with work on clinical governance and National Service Frameworks, although noticeably less so with other aspects of health improvement. However, board members believed that PCOs appeared to non-board GPs to be more accessible and responsive than had been expected. In two cases, informants specified that the allocation of resources to practices was seen as fairer than when it had been done by the health authority.

Management and financial resources

Most sites reported delays in recruiting a full team of PCO managers in the first year:

> *Our management allowance was severely truncated to deal with the prescribing overspend, and whereas I'd anticipated having made both clinical governance and health improvement development manager appointments by now, I haven't been able to.* (chief officer)

In site 6, the small population and high travel costs meant that the management allowance could only support the board, a chief officer and a part-time secretary. In this site alone, size proved to be an important factor: it had insufficient capacity to undertake work programmes either alone or in partnership with others.

Even though most appointments had been made by the second year, it was still difficult to manage the large workload, and health improvement work suffered as a result. For example, there was no administrative support to the health improvement sub-group at one site, or for public involvement work in three others. Professional and lay people involved in such work felt that their time was being used inappropriately in carrying out administrative tasks.

Because of financial constraints in the whole health economy already discussed (Section 3.5.1), some of the sites were struggling to fund their work programmes.

Internally, there was considerable activity to improve the cost-effectiveness of prescribing although, in one site, one GP remained adamant about the clinical need for some very expensive prescribing practice, thereby depriving the PCO of development money. There was a good deal of interest in other schemes which brought in money for particular pieces of work: some of these which relate to health improvement are discussed in Section 3.7. However, the application processes put heavy demands on management time:

> *a lot of hoops to go through, and so many disincentives to people to actually apply for it.* (nurse)

A lack of clarity from the Department of Health at an early stage about criteria for initiatives such as Walk-in Centres and PMS had also caused wasted extra work. One informant spoke for others in saying:

> *there is always the promise of big money and then when it actually materialises, it is a good deal less than it should be* (non-executive PCT board member)

Workforce issues

Some sites reported severe problems in recruitment. Site 2 had a significant number of GP vacancies, and found it difficult to recruit partners, salaried GPs and locums. The resulting additional workload limited the capacity and energy of local GPs for new work such as that required by the National Service Frameworks. Site 3 found it difficult to fill nurse vacancies, and site 4 reported that social care agencies had numerous unfilled vacancies for personal carers. In both cases, improving the quality of care to the frail elderly became very difficult.

Mergers and moving to PCT status

A key contextual issue, experienced by all of the sites, was the progress to PCT status and/or merger with other PCOs. Site 2 reported that becoming a PCT had had a mixed impact on the PCO's health improvement work: although the PCT application had absorbed management resources and time to a significant degree, and had delayed other work, it was also the case that the application had encouraged a more mature

approach to the whole range of PCO business, which would ultimately benefit health improvement. In the case of sites 1 and 3 (i.e. where the move to PCT involved a merger), relatively little distraction had been experienced by the PCO (apart from the chair and chief officer) as cross-agency project teams had managed the application and transition processes on behalf of the three PCGs, community trust and health authority. The actual change was often untidy, with delays in appointing both non-executive board members and executive staff; these delays were attributed to bureaucratic processes at regional and national level.

The loss of a local focus in new and larger organisations was a common fear. In the case of site 6, the merger of five PCGs into one at the end of the second year had been a painful process. The original configuration of five small PCGs had, in the view of local GPs, been imposed by the health authority in the face of widespread reluctance of GPs in small communities to identify with any larger grouping at all. These GPs were very reluctant to accept yet another imposed re-configuration two years later. There were also fears that it would not be possible to maintain the local focus. The new PCG was to have a locality structure, but this did not reflect perceived community differences.

Being a PCT

Sites reported that learning to function as a PCT once the transition had been made had been unexpectedly challenging. In two cases, board members and executive committee members were not yet clear to what extent each group should be involved in governance, strategy and operations. At one site, a non-executive was concerned that the chair interfered too much operationally, while an executive committee member felt that the committee was too involved in monitoring. At another, the board required regular supplies of detailed information for monitoring purposes, which imposed a significant burden on officers both in providing the information and in educating the non-executives how to interpret the data sensibly. At both sites, there were issues about how much non-executives should attend executive committee meetings or lead working groups, and, in one, some of the non-executives clearly saw their role as being lay representatives rather than corporate governors. At site 3, it is as yet unclear what the appropriate relationship between locality executive group and the trust board is: there are perceptions that the locality executives are 'semi-

detached' from the board, or else just rubber-stamping decisions already taken. (However, the admittedly expensive three-localities arrangement provides an infrastructure which enables the large workload to be tackled.)

In one site, it was reported that nurses welcomed the new organisation, which was smaller than their previous employer and was more aware of and committed to the skills and needs of the nursing workforce. At another, about to become a PCT, nurses were reported to be looking forward to belonging to a smaller and more cohesive organisation.

3.5.3 Summary

Table 4 summarises those contextual factors where considerable variation was evident.

Table 4: Contextual factors affecting PCOs

Site	*Board seen locally as effective*	*Limited engage-ment of GPs*	*Develop-ment money available*	*Merger/PCT a major burden for PCO*	*Reported good working with:*			*Local agencies re-organising*
					other PCOs	*health authority*	*local government* *	
1	✓	✓			✓	✓		✓
2	✓	✓	✓	✓			✓ (personal; strategic with DC)	✓
3	✓ (2nd year)	✓			✓	✓	✓ (strategic)	✓
4	✓	✓		✓	✓		✓ (strategic, operational)	✓
5	✓ (2nd year)	✓	✓	✓	✓	✓	✓ (strategic, operational)	✓
6		✓		✓			✓ (operational; personal with DC)	✓

* indicated relationship with social services department, unless otherwise stated. 'Personal' means that the board or sub-group had found the input of or contact with an individual very helpful, but this did not necessarily reflect departmental commitment to joint working.

3.6 The process of improving health

This section describes the 'how' of change, and reports findings thus:

- leadership for health improvement
- financial resources
- public health support
- other partnerships.

Leadership for health improvement

In three sites, there was a clear commitment to health improvement 'at the top of the office' (board members and officers, particularly the chair and chief officer), and an understanding of how many other work streams could contribute to an overall strategic plan for health improvement. In site 2, for example, the PCIP was seen as the local HImP. It was believed that the health improvement strategy should determine investment decisions, rather than the other way round, and the health improvement manager had checked every investment priority to ensure that it linked with the health improvement plan. This PCT had also developed an internal performance management framework, with specific targets and regular reviews by sub-groups, the board and partnerships groups. In another site, a health promotion specialist was identifying the health promotion contribution to every aspect of the business plan. In three sites, however, although the boards showed commitment to primary care development and to a certain extent commissioning, they appeared to be neglecting key components of health improvement work such as partnership working and community participation. The attitude of one board to health improvement was summarised thus:

> *Yes, it's impossible to do anything; we can't do anything; what does it mean?* (nurse)

Nurses, health promotion officers and a community physiotherapist had played important roles in leading the health improvement agenda. However, such a role was demanding and could be isolating:

> *The nurse members of PCO boards ... can't get the GPs to lift their minds off GMS and the money and the more immediate issues around primary care, or indeed even commissioning, to actually say, we're here to improve health.* (health authority officer)

This view was confirmed by two nurse informants.

Champions of health improvement, of whatever profession, did not usually feel supported by GPs within the PCO. Voluntary sector or local government personnel were often regarded as more helpful allies. Three sites had health improvement sub-groups. Of the others, one had combined this with sub-groups on clinical governance and training and education, and one had a health promotion sub-group. The sub-group in site 3 was intending to merge with those in other localities, in the hope that it would be able to achieve more in that way, having struggled to have a voice in the locality hitherto. The existence of a sub-group was not in itself an indicator of greater PCO commitment to health improvement. Only in one case did the existence of a sub-group reflect a corporate commitment, while the commitment at board level at two sites without a health improvement sub-group was nevertheless strong.

Financial resources

Respondents pointed out that it was difficult to improve health when no development monies were available:

> *If I look at where HImPs have been the most successful, it's where they've been partnered by an HAZ, because that's attracted the extra resources, where you can pilot some of the innovative programmes.* (PCO manager)

Certainly, site 5, the only one of our sites to receive development money from its HAZ, illustrates how, where development money was available, from whatever source, it was possible to fund a community development worker and specific community development projects, as well as to create a fund for public involvement work which practices could bid for (one example was a first aid course for parents run jointly with a local college). Bidding for Healthy Living Centre funding is one way of trying to obtain money for health improvement (three sites had committed some

resources to supporting these, and a fourth had given written endorsement to the bid, in which it had otherwise not been involved). Site 2 personnel praised the efforts of their designated public health consultant for bidding successfully on their behalf for funds for a number of developments. This support was particularly welcome since, as several people reported, the application processes for funding were either pressurising because of short timescales (Sure Start) or frustrating because of long timescales (Healthy Living Centres).

Other funding streams were supporting progress. Site 5 was taking part in the national Primary Care Collaborative, while site 2 was benefiting from Cardiac Partnership Funding. Site 5 was using PMS as a way of increasing primary care resources where these were less equitably distributed, and also to set targets for public participation.

Most sites reported a local expansion of smoking cessation services, suggesting that the availability of dedicated funding was instrumental in ensuring progress in this area.

Public health support

Half of the sites reported receiving useful health authority support for health improvement work (health needs assessment data, clinical guidelines), although the data were criticised for being limited, slow to arrive, and/or out of date. One site had on-line access to valued health authority data-sets. It was clear that many primary care personnel had expected ward- or PCO-level data to be readily available, while in fact public health departments had to work hard to obtain these.

PCOs and health authorities appeared to have different understandings of what public health support PCOs could and should expect (data, skills, health promotion). Some health authority informants believed that PCOs' views of what was available and useful at small area level were sometimes unrealistic. One director of public health referred to:

> *this concept of public health as a handle that you turn to produce a number ... [one PCO chair] wanted me to say, 'Buy 27 backs, buy 42.1 hips per year'! ... And we say, 'No, it doesn't work like that.'* (director of public health)

But a member of the executive group acknowledged confusion about what the public health contribution to a PCT could and should be, and the public health member of the executive committee was preparing a paper on the subject. One chief officer suggested that what PCOs need is:

> *a generic public health doctor, who has a wide band of experience and can call on specialists from afar.*

but said that the department currently consisted only of specialists. This echoed the chair of another PCO, who found an allocated health promotion worker far more satisfactory than having access, as previously, to 'fractions of specialists'. One consultant recognised that public health had a 'credibility gap', and emphasised the importance of:

> *making sure public health is seen to be doing something.*

In bringing in extra money for the PCT, he had done this very effectively and was highly valued as a result.

One public health specialist had created an informal network across the district, open to all clinical staff who saw themselves as a public health worker. The purpose was to facilitate a 'bottom-up' development of public health awareness:

> *talking things into existence; talking a consciousness into place.*

The same interviewee considered that there should be a stronger public health presence on the PCT board. As it was, a public health consultant attended as observer, but without voting rights, while other public health staff attended as members of the public; there were no links at all at locality level. In site 6, there was no designated link at all: the health authority had mistakenly believed that the PCG saw its public health needs as being fully met by a trust-employed health promotion specialist.

Other partnerships

Processes which created links and partnerships were also seen as important contributions to a health improvement strategy. The two PCOs situated within a two-tier system of local government reported that some officers and departments in their district councils were sympathetic to (and in one case already very active in) a community development approach to health-related issues. In two sites, the social services department had created partnership co-ordinator posts to facilitate links between all departments of the council, the district council (in one case), the PCOs and the voluntary sector. In most sites, the lay member had been very active in creating and developing links with community groups and voluntary sector organisations, and this could bring an awareness of health issues to joint decision-making. For example, an umbrella group looking at transport in rural areas and including the lay PCG board member found funds to enable a boys' football team to travel long distances to away matches.

Table 5 summarises variations between the sites in the factors discussed in this section.

Table 5: The process of health improvement: variations across the sites

Site	*Board support for broad health improvement*	*Nature of health improvement strategy*	*Funding for health improvement developments*	*Adequate public health support*	*Health improvement sub-group*
1		NHS		✓	
2	✓	broad	✓	✓ (2nd year)	✓
3		NHS			✓
4	✓	broad		✓	
5	✓	broad	✓		
6		NHS			✓

3.7 Summary: developing a health improvement organisation

After only two years, it is too early to make judgements about which of our six sites are more successful in improving the health of their populations. However, it is possible to make provisional judgements about which PCOs appear better placed to deliver such improvements over time, in the light of our initial assumptions about health improvement (Section 2.2 above). These were that good practice in health improvement includes not only core NHS activity but also:

- recognition of the need for perspectives other than those of the NHS
- partnership working with a wide range of local agencies
- attention to the socio-economic determinants of health and to inequalities in the health of the local population (inequalities in morbidity and mortality as well as in access to services)
- the involvement of local communities in the development and implementation of health improvement strategies.

Using these criteria, sites 2, 4 and 5 appear to be better developed, while 1, 3 and 6 are less so.

Careful study of our data suggests that three key factors are associated with the better-developed sites:

- a corporate recognition of local socio-economic inequalities
- support for and leadership of the broader health improvement agenda at senior level within the board
- development money.

The presence or absence of these factors in our sites is outlined in Table 6.

Table 6: Presence and absence of key factors for progress in health improvement

Site	*Board perception of local socio-economic inequalities*	*Leadership for health improvement at senior level*	*Development money*
1			
2	✓	✓	✓
3			
4	✓	✓	
5	✓	✓	✓
6	*		

* This board was aware of differential access to health services across its large geographical area.

Sites 2, 4 and 5 seemed to draw energy from seeing themselves as being, or being part of, an identifiable area with identifiable problems of health and socio-economic inequalities among their populations. In site 1, there was no comparable sense of disadvantage, socio-economic or geographical, and the organisation was content to

pursue a NHS-only agenda. In sites 3 and 6, there was some awareness among a few individuals of both sorts of inequalities (access to health care and socio-economic conditions), but no evidence that this awareness motivated senior personnel at locality/board level to shape the strategy accordingly. In site 3, the bigger inequities were *between* localities rather than *within* the locality studied, which perhaps explained the lack of interest in inequity issues at locality level.

Senior support was necessary, not least because it was clear at all the sites that the majority of GPs in the PCOs were not actively involved in or enthusiastic about the broader health improvement agenda. Where senior support was lacking, individual champions of the health improvement (HI) agenda seemed powerless to bring about change. However, where senior support for health improvement was strong, indifference or resistance among GPs was not a crucially limiting factor. In the face of indifference or hostility within the organisation, senior support needed to consist of more than one person. For example, the chair for the second year in site 6 was a strong supporter of a broader approach to health improvement, but no coalition of support at board level was established.

Where senior support was combined with financial resources (site 5, and site 2 to a lesser degree), a range of health improvement activity had been initiated. In site 4, implementation was less well advanced because of the lack of development money. Funding shortages were not mentioned as an important factor in sites 1 and (in the second year) 3. Apparently, the failure of those PCOs to tackle the broader health improvement agenda resulted not from a lack of means but from the more limited vision of the task of PCOs prevailing at senior level.

4. Discussion

This section has two parts. First, we highlight some of the key messages for PCOs. Second, we suggest ways in which PCOs can be supported in understanding and operationalising the broader health improvement agenda.

Key messages for PCOs

Perhaps the most important message for PCOs in our analysis is that health improvement must be placed at the centre, not at the periphery, of PCOs' work. Only executive/board-level determination can ensure that the health improvement strategy guides and underpins the whole range of PCO activity, and that commissioning and primary care development decisions are consistent with that strategy and its priorities. PCOs should consider whether senior support for health improvement could be strengthened. In future, PCT boards will include someone who will lead work on improving health and reducing inequalities (DoH, 2001). This will be particularly helpful in PCOs where local inequalities are less obvious and more likely to be overlooked. However, strong support from chief executives and chairs will still be needed, and PCOs should consider how this could be promoted: for example, some public health training or experience could be an essential qualification for senior posts, or, alternatively, postholders lacking such experience could be required to undergo relevant training.

This emphasis on senior staff does not minimise the importance of front-line staff, some of whose work includes health improvement activity. However, clinical staff necessarily and appropriately give priority to their clinical workload; PCO boards will need to offer leadership and support if primary health care teams are to have both the motivation and the capacity to contribute more broadly and more fully.

In order to support health improvement work, an effective understanding of public health skills and resources is necessary in PCOs. Such a relationship requires a mutual understanding of what public health is and what can be expected of public health personnel; and PCOs should work with existing public health departments to achieve

this. The future establishment of a public health team in each PCT (DoH, 2001) should further encourage such understanding.

More generally, PCOs gain credibility and influence by working together. They can divide between themselves some of their key priorities, thus reducing the strain on their own infrastructure, and freeing capacity for other activity, which may include health improvement work.

Supporting PCOs in health improvement work

What can be done to support PCOs which are less well-developed as health-improving organisations?

While it must be recognised that 'health improvement' is a term which includes a variety of meanings and cannot be given a single comprehensive definition, it is nonetheless desirable that the tasks and priorities for PCOs which flow from that range of meanings should be clear. It appears that existing Departmental guidance has not clarified these sufficiently. It can reasonably be argued that most of the illustrative list of health improvement activity provided in Departmental guidance (DoH, 1998b) overlaps with the other two functions, either primary and community health service development or commissioning hospital and community services. This may be why some PCO personnel have struggled to understand just what characterises health improvement, and why three PCO boards failed to address a broader health improvement agenda.

As already pointed out, one PCO had limited health improvement exclusively to core NHS activity. Such a view cannot be lightly dismissed; it is clearly not inappropriate for primary care organisations to target their efforts at developing primary care, thus prioritising what they take to be their core business as primary care practitioners.

However, it is equally clear that, as the 'cornerstone of the local NHS' (DoH, 2001), PCTs must embrace health improvement among their priorities. This requires clearer answers to questions such as:

- What specifically are the ways in which health improvement goes beyond commissioning and primary care development as traditionally understood, and how should PCOs be tackling these?
- What should PCOs be doing about health inequalities as a priority, beyond promoting equity in its commissioning and primary care development strategies?
- What needs assessment and demographic data are required to support PCOs in working to achieve better health and well-being, and reduced inequalities in health for their population?
- Which members of the primary health care team should include broader health improvement work among their priorities, and what should this work entail?

The health improvement role of particular professions needs clarification. A review of the health visitor role has been recommended by the Select Committee on Health (2001), for example, while in addressing workload issues, the new GP contract may define GPs' health improvement role more clearly.

We have already suggested that the willingness of PCOs to adopt a broad health improvement strategy may be associated with their awareness of socio-economic deprivation. Certainly, in areas of severe deprivation, PCOs will be aware of local regeneration and neighbourhood renewal initiatives, Health and Education Action Zones, Sure Start, etc. Their environments create a consciousness of both problems and attempted solutions. However, it may be that the absence of these mechanisms locally makes PCOs in more prosperous areas less likely to embrace the broader health improvement agenda, particularly relating to health inequalities. This did appear to be the case in our sample. How can such PCOs serving prosperous communities be encouraged to take seriously their responsibility to address the needs of relatively deprived parts of their populations? It is after all acknowledged (Select Committee on Health, 2001) that addressing the needs of the most deprived communities can only be part of the solution to the problem of inequalities as a whole. Furthermore, if PCOs with prosperous populations fail to target pockets of deprivation, the inequalities between their more- and less-deprived populations will *increase*.

Ensuring that small areas of relative deprivation and small scattered population groups with poorer health or access to health care benefit from strategic targeting of resources is in some ways more of a challenge than working in areas of acknowledged, widespread and entrenched deprivation. The recently announced national inequalities targets should serve to remind every health economy of the need to address health inequalities.

However, we suggest that more is needed, and that PCOs, strategic health authorities, managed public health networks, local government and regional government offices be encouraged or required to work together to draw up deprivation profiles/equity audits of each PCO population. These would draw on data about socio-economic factors (census and local authority data) as well as data about health status and access to health care. In some cases, this work will already be well advanced as a result of work on regeneration and neighbourhood renewal, Health Action Zones, etc. In order to ensure a truly local focus, PCOs should take a leading role in co-ordinating such an exercise. Some of our sites had done some of this work, and as a result were targeting efforts and resources on the most disadvantaged parts of their generally prosperous populations.

Alliances with non-NHS agencies such as local government are of course central to the broader health improvement agenda. PCOs will be key members of local strategic partnerships, which are currently being established. These partnerships should help to broaden and deepen PCOs' understanding of the causes of health and illness, and of local government's power to promote economic, social and environmental well-being (DETR, 2001). A further means of encouraging PCOs to consider in detail local government policies which address the root causes of ill health would be to give PCOs a statutory role in the drawing up of community plans by local government. Such a role might include collaborating to assess the health impact of proposed policies, and an ongoing scrutiny role. This would serve as a further structural reminder to all PCOs of the need for work beyond the confines of the NHS.

Performance management is another way of supporting and steering PCO health improvement activity (already recommended by the Select Committee on Health, 2001). Much of what already exists (high-level performance indicators, NSF

standards) relates directly to health improvement. More broadly, given that a successful health improvement approach is likely to involve partnership working, it may well be partnerships, rather than PCOs, which should be accountable. For example, the existence of adequate smoking cessation services does not count as a 'tick' or 'cross' for individual PCOs: the Government made money for smoking cessation services available to health authorities, who had the option of building on existing services already provided by other health promotion services (NHS or local authority), by community pharmacists, or partnerships such as Health Action Zones. It is therefore necessary to performance manage whole health economies on aspects of health improvement which are not the responsibility of PCOs alone, such as health promotion, community development, and work to reduce socio-economic inequalities.

It is important that the performance management of PCOs reflects local diversity. For example, whereas some PCOs may find PMS an important mechanism for targeting resources on practices in deprived areas (like site 4), local opposition to PMS may be too strong elsewhere to make this a sensible strategic option (like site 5). It would therefore be inappropriate to use PMS as a universal performance indicator.

Furthermore, strategic health authorities will need to develop a method of performance managing PCOs and health improvement which is 'joined up' with policy and strategy development work, so that, rather than being no more than a checklist of relatively superficial process indicators, the performance management process supports PCOs in becoming effective and strategic health improvement organisations.

Appendix 1. Interview schedules

Interview schedule: year one

1. What do you understand by the phrase 'health improvement'?

2. How were this PCO's health improvement priorities decided?
[prompts: national and local policy contexts? existing work? key individuals and organisations? health needs assessment?]

3. How are the PCO's health improvement priorities being tackled?
[prompts: who? what? resources (human, financial, information, partnership)?]

4. What problems do you anticipate in implementing your plans? What external and internal factors will help or hinder?
[prompts: relations with: health authority; social services; other local authority departments; acute and community trusts; other PCOs; voluntary sector organisations; policy direction, national and local (HImP); variations in practice and belief within PCO]

5. What actions is the PCO taking to address inequalities in health, and how do these relate to other local activity?
[prompts: unequal access; socio-economic inequalities; inequalities in morbidity and mortality; local regeneration and community development initiatives]

Interview schedule: year two

1. Progress

- Could you update me on progress with the activity identified in first round?

  Are there new areas of work which have become prominent since we last spoke? What are they? [checklist/prompts: community development? health inequalities?]

- How is this work being resourced (human, financial, information, partnership resources)?

- How are the PCO and the health authority monitoring progress in these work streams? [checklist/prompts: timetable? progress monitoring? process and/or health outcomes? performance indicators?]

2. Helps and hindrances

- In the last round of interviews, informants anticipated the following potential helps/hindrances:

- How have these factors affected progress in practice?

- What have the unanticipated helps and hindrances been? [checklist/prompts: health improvement sub-group/lead/other structures; relations with: health authority; social services; other local authority departments; acute and community trusts; other PCGs; voluntary sector organisations; access to adequate expertise in public health, health promotion, education and training, organisational development, etc.; policy direction, national and local; variations in practice and belief within PCG]

3. Health improvement's place in the PCO agenda

- Where do you see health improvement sitting now within the whole PCO agenda?
- Has this changed over the last year, and if so, how?

Appendix 2. Description of sites

Site 1

This began as a level 2 PCG. It merged with two others in the same London borough in April 2001 to become a single PCT. The PCG had a population of about 90,000, with relatively few deprived areas or minority ethnic inhabitants.

What health improvement activity is being undertaken?

The PCG did not have a health improvement sub-group. Health improvement priorities were set out in the Primary Care Investment Plan, which included detailed action plans with targets, timetables, responsibilities and resources.

Primary care development

The PCG has taken a practice-based disease model for its health improvement work. It has supported practices in improving information systems and their use, in setting up disease registers, and introducing evidence-based guidelines developed by the health authority, particularly for coronary heart disease (CHD) and respiratory disease. Spirometers have been bought for practices, and it is intended to increase the numbers of nurses with specialist training in respiratory disease.

Commissioning

Because a new acute hospital is planned in the borough, the PCG has worked with other health economy partners to develop a strategic view of the appropriate balance of resources for provision by both hospital and non-hospital services. At PCG level, a single contract for community physiotherapy with the community trust has replaced the various fundholding contracts, and a review of the range of counselling services provided locally is underway.

Health promotion

Smoking cessation services are provided by the community trust, and also by some community pharmacists, who have developed a protocol for joint working with GPs. The PCO is leading on a falls prevention project for older people. Most practices have

taken part in voluntary schemes to identify and support patients at risk during the winter.

Public involvement

Few members of the public attend board meetings; slightly more attend open days to which professional staff are also invited. The lay member has been very active in visiting voluntary sector organisations, a task all the more daunting because there is no umbrella organisation for these locally. However, she lacks administrative support. The borough council runs community forums, but these tend to focus on planning and education issues and have not proved a useful consultation mechanism for the PCG.

Community development and health inequalities

No activity was reported in these areas.

Contexts for health improvement

The PCG

The PCG now has a full management team. The vision and drive of the chair contrasts with the still somewhat limited engagement of non-board GPs.

Local and national contexts

Locally, the context is one of extensive organisational change. In particular, the PCG has been working with health economy partners to merge and become a PCT. This has been a time-consuming process, involving many task groups.

The health authority has recognised the PCG's ability to function and has 'let go', devolving many responsibilities. Performance management is done with a 'light touch', made possible by good relationships across the health economy.

Implementing change

Progress has been made in the last year in engaging GPs and other primary care staff in the work of the PCG. There have been no major funding streams accessed over and above the money generally available to PCOs.

Site 2

This PCG became a PCT in April 2000. It is co-terminous with the district council, serves a population of 129,000, and is a 'coast and country' community with some deprived wards.

What health improvement activity is being undertaken?

The health improvement plan is intended as the 'life blood' of all PCO activity, and the health improvement sub-group was established early on. It is being developed incrementally, with priorities added and targets made more specific.

Primary care development

The PCT, together with a neighbour, is a national 'CHD collaborative' site, which will build on work already undertaken to improve audit and the management of heart disease in primary care. A third-wave PMS now employs salaried GPs.

Commissioning

The PCT has recently taken over management of two community hospitals, and plans to develop intermediate care services there. The drugs misuse service (provided partly by the voluntary sector organisation) has been re-organised so that GPs can now refer to a named worker. A chest pain clinic has opened.

Health promotion

A health promotion officer has been devolved to the PCT by the health authority, and is working with a schools education programme. The PCT supports the Healthy Heart campaign run by the district council, and health promotion money has funded training for instructors in cardiac rehabilitation. The social services department is piloting a seated exercise programme, and practices have been offered training in falls prevention. The PCT has improved uptake of breast screening in some deprived wards, and a Sure Start initiative is underway. Smoking cessation clinics are available, and a study of the health impact of domestic violence is being carried out.

Public involvement

Board meetings are well attended by members of the public, whose questions are encouraged, and the chief executive offers a regular 'surgery' for the public. The PCT participates in the MORI poll commissioned by the district council, and is keen to use effective PR to communicate its purpose and achievements to the public.

Community development

The PCT made links with the voluntary sector at an early stage, and has, jointly with social services, revised the process whereby voluntary sector organisations can bid for grants from both health and social services budgets. The PCT helped to fund the bidding process for a Healthy Living Centre.

Health inequalities

The PCT's strategy is to arrange more local access to services (e.g. the chest pain clinic) as there is no acute hospital locally; and to target health promotion initiatives on the most deprived wards (e.g. the Healthy Living Centre).

Contexts for health improvement

The PCT

The PCT has an explicit commitment to health improvement as the driver of all of its activity. Practices are a little more engaged now than at the outset, and are all represented on working groups, despite the stresses created by a shortage of GPs and serious recruitment problems. The small management team is very stretched. Becoming a PCT required a lot of work and attention both prior to April 2000 and since. Regional/national delays in appointing the full complement of non-executives were unhelpful, and it took the organisation longer than expected to learn how best to educate non-executives about how the NHS works. The board's requirements for very regular and detailed reporting has required a great deal of work by officers. The PCT is underfunded relative to weighted capitation; the health authority is moving towards target by gradual increases in the PCT's budget.

Local and national contexts

Locally, some departments of the district council are seen as committed to health promotion, although like the PCT, the council is financially constrained. Although the county council seems very distant, a partnerships co-ordinator in the social services department facilitates joint working (e.g. Healthy Living Centre, Sure Start, community safety). The health authority offers limited practical and infrastructural support, although the contribution from the public health department is valued, particularly as a result of successful bids for funding (chest pain clinic, health impact assessment, the CHD collaborative). Performance management is seen by the PCT as an unilluminating 'tick-box' exercise. Parts of the health authority and the local trusts are thought not yet to have recognised the PCT's status and independence. Progress in developing mental health services has been slowed by the need to plan the reconfiguration of the mental health trust, while the acute trust has appeared to be reluctant to relinquish responsibilities for the community hospitals or to provide practice-based data.

Implementing change

A number of processes and mechanisms have proved helpful to the PCT in focusing its health improvement work:

- the Healthy Living Centre application, stimulating local partnerships and targeting deprivation
- the 'CHD collaborative', providing impetus, support and finance
- the partnership co-ordinator, facilitating inter-agency working
- a health promotion officer, devolved to the PCT by the health authority.

Site 3

This PCG became one of three localities in a primary care trust on 1 April 2000. The PCT is co-terminous with a London borough. The locality has a mainly prosperous population of 94,000, with higher than average numbers of older people.

What health improvement activity is being undertaken?

Unlike the other two localities in the PCT, this one has a health improvement sub-group, which includes the nurse and lay board members, a community pharmacist, a community physiotherapist, and a social services representative. It has not been possible to recruit a GP member; perhaps a symptom of the difficulty this site has had in focusing on health improvement.

Primary care development

The locality is leading on coronary heart disease for the whole PCT. It is improving software to collect data in accordance with the National Service Framework. At a locality level, some GPs are training as specialists, and the locality is taking part in a quality team development project with the Royal College of General Practitioners.

Commissioning

The locality is actively involved in plans across the district to improve intermediate care; locally, it is reviewing the use of a community hospital and its site. There are severe problems in recruiting nurses, and it has not been possible to appoint nurse consultants in intermediate care, as planned.

Health promotion

A project to prevent falls in older people is being developed; assessment forms have been devised, and training is planned for NHS staff and exercise instructors. The local authority-led joint health promotion service is providing smoking cessation services, exercise on prescription schemes, healthy pubs projects, etc. across the district.

Public participation

The Community Health Council set up a strong and effective public panel which comments on the locality executive group's agenda and activity, sometimes controversially.

Community development

No community development work was reported, other than a community self-help dimension to the falls project.

Health inequalities

The locality is seeking to improve access to family planning, particularly for teenagers, in a relatively deprived and geographically isolated part of the locality.

Contexts for health improvement

The locality

The appointment of a new chief officer for the locality has resulted in a better-organised management team and a better-functioning locality executive group.

It is as yet unclear what the appropriate relationship between locality executive group and the trust board is; there are perceptions that the locality executives are 'semi-detached' from the board, or else just rubber-stamping decisions already taken. However, the admittedly expensive three-localities arrangement provides an infrastructure which enables the large workload to be tackled. GPs work to a 'medical model', and show little interest in a broader health perspective.

Local and national contexts

The district HImP is widely perceived as too 'upstream', not related to the activity and interest of local practitioners, who as a result tend to be somewhat disengaged. A few see the HImP as clearly complementing the NSFs and the NHS Plan; others see it as distinct from and less important than these.

The health authority has delegated many of its roles to the PCT, and shares its chief executive and finance director with a neighbouring health authority. It retains public health and strategic functions. Effective performance monitoring is not yet developed.

Problems in obtaining data from the public health department were not reported, unlike in other sites, but opportunities for public health input into strategic work at PCT and locality level could be greater. At present, a consultant is only an observer on the PCT board, while other public health staff attend as members of the public, and there is no regular presence at locality level.

The local authority has recently been re-structured, and there has been considerable discontinuity among senior staff: not all new positions are yet filled. Nevertheless, at a senior level, the health economy and the local authority are forging close strategic links to work together to promote health, and to move quickly towards Care Trust status, although this relationship is not yet apparent at operational level. Severe financial problems in the health economy are now rectified, but persist for the local authority.

Implementing change

In general:

- A 'buddy' system links each executive group GP with two practices to encourage participation, although GPs are slow to engage actively with locality work.
- Efforts have been made to improve the quality and usefulness of primary care and community nursing data.

In relation to health improvement:

- A public health specialist has recently begun an informal network of practitioners who see themselves as public health workers, which meets regularly to share ideas and experiences.
- The HImP sub-group has no budget and lacks administrative support. Apart from for one short period, no GP has sat on the HImP sub-group, nor the sub-group working on the falls programme. The HImP sub-group is to merge with those of the other localities, which it is believed may be more suitable, since so much health improvement activity is determined at national and district rather than locality level.

Site 4

This PCG became a PCT in April 2001, as did each of the other three PCGs in the same city. It serves a mainly very prosperous population of 120,000, although there are pockets of significant deprivation.

What health improvement activity is being undertaken?

The health improvement sub-group has now merged with those for clinical governance and education and training.

Primary care development

Practices are improving their capacity to monitor and manage CHD in their patient populations, and developing practice-based cardiac rehabilitation. The re-configuration of fundholding services (physiotherapy, counselling and chiropody) is working well. A project is exploring how to improve PC support to patients living in nursing homes. Significant progress has been made in cost-effective prescribing. Practices have taken part in a Health Quality Service programme.

Commissioning

The four PCOs in the city work closely together on the commissioning agenda; site 4 leads for the city on intermediate care. An integrated care pathway for stroke (which has high incidence in the PCT population) provides a single point of access and is improving consistency in secondary care. A drugs worker has been part-funded (jointly with the police) to work on an outlying estate poorly served by existing drugs services.

Health promotion

Practices and community nurses are delivering expanded smoking cessation services. A designated public health visitor has developed an information 'roadshow' to support parents ('Surviving Teenagers') under the Healthy Schools Initiative. The PCO leads on a Sure Start initiative in a deprived area straddling three PCOs.

Public involvement

Public board meetings of the PCG were very well attended, and members of the public were invited to contribute after each agenda item. Members of the public sit on some working groups. The PCG set up an active community participation group which has developed guidelines for public involvement (confidentiality, reimbursement, etc.), and the lay board member has many links with community organisations in one neighbourhood, where the PCG has participated in community

festivals. There were attempts to set up a patients' forum, but this lost impetus when the PCG became preoccupied with the move to PCT. The city council runs area panels, three of which relate to the PCT, although their value as a consultative mechanism was questioned.

Community development

The PCO is leading an advocacy project for minority ethnic women, and a Healthy Living Centre bid, both in the deprived area covered by three PCOs.

Health inequalities

From the outset, the PCG sought ways to address the needs of its deprived patients within what is generally a very prosperous population, and this commitment underpins its leadership of the projects mentioned above. The inequitable legacy of fundholding was tackled immediately.

Contexts for health improvement

The PCO

Although overall levels of GP engagement in the organisation are disappointing, GPs and nurses value clinical governance support and protected learning sessions: the latter are open to and attended by administrative and clerical as well as clinical staff. The chair's leadership is admired, and organisational development (OD) input to the board from a public health consultant in the first year was valued. The management team has increased in size, although it was difficult to substitute for the health improvement manager when she was on maternity leave, and there is no administrative support for community participation work. Local practices are very successful businesses under GMS, and consequently very resistant to the idea of PMS, which troubles PCT managers mindful of the requirements of future 'green light' status. Development money was eroded by prescribing costs in the first year, when generic drugs' prices rose sharply, and one GP's prescription costs continue to be particularly high: these have eroded Modernisation Fund money. The move to PCT preoccupied the chair and chief officer, and reduced the regular contact they had intended to have with practices.

Local and national contexts

The PCOs in the city work closely together, thereby increasing their 'muscle', for example in negotiating the Service and Financial Framework with the newly merged and very large acute trust. There is an HAZ in the city, but none of its target areas are within site 4, although there are city-wide projects from which the PCT benefits (for example, the HAZ has funded some work on the Healthy Living Centre bid, and intends to fund an elderly care intensive squad). The health economy as a whole, and the PCO in particular, are well-funded in comparison to weighted capitation targets, and therefore do not receive much growth money. Performance management by the health authority is based on a tick-box model (nearly 200 performance measures) which includes a series of very specific indicators rather than a problem-solving/supportive model. There are good links with the social services department, which has restructured most services to reflect PCT boundaries, although the city council's area panels' boundaries are not co-terminous. The pace and size of the centrally-determined agenda of 'must-dos' continue to be experienced as excessive.

Implementing change

- There is good access to detailed information contained on health authority databases.
- Co-operation between the PCTs releases management resource by avoiding duplicated effort.
- Health promotion staff have been transferred from the health authority to the PCT.
- Close links between the lay and nurse members of the PCG board with community organisations in a deprived area support attempts to address health inequalities.

Site 5

The PCG became a PCT in October 2000, together with the other three PCGs in the city. It has a population of about 91,000, with a mixture of affluent and deprived areas.

What health improvement activity is being undertaken?

There is no health improvement sub-group; the health improvement agenda is driven by clinical governance and Health Action Zone-funded activity.

Primary care development

Major themes include: improving coronary heart disease registers and routine management; the continued development of GP specialists, substituting for out-patients clinics; a large cohort of third-wave PMS pilots; and a number of initiatives to accelerate patient access to primary care. The vision for the PCT is of 'a federation of networked teams', and a key objective is to build capacity, e.g. by means of protected learning and the 'Investors in People' scheme. Specific service innovations include cardiac rehabilitation and a drug dependency primary care nurse specialist.

Commissioning

The PCT has unusually short waiting times, a wide network of outreach clinics, and a number of schemes whereby practices book out-patient hospital appointments directly. It is containing its expenditure on hospital services. A city-wide scheme allows High Street opticians to refer cataract cases directly to hospital services.

Health promotion

The Health Action Zone funds a number of city-wide developments (e.g. smoking cessation services), as well as local projects (e.g. promoting young people's health, welfare benefits advice, etc.). There is a Sure Start scheme for part of the PCT population. A health promotion worker has identified the health promotion contribution to all aspects of the PCT's business plan.

Public involvement

The HAZ funds a community development worker, and local schemes include a project to support carers in identifying their needs. There is a small budget for public participation projects, and a PCT group to support such activity. PMS contracts include public involvement targets.

Community development

There are two Healthy Living Centre bids in progress in the area, and the PCT has funded a short-term post to contribute to the application process. The PCT has used HAZ money to fund volunteer handyman and gardening schemes to assist older people living at home, and has provided health promotion exhibits and information at a community festival.

Health inequalities

PMS is being used to enhance primary care resources where these are perceived to be fewer. Mental health out-patient appointments, formerly available only at one end of the PCT, are now offered in an additional setting much more accessible to a deprived section of the PCT population. Most GPs are making more use of the range of GP specialist and outreach clinics across the area, enhancing access for patients.

Contexts for health improvement

The PCO

The PCG has built on the strategy pursued locally by fundholding and total purchasing of developing specialist GP and outreach clinics. Individual GPs who originally championed this strategy have key roles in the PCO.

The move to PCT was labour-intensive and to a degree disruptive, and was particularly painful for PCG personnel who lost status by the change. The executive committee and the board are still negotiating roles and the correct distribution of operational and strategic work between the two groups. Some non-executive board members may not yet fully have appreciated their governance role. The new chief executive is admired for his strategic drive and the ability to engage 'hearts and minds'.

Local and national contexts

The health economy as a whole is receiving growth money, enabling a range of new work at city and PCT level. The four PCTs work well together, and there are good strategic links with the local authority, including social services, despite recent re-structurings. The health authority delegated budgets to PCGs at an early stage, and

continues to offer supportive leadership. However, the PCT does not yet feel that it receives the right level and sort of public health support. The size of the national agenda continues to be daunting.

Implementing change

A range of mechanisms is supporting the PCO's development: PMS, the Health Action Zone, Sure Start. Six practices are part of the national Primary Care Collaborative, which supports work in coronary heart disease, waiting lists and access to primary care; the PCT has used mechanisms of change management used in the Collaborative to spread learning across other practices. Other enabling factors include: the inheritance of fundholding and total purchasing, the availability of growth money, good cross-city joint working, dynamic leadership.

Site 6

In April 2001, this PCG merged with four others to become a large county-wide PCG, within which it has become one of three localities, together with a neighbouring ex-PCG. Its population was about 43,000, living in small towns and villages dispersed over a wide geographical area, and with an average list size of 1400 patients per GP.

What health improvement activity is being undertaken?

The health improvement sub-group is led by a health promotion specialist, with representatives of the district council, county council (education department) and the voluntary sector, as well as one GP and the lay board member.

Primary care development

No specific developments were reported, although there was county-wide activity, e.g. on coronary heart disease. Board members visited every practice to gain detailed baseline clinical governance information, and a health authority-funded community pharmacy adviser was working effectively with GPs to improve prescribing.

Commissioning

There was a commissioning consortium board made up of representatives of all five PCGs in the county and the health authority. Locally, a review of twilight community nursing found a need to improve access to out-of-hours palliative care when needed, and plans are now being made to meet this need.

Health promotion

A number of local activities were mentioned, although these were not initiatives in which the PCG had a role: Ageing Well, breakfast clubs in schools, and exercise on prescription (supported, for those living in isolated places, by voluntary transport networks).

Public involvement

The health improvement sub-group had drafted a communications and public involvement strategy, which was presented to the board just as the forthcoming merger was announced, since when it had been 'on hold'. Some practices have or are planning patient participation groups, and the lay member has linked with a wide variety of local groups and worked closely with the local Council for Voluntary Service (CVS).

Community development

One bid for a Healthy Living Centre has been successful, and another is in preparation, although the PCG has not had resources available to actively support these.

Health inequalities

The PCG's main inequalities concern has been differential access across the PCG because of the variety of hospitals used, and the long distances between some communities and NHS facilities.

Contexts for health improvement

The PCO

GPs felt that the original PCG configuration was imposed, and that it did not reflect actual communities or common interests. However, it has developed a strong sense of identity, partly due to a more inclusive leadership style after a change of chair for the second year. The small PCG was able to fund only a minimal infrastructure (board, chief officer, part-time secretary).

Local and national contexts

The local health economy is financially straitened, with little development money available for primary care. The health authority is regarded as somewhat autocratic, lacking an understanding of primary care, preoccupied with the acute sector, and taking a very 'medical model' view of health and health improvement. This PCG has, more than others, felt a lack of public health support.

Strong strategic links with the county and district councils were not reported, though there are some good personal and operational links.

The size and pace of the national agenda was felt to be overwhelming and unhelpful.

Implementing change

In general:

The PCG has been severely limited by its inadequate infrastructure, and also by the financial constraints of the district. It was uniquely articulate in expressing its dislike of the planned merger, the advent of which has inhibited planning and activity in the second year. The two parts of the relevant locality of the new PCG have hitherto worked very separately, and it is not clear that the former PCG will manage to maintain its identity and voice in the new PCG as it wants and intends to.

In relation to health improvement:

The health improvement sub-group has been proactively led by a health promotion specialist taking a cross-agency approach and adopting a social model of health not representative of the PCG as a whole. This approach, unique in the county, has

resulted in inter-organisational links much valued by those involved. The group intends to continue meeting, not least because the new PCG has no health improvement sub-group and interprets health improvement in terms of NSFs and the NHS Plan rather than anything broader.

Appendix 3. Personnel interviewed in the study

* = different person held this role in the second year; # = person had changed role by second year; + = same person has more than one role

Site	Chief officer	PCO officer	Chair (PCG board, PCT exec.)	PH	SSD	Nurse rep.	HP	DC	Lay rep.	GP (excl. chair)	Other
1: year 1	✓		✓	✓	✓	✓	✓	n/a			HA officer
year 2	✓	✓	✓	✓	✓	✓		n/a	✓	✓✓	
2: year 1		✓	✓	✓	✓	✓	✓	✓	✓#	✓✓	
year 2		✓	✓	✓	✓	✓		✓		✓	2 NEs (1#), LA
3: year 1		✓	✓	✓	(✓not bd. member)	✓	✓	n/a			HA non-exec., CHC, CVS;,physio
year 2		✓	✓	✓	✓	✓		n/a	✓	✓	physio
4: year 1	✓		✓	✓	✓	✓*		n/a	✓		HA, practice manager
year 2	✓		✓	✓	✓	✓*	✓	n/a	✓	✓	LA
5: year 1	✓*	✓	✓	✓	✓	✓		n/a	✓#	✓✓	LA
year 2	✓*	✓	✓+	✓	✓	✓+		n/a			PCT chair#, NE, community worker
6: year 1	✓*		✓*	✓*	✓		✓	✓	✓	✓#	CVS
year 2	✓*		✓*#	✓*	✓	✓	✓	✓	✓	✓	

Abbreviations:
PH = public health specialist
SSD = social services representative
HP = health promotion specialist
DC = district council representative
CHC = community health council representative
NE = non-executive director of PCT
LA = local authority officer
CVS = Council for Voluntary Service
HA = health authority

Appendix 4. Outputs from the research

Report

Abbott S, Florin D, Fulop N, Gillam S. *Primary Care Groups and Trusts: improving health. Interim report.* www.kingsfund.org.uk/primary_care, 2000.

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