Primary Care Groups and Trusts

Improving Health

Interim report, October 2000

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Executive summary

This report presents the findings from the first phase of a two-year research project comprising six case studies of how Primary Care Groups and Trusts (PCG/Ts) are carrying out their health improvement role. Specifically, its purpose is to record:

(a) the development of their health improvement role by the six sites in their first year

(b) the processes that have been adopted, particularly with respect to partnership working

(c) those aspects of PCG organisation and working thought likely to help or hinder progress.

Methods

Data was gathered by means of 54 face-to-face semi-structured interviews with key personnel from the PCG and its partner organisations, conducted between February and June 2000. There was a maximum of ten interviewees per site, including the chair, the chief officer (or health improvement manager), the social services board member, a health authority officer, and a public health specialist if not already included. Site selection was designed to capture the range and diversity of PCG/Ts. Criteria included: population size; PCG level and early PCT status aspiration; inclusion in a Health Action Zone (HAZ); urban and rural location.

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 been able to have 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.
- *Inequalities in health care:* withdrawing or widening access to services previously purchased by fund-holding practices; addressing deficits in access to care in parts of the community.
- *Health promotion initiatives:* smoking cessation; teenage contraception and advice; physical exercise for older people.
- *Community development:* linking with other community activity; supporting bids for healthy living centres; public involvement.

The following factors have influenced progress towards health improvement objectives:

- PCG/Ts have found it difficult to prioritise health improvement among the multiplicity of national and local priorities. Some PCG/Ts find it difficult to distinguish 'health improvement' activities from primary care development, clinical governance and commissioning.
- PCG/Ts have delayed employing management staff due to prescribing overspends and other resource constraints. Lack of development money has limited new work.
- The transition to PCT status is a large organisational burden that tends to overshadow other activities. All work not seen as a 'must-do' is vulnerable to neglect (e.g. the broader inter-agency work around health promotion and community development).
- Some boards have still to achieve cohesion and dynamism. Board members have worked hard to engage GPs throughout the PCG/Ts, but with only limited success. The legacy of fundholding has prompted PCGs to look at equitable access issues but, as a result, ex-fundholders feel that they and their patients are losers.

- The disruptive effects of rapid systems change are in evidence. PCG/Ts have had difficulty in building on previous strengths and experience, and in only one of the three sites where there was formerly a Total Purchasing Pilot has the energy and progress of the pilot been sustained and developed. In another case, previous commissioning consultation arrangements have lost impetus and focus.
- There are some committed 'product champions' for health improvement initiatives, often not GPs: they may be district council officers, health promotion personnel, lay board members, nurses, professions allied to medicine. In several sites, PCGs are making links with other agencies (e.g. voluntary sector, local government), some of which are very committed to health improvement work. Relationships with health authorities and public health departments are crucial but problematic in some sites, with a lack of clarity about roles and about relationships. There are different views of how district resources should be distributed, and whether these are adequate.
- Most of the PCG/Ts do not see themselves as representing 'actual communities', and are even less likely to do so as PCGs merge and PCTs are created. Larger scale organisations will have to work harder to recognise and be responsive to health needs and inequalities within their populations.

Recommendations

The following recommendations arise both from the data collected in this study and from other relevant work such as the National Tracker Survey (Wilkin *et al.* 2000) and the Evaluation of the Implementation of the Health of the Nation strategy (Fulop *et al.* 1998).

- NHS organisations locally and nationally need to recognise that PCG/Ts feel the number of national NHS priorities to be overwhelming and that they have insufficient management allowances and development money to pursue them.
- PCG/Ts need help to give more emphasis to health improvement. This may be achieved by integrating health improvement more closely with other functions, such as commissioning, rather than by attempting to undertake new work for which management and development resources are not available.

- Improving PCG/Ts performance in health improvement might best be done by regionally-led workshops or learning networks. This may be preferable to additional guidance from the NHS Executive, which might be perceived as yet another 'top-down' burden placed on already overloaded organisations. Such an approach would also foster collaboration between PCGs, would support local champions of health improvement, and could help to foster relationships between PCG/Ts and trusts, health authorities, local authorities, the voluntary sector and others.
- Health authorities and PCG/Ts need help in finding more effective ways of working together and using local resources such as public health and health promotion: again, regionally-led workshops or learning networks may be helpful.

1. Introduction to this report

This interim report presents the findings of the first phase of a two-year research project comprising six case studies of how Primary Care Groups and Trusts (PCG/Ts) are carrying out their health improvement role. Specifically, its purpose is to record:

(a) the development of their health improvement role by the six sites in their first year
(b) the processes that have been adopted, particularly with respect to partnership working
(c) those aspects of PCG organisation and working thought likely to help or hinder progress.

The second phase of the research will monitor progress in (a), and seek to explain this in the light of (b) and (c).

2. Aims and methods of the research

2.1 Aims

The aim of the research is to explore how six PCG/Ts 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 PCG/Ts?
- what health improvement priorities has each site chosen, and why?
- to what extent do these priorities address issues of population health and health inequalities?
- how are the PCG/Ts intending to pursue those objectives?
- are those intentions being fulfilled in reality?
- 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 PCG/Ts should do, but to indicate the range of perspectives and approaches that 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 PCG/Ts will be diverse
- that the 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 and organisational development, and the nature and development of relationships between them.

In addition, we have assumed that within and between case study sites, and within and between PCG/Ts and their partners, understandings of what health improvement is would be diverse.

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 PCG/Ts and health improvement.

First, the 'mechanisms' for health improvement are not distinct interventions, but complex, prolonged and iterative processes. As new organisations, PCGs have had to devise structures and processes for making strategic choices about what 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; and so on.

We have taken the view that the term 'mechanism' does not reflect adequately this complex process.

Second, the term 'outcome' is in this context problematic. Given that this is a study of health improvement, 'outcomes' should include population health outcomes, which, it is recognised, 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. However, 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 be unlikely to have statistical significance, nor could they be reliably attributed to specific efforts of PCG/Ts.

We have 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 as 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 PCG/T itself. Outer contextual factors are those relating to the local NHS (health authority, trusts, other PCGs or PCTs), and other agencies (local government, voluntary and community organisations), as well as the national economic, political and social context. (In the analysis of the second phase of data, we will draw on Pettigrew *et al.*'s concept of receptive and non-receptive contexts – that is, contexts receptive or not receptive to change and innovation – in examining which contextual factors appear to have facilitated health improvement work.)

'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.

Our analytic framework is thus:

content – context (inner and outer) – process

However, this model can be applied only *in part* at this first stage of the research. As processes are only just beginning, many of the activities with which the environment will interact are still being planned. Data that may later illuminate *processes* are therefore difficult to distinguish at this early stage from *contextual* data. For example, if existing joint working between health and social care agencies is thought very effective, this is a contextual factor influencing what joint work is attempted by a PCG; whether or not effective joint working is also a processual factor will depend on whether or not it is sustained in the future, and whether PCG activity continues to draw on it. The processual factors identified in this phase of the research are therefore conjectural, and not clearly distinguishable from contextual factors. Contextual and processual factors are presented separately here: conjectures about processual factors will be tested in the next round of interviews.

2.4 Methods

The research consists of two phases, the first of which is reported here. The chief method of gathering data was a round of face-to-face interviews with key personnel from each PCG and its partner organisations, conducted between February and June 2000. Those interviewed included:

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

These interviewees were asked to suggest additional personnel who were involved in the PCG's health improvement strategy. A maximum of ten people per site were interviewed.

The interviews were semi-structured, based on the following topic guide (although adapted to some extent depending on the role, profession and employing organisation of the interviewee):

1. What do you understand by the phrase 'health improvement'?
2. How were this PCG's health improvement priorities decided?
3. How are the PCG's health improvement priorities being tackled?
4. What problems do you anticipate in implementing your plans? What external and internal factors will help or hinder?
5. What actions is the PCG taking to address inequalities in health, and how do these relate to other local activity?

It was anticipated that question 5 would usually have been already answered in the interview, but was included as a check to ensure that data relevant to this topic was not missed. A number of prompts were also included: the complete schedule appears in Appendix 1.

In addition to the interviews, relevant documentation was obtained from the sites (e.g. the local health authority Health Improvement Programme (HImP), the PCG/T's

Primary Care Investment Programme or its own health improvement plan), in order to be able to confirm and clarify interview data.

As already explained, many of the outcomes from health improvement activities are likely to be evident only after time. We have therefore not included quantitative data about inputs, outputs and/or outcomes.

The next round of data-gathering will:

- gather data on the progress of health improvement strategies, plans and activities identified here (including, if appropriate, quantitative data)
- distinguish the content, context (inner and outer) and process of health improvement activity
- test the hypotheses voiced by informants in the first round about helps and hindrances
- seek explanations for why particular factors and their interactions over time were helpful or unhelpful.

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 time frame 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.

We chose sites according to criteria designed to capture some of the range and diversity of PCG/Ts:

- 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 PCG and aspiration to early PCT status

- inclusion in a Health Action Zone (HAZ) (using the HAZ as a proxy for poverty: it is recognised that there are substantial differences in health issues in affluent and deprived areas (*Saving Lives: Our Healthier Nation*, 1999))
- both urban and rural PCGs.

We also aimed at a geographical range. (The north-east and south-west regions were excluded for pragmatic reasons in order to reduce travelling time and costs.) This does not guarantee variety of PCG 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 rather than a narrow range of health improvement activity.

2.6 Data analysis

Data has been analysed as set out in Table 2.1, 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 Pettigrew *et al.*'s framework: the method used is explained in detail below (Section 3.3).

Table 2.1: 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

3.1 *Structure of this section*

The structure of this section is as follows:

- who was interviewed?
- what is meant by 'health improvement'? (question 1)
- how were health improvement priorities decided? (question 2)
- how are health improvement priorities being tackled? (question 3)
- what is likely to help and what will hinder progress? (question 4).

As expected, answers to question 5, concerning local activity to address inequalities in health, often repeated or referred back to answers to questions 2–4, and have therefore been presented together.

3.2 *Who was interviewed?*

Fifty-four interviews were carried out with PCG and associated personnel, as illustrated in table 3.1. As already outlined, we attempted to ensure that at each site interviews were conducted with the chair, the chief officer (or the health improvement manager), the social services board member, a health authority officer liaising with the PCG, and, where this person was not a member of the public health department, a public health specialist. This was achieved in every case except one: site 3 had had no consistent representation from social services on the PCG board, and the social services representative interviewed was a member of the health improvement sub-group but not of the board.

Table 3.1: Personnel interviewed in the study

Site	CO or HI lead	Chair	HA	PH	SSD	Nurse	HP	vol. sec.	Lead on specific priority area	DC	lay rep.	CHC	other
1	✓	✓	✓	✓	✓	✓	✓						
2	✓	✓	✓		✓	✓	✓		✓✓(GPs)	✓	✓		
3	✓	✓	✓		✓	✓	✓	✓	✓			✓	✓(HA non-exec)
4	✓	✓	✓	✓	✓	✓					✓		✓(PM)
5	✓✓	✓	✓		✓	✓			✓✓(GPs)		✓		✓(LA)
6	✓	✓	✓		✓		✓	✓		✓	✓		✓(GP)

Abbreviations:

CO = chief officer of PCG
HI = health improvement
HA = health authority link person
PH = public health specialist
SSD = social services representative
HP = health promotion specialist

vol. sec. = voluntary sector
DC = district council representative
CHC = community health council representative
PM = practice manager
LA = local authority officer

A description of the six sites appears in Appendix 2.

3.3 What is meant by 'health improvement'?

The original guidance on PCGs (DoH, 1998) 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 that is neither provided nor commissioned, and therefore *outside* the scope of the NHS 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 HImPs that health authorities were to draw up, the White Paper offered a definition of the concept 'health improvement' that *includes* core NHS activity:

- 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.

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.

Given the variety of meanings evident in government documents, we anticipated that there would be a variety of understandings of health improvement among our interviewees. We therefore asked every respondent: 'What do you understand by the phrase "health improvement"?'.

In all but two cases, the question was asked at the very beginning of the interview. This was to ensure that the interviewee was not in any way influenced by interpretations or beliefs implicit in the phrasing of later questions. In the two exceptional cases, the interviewee had already begun talking informally about interview topics prior to the formal start of the interview; the tape recorder was therefore switched on at that point, and the interviewee was asked to define health improvement later in the interview.

The transcribed data were coded according to a large number of emerging categories, which were then aggregated into eight key concepts:

- a **broad definition** of health ('health in its broadest sense, a holistic view of health')
- a **population health** approach
- individual **well-being**: wellness; quality of life; emotional, spiritual, psychological and social well-being
- **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
- **health promotion** and health education: lifestyle advice; individuals' responsibility for their own health

- **partnership** working
- **NHS** core activity: primary care, commissioning, improving quality, improving access, strategy and prioritisation
- health outcome **targets**: *Saving Lives: Our Healthier Nation* targets, reductions in morbidity and mortality.

Data were then re-analysed using these codes. No code was used more than once for any one interview.

These concepts of course overlap, but they reflect the choices made by respondents, who often chose not to explore the links between concepts. Where one concept was explicitly used to amplify another, only the amplification was coded; e.g. *'Health improvement is broad – it's more about poverty than prescribing'* would be coded as 'root causes of ill health' but not as 'a broad definition of health'. Where informants distinguished two separate concepts but linked them, both concepts would be coded, e.g. *'It's about population health rather than individual health; and it's therefore also about looking at poverty, housing, employment and so on.'*

Typically, informants did not take a simple view of health improvement, and used two or three of these concepts to explain their understanding of health improvement. Public health specialists included noticeably more, unsurprisingly since they are likely to have given prolonged thought to their own understanding of public health and health improvement issues.

The frequency with which each of these concepts was mentioned was as follows (in descending order of frequency):

the NHS (just under half of all informants mentioned this)
root causes of ill health
a broad definition of health
health promotion
a population health approach
individual well-being

partnership (just under a quarter of all informants)
health outcome targets

There was little consensus in the replies: for example, none of the concepts was mentioned by half or more informants. Although most believed that health improvement had a number of components, there was no sense that these different components could 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 the different shades of meaning could be combined to create a single working definition.

If data from PCG board members and staff are compared with those from other informants, it is noticeable that PCG personnel were more likely than others to mention NHS activity, and less likely to mention the root causes of ill-health or partnership. These findings can only be taken as suggestive and not conclusive, but they imply that PCGs are focused primarily on NHS activity, a finding that is not surprising.

We looked for differences between different PCG/Ts, including data from board members and employees only. Given the small number of interviewees, we did not expect that any such differences would be conclusive, and found that generally they were not. In two cases, however, clear differences in these data are borne out elsewhere (see Appendix 2). Site 1 PCG 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 PCG chose a disease focus, building on existing health authority work on clinical effectiveness. Site 2 PCG 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.

3.4 How were health improvement priorities decided?

All the sites described a very similar content, context and process for deciding health improvement priorities.

As regards content, it had been intended by the relevant health authority that each PCG should establish its own local priorities, selecting from and perhaps adding to the district HImP priorities in the light of what was already known about local needs. In most cases, the PCGs consulted local health professionals and voluntary/community organisations.

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, emergency services, and so on. Locally, these priorities had been embodied by most health authorities in their HImPs (Abbott and Gillam, 2000), which were universally regarded as contextual factors that had been very influential, even constraining, on PCGs making their own health improvement plans. The inner context was that, while health authority HImPs were being drawn up, PCGs existed only in shadow form, and were therefore pre-organisations with no infrastructure.

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, although some PCGs nevertheless regretted how little input they had had. (The national tracker survey of PCGs has recorded that PCGs generally felt that their input to HImPs had been limited (Wilkin *et al.* 2000).) Shadow PCGs, 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 choosing a small number of local priorities out of a large number of district ones had been a less thoughtful exercise than was desirable, and indeed, the original priorities had been changed during the first year in two cases.

Overall, most informants held the view that there had been little opportunity to make local priorities genuinely local; partly this was because of time constraints, precluding the possibility of thorough consultation, and partly because the number of national priorities was already so large that there was little chance of including priorities of local concern that 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 is a feeling that, well, if you try to do everything then you won't achieve anything.* (nurse board member)

It was also acknowledged that expertise in public consultation was lacking in PCG/Ts, and that much of such activity had been ad hoc rather than underpinned by a public consultation strategy (this confirms other research evidence (Anderson and Florin, 2000; Edwards, 2000)).

3.5 How are health improvement priorities being tackled?

This section outlines the health improvement priorities chosen by sites, and the activities they are undertaking or planning to undertake to pursue those priorities; in other words, content factors, the 'what' of change.

Data presented here reflect the perceptions reported by informants, and may therefore not be exhaustive or complete. Data from one interview that appear to be inconsistent with data from others have not been included, unless documentary evidence could provide clarification (e.g. Primary Care Investment Plans, or the health improvement plans of PCG/Ts).

No clear distinction is made at this stage between activities that are already underway and activities that are being planned because, as already pointed out, the development of health improvement work programmes is a complex iterative process (gathering views and information, defining priorities, determining methods and finding resources for pursuing those priorities and implementing these methods). It would not be reasonable to expect each PCG/T to have a fully developed health improvement work plan being implemented after approximately one year. The distinction between actual and planned activity will be much more important in the second year's analysis and report. It is also important to note that PCG/Ts have sometimes built on existing activity, and that existing initiatives pre-dating the formation of PCG/Ts may have been included if the PCG/T plans to support and expand such work.

The content (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
- inequalities in health care
- health promotion initiatives
- community development.

Initiatives to address inequalities in health (as distinct from inequalities in health care) are to be found in all of the above.

In each of those categories, the sites reported a range of activities and/or plans, and these are summarised below. Each PCG/T was of course tackling only a proportion of such work.

Primary care development

- 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)
- auditing existing practice (e.g. spirometry equipment and skills, how checks on patients aged 75 and over are carried out, primary health care team (PHCT) learning needs in mental health)
- health needs assessment (e.g. collecting data on falls among older people, numbers of smokers in practices, carers' needs)
- providing new or extended services (e.g. nicotine replacement therapy, a falls prevention programme, appropriate primary care to nursing home residents, anti-coagulation clinics in primary care).

Commissioning

- improving existing services (e.g. optimising use of community hospitals to maintain services and improve access, providing appropriate specialist services to nursing home residents, practice management of hospital waiting lists)
- developing new services (e.g. intermediate care, voluntary sector handyman scheme)
- assessing need for service developments (collecting data on falls, exploring needs and options for out-of-hours community nursing, access to cardiac rehabilitation, specialist nursing).

Inequalities in health care

- managing the fundholding legacy: withdrawing or widening access to services (e.g. physiotherapy, counselling, chiropody, dietetics, benefits advice, ultrasound, phlebotomy, outreach clinics)
- addressing deficits in access to care (e.g. providing dentistry on an estate where none exists, improving access to rehabilitation and mental health out-patient services in one part of the PCG).

Health promotion initiatives

- smoking cessation clinics (particularly in deprived neighbourhoods)
- sex education and contraceptive services for teenagers
- advice services to young people in deprived areas
- improving breast cancer screening uptake
- physical exercise programmes for older people
- a healthy workplace scheme.

Community development

- employing community development staff
- health advocacy (e.g. for Asian women)
- supporting bids for healthy living centres
- linking with other community activity (e.g. transport initiatives, voluntary sector)

- public involvement (e.g. public consultation on the PCG's priorities, developing public involvement and information strategy, a poll on health issues, a public panel that discusses PCG board meeting agendas).

There are some fairly clear differences between the approaches that different sites have taken. For example, sites 1 and 5 have chosen already existing local NHS activity on clinical effectiveness as a driver for health improvement, while sites 2 and 4 are emphasising the importance of community development work in their plans. Sites 3 and 6 have found it harder to establish a health improvement strategy, although some progress is being made. Individual site descriptions providing more detail appear in Appendix 2.

It was not self-evident to respondents what the balance of activities should be, either because of the sheer range of PCG responsibilities, or because of different views about what should take precedence.

> *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 PCG time and energy are at risk of being drawn into managing the traditional machine* [i.e. acute hospitals]. (chief officer)

> *Where some of the PCGs get particularly excited is looking at some of the issues around secondary care services. And we find ourselves saying, 'Primary care is hugely important, this should be your focus.'* (health authority officer)

3.6 What is likely to help and what will hinder progress?

In this first phase of the research, 'progress' is taken to mean simply the implementation (partial or complete) of plans made, or the development and amplification of plans begun. No judgements have been made about the appropriateness or achievability of plans. Factors which hinder progress are those that appear to impede implementation; factors that help are those facilitating implementation.

Many of the factors recorded below have already been identified by other research as being of relevance to PCG 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. This report can therefore confirm those findings.

3.6.1 The outer context

There was virtual unanimity in emphasising that the new primary care organisations face a very taxing agenda, the totality of which represents a hindrance to progress. The need to pursue simultaneously such a range of objectives makes it harder to pursue a single set of objectives such as those relating to health improvement.

> *We've not really as a PCG been able to think big enough about our health improvement agenda ... because we inevitably are focused much more on getting the immediate business sorted. It all seems a bit much, really.* (social services board member)

The components of this agenda regarded as particularly challenging are:

- the large number of central NHS priorities and targets
- the speed with which formerly disparate practices have had to attempt to become complex and cohesive organisations
- what was widely seen as the Government's expectation of a rapid pace of change, particularly as regards progress towards PCT status.

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

Other outer context factors were as follows. It will be noticed that more potential hindrances than helps were identified. Factors expected to help appear in **bold type**.

Relationships within the local NHS

Sites were actively collaborating with neighbouring PCGs, and/or planning to become PCTs at the same time as neighbours. Such collaborations should empower PCG/Ts and minimise disruption to the local health system. A few observers commented on competitiveness between PCGs, although opinions varied as to whether or not this was helpful. Where sites serving predominantly prosperous populations are situated in districts with mainly more deprived populations, it is harder to identify shared interests, while there are also different views about equitable resource allocation. One prosperous PCG situated in a Health Action Zone (HAZ) receives no HAZ money, for example, whereas its neighbours all do. Another is under-funded relative to the rest of the district, and three appear to be over-funded: two of these also report ongoing debates about identifying the most appropriate funding formula, believing that that currently used disadvantages them unfairly. In site 6, there seemed to be a reluctance to collaborate: dispersed small rural communities found it very difficult to identify with each other, even at the level of small PCGs.

Two sites reported good clinician relationships in the local NHS. Some acute services managers were regarded as intransigent, however, particularly in defending levels of funding that PCGs thought inappropriate.

Some reported good relationships with health authorities, and were using health authority information (health needs assessment data, clinical guidelines) as the basis for health improvement work. Others found their health authority distant and less helpful. There were concerns that health authorities were not making their expertise sufficiently available to PCGs (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 defensive and controlling behaviour. PCGs and health authorities appeared to have different understandings of what public health support PCGs could and should expect (data, skills, health promotion). Some health authority informants believe that PCGs' views of what was available and useful at small area level were sometimes unrealistic.

> *This concept of public health as a handle that you turn to produce a number ... [one PCG 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)

There were similar issues with health promotion services: some PCG/Ts wished to manage them themselves, while health authority personnel tended to think that PCGs misunderstood the purpose of the service:

> *[We tell PCGs that health promotion is] there not to fish for you but to teach you and the public how to fish.* (director of public health)

There was no evidence that informants could envisage the future role of health authorities with any clarity. However, it was clear that 'getting free of health authorities' is a strong motive for PCGs to become PCTs (a finding confirmed in the National Tracker Survey (Wilkin *et al.* 2000)).

Other local relationships

The two PCGs situated within a two-tier system of local government reported that their district councils were sympathetic to (and in one case already active in) a community development approach to health-related issues. However, the county councils were perceived as rather distant, and unresponsive to local issues, although **individual officers had been of great value to the PCG board.**

Re-organisation of the local social services department had hindered some PCGs' attempts at joint working:

> *The problems that social services have been experiencing internally have not enabled them to establish inter-agency working.* (nurse board member)

However, **in three cases, PCGs were making use of local authority mechanisms for public involvement (local neighbourhood action groups, and a public survey panel).**

Some PCGs had already established good working links with local voluntary sector organisations; however, a few respondents commented on duplication among such organisations, and another mentioned the difficulty some had in understanding the nature and purpose of PCGs. Affluent and articulate middle-class lobbying groups needed to be handled with considerable sophistication if PCGs 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.*

3.6.2 The inner context

Previous primary care organisations

The sites reported little history of primary care collaborations across localities. In one, there had previously been a county-wide commissioning forum through which interested GPs had felt able to exert some influence; arrangements for PCGs to discuss commissioning with the health authority seemed to informants to be weaker.

All but one PCG included practices that had previously been fundholders, and were therefore faced with the problem of finding an equitable way of dealing with the differential services that had resulted from fundholding. All sites reported the difficulties of handling this issue, and some had progressed slowly, wary of risking the hostility of fundholding GPs and their patients, whose experience of PCGs, where the problem had already been tackled, was of fewer services rather than of more or better.

> *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, although only **in one case the energy and expertise thus acquired appeared to be driving forward the PCG agenda** (in this case, a significant overspend had also been inherited). **At this site, a number of other organisational arrangements were helping to progress the health improvement agenda: a local Promoting Action on Clinical Effectiveness**

network, for example, predated the PCG, and some practices were taking part in a new government initiative as a primary care collaborative, aiming to bring about swift improvements in ischaemic heart disease, waiting lists and times, and access to primary care.

The PCG

Some boards were reported to have won general esteem locally. Factors often mentioned in this context were fairness, inclusivity, openness, and sensible decisions. Others had not yet achieved cohesion, and there appeared to be leadership issues within two boards. In a minority of sites, evidence suggests that the boards had yet to make a commitment to key components of health improvement work such as partnership working and community participation. There were reports from several sites, however, that membership of the board did not guarantee a commitment to health improvement.

> *The nurse members of PCG 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)

Most sites reported delays in recruiting a full team of PCG managers, often because of significant prescribing overspends during 1999.

> *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)

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 HAZs, because that's attracted the extra resources, where you can pilot some of the innovative programmes.* (PCG manager)

Certainly, the only one of our sites to report development money had received these funds from its HAZ. Bidding for healthy living centre funding is one way of trying to obtain development money.

Generally, it was thought that most non-board member GPs had not yet properly engaged with the PCGs and their work.

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

However, most sites reported a gradual increase in GP participation, for example in specific PCG sub-groups. In one PCG, there was also a GP advisory group, open to all GPs, to link the GPs and the board more closely.

The leaders of the health improvement agenda were GPs in two sites. Elsewhere, nurses, health promotion officers and a community physiotherapist had played important roles in leading this agenda. However, such a role was demanding and could be isolated:

> *[The champion] is a bit of a voice crying in the wilderness.* (health authority officer)

Such champions, of whatever profession, did not usually feel supported by GPs within the PCG; **voluntary sector or local government personnel were often regarded as more helpful allies. Four sites have health improvement sub-groups: in one case, this is combined with clinical governance and training and education.** However, some thought that the lack of GP support at board level might be a barrier to progress. Although all the sites in this study serve relatively prosperous populations, all acknowledged

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

Such pockets pose problems of equity within PCGs that, in the absence of increased funding, cannot be addressed without 'robbing Peter to pay Paul'. Even where areas of deprivation were small and not severe, there were other factors preventing cohesion:

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

However, one public health director had had some success in explaining to affluent members of the public the justification for targeting future district development money on poorer areas in other PCGs.

3.6.3 Process

As previously pointed out, this section deals primarily with *anticipated* process factors, since so much of the work was only just beginning at the time of the interviews. All of the contextual factors already identified and reported above were thought likely to be continuing processual factors.

A key process issue, experienced or anticipated by all of the sites, was the progress to PCT status. One PCG reported that becoming a PCT had had a mixed impact on the PCG'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 PCG/T business, which would ultimately benefit health improvement.** In the case of site 3, relatively little distraction had been experienced by the PCG as **the health authority had set up a project team to manage the application and transition on behalf of the three PCGs**, although this had naturally involved some work by the chair and chief officer.

The other sites anticipated considerable distraction and disruption as they prepared for PCT status. In two cases, this would also involve mergers with neighbouring PCGs, and in one of these there were fears that, if four PCGs merged into one PCT (the most likely option at the time of the interviews), the loss of local focus would discourage participation by stakeholders.

Other anticipated process factors also involved 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, a radical re-structuring of the local council. Such re-configurations might result in a sort of ‘planning blight’:

> *If you have a transient organisation, its 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)

4. Key messages

What early learning can be derived from these research findings? A number of key issues can be identified. All of these are perhaps different facets of a single major theme: it is proving very difficult to effectively establish health improvement as a priority for PCG/Ts. This is illustrated in a number of ways in the more detailed points that follow.

It is difficult for PCG/Ts to distinguish 'health improvement' from primary care development, clinical governance and commissioning. There is a risk that health improvement is 'everyone's problem and nobody's baby'. Many respondents spoke of the difficulty for PCG/Ts in giving health improvement due weight among the multiplicity of national and local priorities.

As ever, the allocation of resources is an important issue. Because of prescribing overspends last year, PCG/Ts have had to delay employing staff, and the resulting lack of management resources means that a lot of PCG work is done on 'borrowed time'. Lack of development money makes it hard to begin new work (a perennial issue in population health work: see for example Fulop *et al.* 1998). In addition, the transition to PCT status is a large organisational burden that tends to overshadow other activities. All work not seen as a 'must-do' is therefore vulnerable to neglect (e.g. the broader inter-agency work around health promotion and community development).

Organisational and corporacy issues are prominent. Some boards have still to achieve cohesion and dynamism, and though board members work hard to engage GPs throughout the PCG/Ts, success thus far has been limited. The legacy of fundholding has prompted PCGs to look at equitable access issues, but as a result, ex-fundholders feel that they and their patients are losers.

The disruptive effects of rapid systems change are in evidence. PCG/Ts have had difficulty in building on previous strengths and experience, and in only one of the three sites where there was formerly a total purchasing pilot has the energy and progress of the pilot been sustained and developed. In another case, previous commissioning consultation arrangements have lost impetus and focus.

There are some committed 'product champions' for health improvement initiatives, though these are typically not GPs: they may be district council officers, health promotion personnel, lay board members, nurses, or members of other professions allied to medicine. In several sites, PCGs are making links with other agencies (e.g. voluntary sector, local government), some of which are very committed to health improvement work. Relationships with health authorities and public health departments are problematic in some sites, with a lack of clarity about roles and about relationships with PCG/Ts. There are different views of how district resources should be distributed and delegated, and whether these are adequate.

Most of the PCG/Ts do not see themselves as representing 'actual communities' (Secretary of State for Health, 1997), and are even less likely to do so as PCGs merge and PCTs are created. Larger-scale organisations will have to work harder to recognise and be responsive to health needs and inequalities within their populations. All parts of the NHS need to recognise that PCG/Ts cannot be taken as proxies for communities as perceived by those living in them.

5. Recommendations

The following recommendations arise both from the data collected in this study and from other relevant work such as the *National Tracker Survey* (Wilkin *et al.* 2000) and the *Evaluation of the Implementation of the Health of the Nation* strategy (Fulop *et al.* 1998).

- NHS organisations locally and nationally need to recognise that PCG/Ts feel the number of national NHS priorities to be overwhelming and that they have insufficient management allowances and development money to pursue them.
- PCG/Ts need help to give more emphasis to health improvement. This may be achieved by integrating health improvement more closely with other functions, such as commissioning, rather than by attempting to undertake new work for which management and development resources are not available.
- Improving PCG/Ts performance in health improvement might best be done by regionally-led workshops or learning networks. This may be preferable to additional guidance from the NHS Executive, which might be perceived as yet another 'top-down' burden placed on already overloaded organisations. Such an approach would also foster collaboration between PCGs, would support local champions of health improvement, and could help to foster relationships between PCG/Ts and trusts, health authorities, local authorities, the voluntary sector and others.
- Health authorities and PCG/Ts need help in finding more effective ways of working together and using local resources such as public health and health promotion. Again, regionally-led workshops or learning networks may be helpful.

Appendix 1

Interview schedule

The interviews will be semi-structured, based on the following schedule:

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

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

3. How are the PCG'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 PCGs; voluntary sector organisations; policy direction, national and local (HImP); variations in practice and belief within PCG]

5. What actions is the PCG 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]

Appendix 2

Description of sites

Site 1

This is a level 2 PCG with a population of about 90,000. It is one of three PCGs within a London borough, and one of five within the health authority area. The PCG does not serve the areas of most socio-economic deprivation in the borough.

Seven interviews were carried out (January–March 2000) with chair, chief officer, nurse and social services board members of the PCG, two health authority officers, including a public health consultant, and a health promotion manager.

The PCG does not have a health improvement sub-group. However, health improvement priorities are set out in the Primary Care Investment Plan, which includes detailed action plans with targets, timetables, responsibilities and resources. This PCG has adopted a disease focus, and its reported activities and plans include:

- coronary heart disease (the rate of improvement in CHD in this district is lower than elsewhere in London): implementing guidelines developed by health authority (stable angina, atrial fibrillation, prevention); auditing access to cardiac rehabilitation; setting up CHD registers in primary care
- chronic obstructive pulmonary disease (there are higher than average levels of hospital admission for COPD in this district): auditing spirometry in practices (equipment and skills); auditing access to specialist nursing; implementing health authority guidelines
- chronic disease in general: auditing IT readiness for disease registers
- managing the fundholding legacy (physiotherapy, counselling, chiropody, dietetics, outreach clinics)
- other local activity: smoking cessation clinics; healthy workplace schemes operated by the health promotion service (of which the PCG is one).

Site 2

This level 2 PCG became a PCT on 1 April 2000, and serves a population of about 129,000. It is coterminous with the 'coast and country' area served by the local district council. There are some areas of deprivation, and some transient and homeless residents. There are also access problems typical of rural areas, with poor public transport.

Ten interviews were carried out (February–June 2000) with chair, two GPs, one nurse, one social services and one lay board member (the latter the local voluntary services co-ordinator), a PCG manager, a health authority public health consultant, a health promotion manager, and a representative of the district council.

The health improvement plan is intended as the 'life blood' of all PCG/T activity, and the health improvement sub-group was established early on. It is being developed incrementally, with priorities added and targets made more specific. This site has emphasised health promotion and education, and is seeking to address health inequalities within the area. Its reported activities and plans include:

- mental health: needs assessment (at risk population groups, patient registers (severe and enduring mental illness), people with mild to moderate mental illness)
- breast cancer (higher rates of breast cancer than elsewhere in the district): improve screening uptake, especially in deprived wards
- smoking: increase nicotine replacement therapy; smoking cessation clinics, especially in deprived wards
- teenage pregnancies: making links between the PCG and school nursing and those giving sex education in schools
- optimising use of community hospitals to maintain services and improve access
- supporting a bid for healthy living centres in deprived wards (parenting, health promotion, advice, before- and after-school clubs)
- co-ordinating voluntary sector provision, particularly drugs misuse services
- encouraging public involvement: poll of population on health issues; public meetings have disabled access and an induction loop, and papers are clear and easy to read.

Site 3

The PCG became one of three localities in a PCT on 1 April 2000. This PCT is coterminous with a London borough. This locality has a mainly prosperous population of 94,000, with higher than average numbers of older people; the other localities have more deprived populations.

Ten interviews were carried out (February–June 2000) with chair and nurse board members, one manager of the PCG, one health authority officer (public health department), one non-executive director, a health promotion manager, a community physiotherapist, a social services officer, two staff from the Community Health Council, and two from the local association of voluntary services.

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. Its reported activities and plans include:

- teenage pregnancies: finding a location for accessible contraceptive service in one neighbourhood where rates of teenage pregnancy are high
- older people (there is a higher than average number of older people in this locality): collecting data on how checks on patients aged 75 and over are carried out; collecting data on falls; training PHCT members in falls prevention skills
- smoking cessation: collecting data on numbers of smokers in practices
- public involvement: a public panel discusses PCG board meeting agendas
- managing the fundholding legacy (physiotherapy, counselling, benefits advice, outreach clinics, ultrasound, phlebotomy).

Site 4

This is a level 2 PCG with a population of about 120,000. It is the smallest of four PCGs within a city with a unitary local authority and a single health authority. The city is a Health Action Zone. It has a very prosperous and healthy population, except for two small areas of significant deprivation (one white 'sink' estate; one Asian inner city area).

Eight interviews were carried out (March–May 2000) with chair, chief officer, lay, nurse and social services board members of the PCG, two health authority officers, including a public health consultant, and a practice manager (who works extensively for the PCG).

The health improvement sub-group has now merged with those for clinical governance and education and training. The PCG places a high value on equity of access to services for all of its population, and favours a community development approach in its deprived areas. Its reported activities and plans include:

- older people (high numbers compared with the rest of the city): appropriate primary care and specialist services to nursing home residents; intermediate care (city-wide)
- coronary heart disease (high incidence of stroke, although low CHD rates): disease registers (atrial fibrillation, ischaemic heart disease, stroke); primary care anti-coagulation programme
- smoking cessation clinics
- providing dentistry on an estate where none exists
- part-funding a drugs worker on a deprived estate
- managing the fundholding legacy: rolling out physiotherapy, counselling and podiatry across PCG (much stricter criteria)
- public consultation on PCG priorities
- developing a health advocacy service for Asian women.

Site 5

This PCG is a level 2 PCG serving a generally fairly affluent population of 91,000. Unlike the city as a whole, it has a very low percentage of ethnic minority patients, but there are some areas of significant deprivation. The city has one health authority and one city council and is a Health Action Zone.

Ten interviews were carried out (March–May 2000) with chair, five board members (two GPs, nurse, social services and lay members), two PCG staff, one health authority officer (public health department), and one local authority officer (who runs a neighbourhood panel).

There is no health improvement sub-group: the health improvement agenda is driven by clinical governance and Health Action Zone-funded activity. Its reported activities and plans include:

- managing the fundholding legacy: locality outreach clinics extended and made available across the PCG
- chronic disease registers (CHD, asthma, diabetes): raise standards across the PCG
- improve access to mental health services and rehabilitation in one part of the PCG
- practice management of hospital waiting lists
- local HAZ-funded projects: health promotion and advice services to young people in deprived areas; handyman scheme; assessing carers' needs; healthy living centre bid
- city-wide HAZ activity: community development worker for PCG; health promotion workers; primary care development worker in mental health to improve interface and assess PHCT learning needs.

Site 6

This PCG began at level 1 and became level 2 in 2000. It covers a very extensive, sparsely populated area (46,000 people), and suffers from severe problems of transport and access. The PCG is roughly coterminous with the district council. It is one of six PCGs in the county, four of which are small (50,000 approx.). There are small pockets of deprivation in a generally affluent area, with a higher than average proportion of elderly people.

Nine interviews were carried out (May–June 2000) with chair, GP, social services and lay board members, the chief officer of the PCG' a health promotion specialist, one health authority officer (public health department), and one district council officer.

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. The new group has recognised the need to work in partnership, and has made communication and public consultation priorities. Its reported activities and plans include:

- exploring needs and options for out-of-hours community nursing
- linking with a local initiative to better co-ordinate transport
- developing a public involvement and information strategy
- assisting with a local bid for a healthy living centre.

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