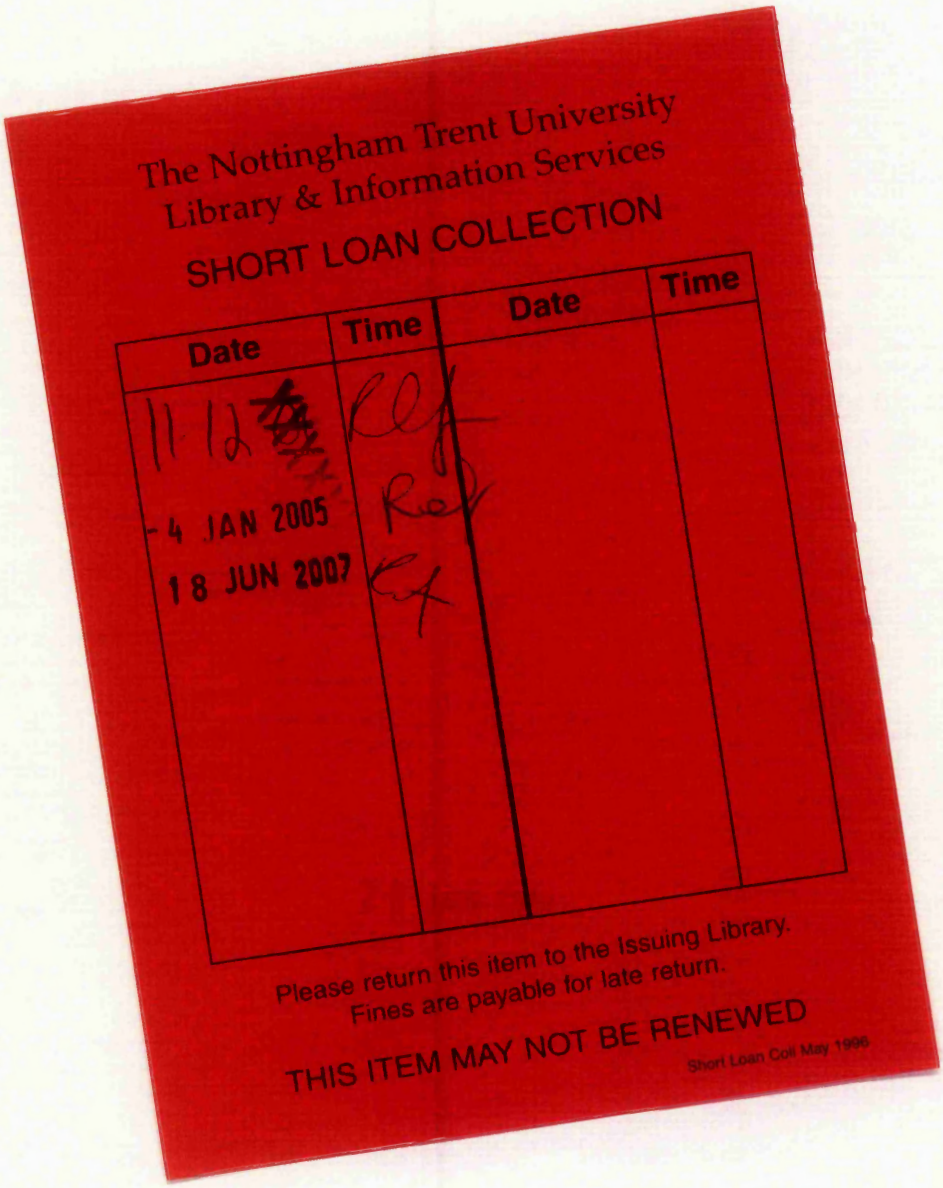

A Critical Analysis of Management within General Medical Practice

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Abstract

The purpose of the research is to attempt to examine some of the ways GPs are reacting to the pressures to become more "managerial". (Brown 1979). Research has shown that this has been in diverse and different ways-that management in General Medical Practice might be defined in a different way. Whilst traditional methods of management analysis might go some way to explaining the actions of GPs a wider definition is required. This was because often GPs them selves did not know and certainly found it hard to articulate their business objectives. There was some, commonality between them but generally each practice could be seen as unique, due to its location, patient population, and motivation of the GPs.

The main way in which this subject was examined was through a pilot study, then subsequently four in depth case studies. This helped show the areas where the practice did well and places where it did not. It was from observations in the pilot that four dimensions of practice management were proposed. These areas of "managerial competence, were then broken down into specific parts and employed in an analytical inventory for General Medical Practice. This was called the Practice Audit Matrices (PAM). The four dimension where i) Management values and methods. ii) Concern for operational efficiency and income Maximation. iii) The focus of service delivery. iv) Clinical standardisation and the relation ship between clinical principals.

Some practical application was envisaged from PAM. If a practice could identify its weaknesses along four dimensions it could decide where there was scope for further investigation or audit. It might help order a list of priorities for action and assist in monitoring how well the problems were addressed.

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Academic

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Personal

Thank you to my wife, Sylvia, who sacrificed precious time to allow me to work at the weekends and in the evenings. Finally an apology to my three children, Isabell, Rosemary and Alistair for occasionally being "grumpy" and expecting three healthy, lively children to behave like monks in a silent order.

Abbreviations

Abbreviations

A&E	Accident and Emergency
AHA	Area Health Authority
AMC	Area Medical Council
BMA	British Medical Authority
BMJ	British Medical Journal
CHC	Community Health Centers
CMB	Central Medical Board
DHA	District Health Authority
DHSS	Department of Health and Social Security
FHSA	Family Health Services Authority
FPC	Family Planning Committee
GMP	General Medical Practice
GPs	General Practitioners
NHS	National Health Service
PACT	Prescribing Analysis and Costs
PAM	Practice Audit Matrices
RAWP	Resource Allocation Working Party
RHA	Regional Health Authority

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Chapter 1
Introduction

1.0 Introduction

This dissertation is concerned with management in General Medical Practice in England and Wales, in the light of the 1990 reforms (Secretaries of State 1989 [a] and [b]). It could be argued that the implementation of the new contract for GPs in 1990 (Department of Health, 1989) was one of the greatest influences in encouraging GPs to become involved in matters managerial. Certain payments were linked to achievement targets, whilst the fixed element of practice allowance was reduced by about 25%. There have also been other pressures that have influenced more managerial awareness, some doctors have recently been taken to industrial tribunals for breaches of employment law (Ellis, 1994), whilst others have contravened health and safety laws (Fisher & Best, 1995). Another reason is that there is a tendency for practices to become larger (Department of Health, 1982, 1993) and with this comes the need for greater communications and co-ordination. As well as these reasons the practices that elected to become fundholders have had to accept a wide range of managerial demands.

There are two main themes within the dissertation. The first is that the State has, since the inception of the NHS, attempted to control the way in which GPs conduct their work in various ways. An early example of this is the tensions that existed between the government and the BMA upon the implementation of the **National Health Insurance Act** of 1911 (Section 2.1). By 1979 a Royal Commission (1979) found that there were too many administrative tiers, administrators and a slow decision making process (Section 2.3). This resulted in the reorganisation in 1982 (Section 2.4) of the NHS. More recently this tension and wrestling for control has

been emphasised by the 1990 reforms which sought to review the financial underpinnings of the NHS. The effect of this legislation was to coerce GPs to become more managerial, in terms of their health care provision (section 2.5).

The second theme is that, whilst doctors often express negative feelings towards the management aspects of their jobs (NHSTD, 1994), things are more complex than that and often doctors do embrace aspects of managerialism wholeheartedly. Harrison (1988) suggests that prior to the reforms of 1982 (Section 2.4) the emphasis on management in the NHS was relatively weak. This was further addressed by the legislation of 1991 (Secretaries of State 1989), which placed increased managerial responsibility on GPs (Section 2.5). At this point, it is argued (Section 3.2), that the government achieved the control over GPs that it favoured in 1944. Section 6.2.2 illustrates how some GPs now regard aspects of their managerial activities as an integral part of their duties.

These reforms have required GPs to become more managerial, a role that few have been prepared for in their professional training. This research will examine how GPs are addressing the need for a stronger managerial role. There are numerous management models available but in this instance they fail to address the unique nature of the GP managerial role. Because of the lack of focus on business in their professional training GPs often did not have the understanding of business concepts to be able to articulate their business objectives.

The structure of this dissertation takes the following form. Firstly the background and history of the NHS is examined (chapter 2). Analysis of the three major reforms show

an evolving relationship between the state and the GP, culminating in the requirement that encouraged GPs to become more managerially aware. These managerial values are described and criticised in chapter 3 with reference to some theoretical models of management [see Watson (1994) and Pollitt (1993)].

Examination of how GPs are addressing the requirement for a stronger managerial role was undertaken initially by conducting a pilot study (Section 4.3) to determine the parameters by which managerial values might be compared. This led to the development of an analytical tool called Practice Audit Matrix (**PAM**). The development of this tool helped to understand the complexity and role of management in general medical practice (Section 4.4, appendix X), from which the indicators were identified. This was used to assess different facets of a practices' managerial profile. A case study approach was taken and four General Medical Practices were selected, where **PAM** was used as the vehicle to obtain data. Discussion of the various forms of data collection are found in chapter 4, the findings of which are presented in chapter 5. The dissertation concludes with an overview of the prominent themes to emerge from earlier arguments and recommendations are made concerning effective practice management models (Chapter 6).

Chapter 2

National Health Service History

2.0 The History of the NHS 1948 - 1997

It is important to look at the development of the NHS as it contextualises the attempts that were made, by successive governments to control its medical employees and contractors, in the case of GPs. This chapter will outline the history of the National Health Service from its foundation and trace its development to May 1997, by which time the emphasis was more on market orientation (Kelly & Glover 1996:15). Because there is separate legislation for Northern Ireland and Scotland, with significant differences in the administrative structures in these countries (Brown 1979:3) (and separate administration for Wales since 1969), for simplicity the chapter contains an analysis to that of England and Wales. To understand the issues currently facing general medical practice in England it is important to set these in the context of the broad historical processes involved in the development of the National Health Service.

This chapter firstly (Section I) examines the background relevant to the creation of the National Health Service in 1948, then (Section II) describes the structure between its creation and the reforms of 1974. This is followed by an analytical review of the 1974 reforms (Section III). The final section (Section IV) investigates the major reforms of the late 1980s and early 1990s with the underlying philosophies that influenced their formation and the current provision of health care

(2.1) The Creation of the National Health Service (1948).

In 1941 the government commissioned an independent body, under the chairmanship of Sir William Beveridge, to conduct a study of all hospitals in the country to assess how well they performed and to evaluate the facilities they provided. There had been some organisation of public hospitals and public health provision prior to that in the late 1930s in the face of the threat of war. It was believed that the voluntary hospitals simply would not be able to cope with the expected volume of civilian and military casualties (Webster 1988). The Beveridge report was the corner stone of what became the National Health Service. One of the main findings of the commission was that in order to improve the health and living standards of the nation as a whole, a comprehensive health care system was vital. This was defined as being accessible and available as and when a citizen required medical treatment (Ministry of Health and Department of Health for Scotland, 1944). The emergence of the National Health Service was, then, part of a broader social welfare programme, to become a nation that provided a standard of living and care that was "fit for heroes".

In 1944 the Minister for Health, Henry Willink, published a White Paper, called **A National Health Service**, describing how the envisaged service would run. At this time it was normal for medical provision to be made only to those who had taken out insurance or those who were wealthy enough to pay for private treatment. What was proposed was very radical: free medical services were to be provided on the basis of

need, not of financial status and medical treatment was to be provided for every citizen of Britain as a *right*. The White Paper stated their intentions thus:

> "...to ensure that in the future every man and woman and child can rely on getting all the advice and treatment and care which they may need in matters of personal health: that what they get shall be the best medical and other facilities available; that their getting these shall not depend on whether they can pay for them, or any other factor irrelevant to the real need - the real need to bring the country's full resources to bear upon reducing ill-health and promoting good health in all citizens" (Ministry of Health and Department of Health for Scotland, 1944:5)

The National Health Service Act was passed in 1946 under the Minister of Health, Aneurin Bevan, and the British National Health Service was created on the 5th July 1948. However this was not a straightforward transition. The plans for the National Health Service were a result of the negotiations of the, then, coalition government and the medical profession. Most hospitals in the UK had previously been operated as non-profit making concerns. For the most part, hospitals had been run by local authorities (the bodies also responsible for local fire services, schools, roads etc.), with about one third of them run independently as voluntary hospitals. With the National Health Service Act, these were compulsorily acquired and subsequently administered by the State, and all treatments became universally available at no cost at the point of provision, the whole being centrally funded by taxation. From then on hospital doctors, nurses and all other hospital staff became salaried employees of the state. (Webster, 1988)

At the same time GPs managed to remain outside the direct employ of the state and have ever since been contracted by the state as a private business, providing primary health care. This means that, even though the state is effectively the monopoly employer of GPs, these practitioners are classed as self employed. Thus the state has never had direct control over what activities GPs undertake beyond deciding what services it will and will not buy from them. Currently the contract between GPs and the government is contained in what is known as the 'red book'. This describes the list of General Medical Services which the GPs may choose to provide and receive additional remuneration for. Failure to provide the core services in the contract (such as refusing to see a patient) is an offence and will result in disciplinary action being taken by the appropriate authority.

The creation of the NHS involved considerable tensions and dilemmas between the various parties that, arguably, continue to have a great bearing on the later reforms of 1990. The first dilemma involved the proposed payment system of General Practitioners. Ever since Lloyd George introduced the **National Health Insurance Act** of 1911, the BMA had been fighting hard to protect the interests of their members, particularly with regard to their autonomy and their financial position (Ham, 1985). In 1911 they had forced several concessions from the government (Mohan, 1995). Possibly it was this success that prompted them to take a strong stand concerning the proposals in the 1944 White Paper. The main area of concern was how doctors should be employed and salaried, as the government wanted GPs to be employed by the local authorities. This suggestion was opposed by the BMA and they refused to discuss this point with the Government (Honigsbaum, 1989). A quote from a contemporary BMA Journal arguably summed up the mood at the time:

> "Except for a vocal minority of doctors grouped round a party political flag (The Socialist Medical Association), by far the greater part of the profession is rigidly opposed to a whole-time State salaried medical service, and it is upon this one issue that opposition must be unshakably offered in the coming months" (BMJ, 1944:113)

The themes and issues raised here emerge in later analysis of professional autonomy and serve to illustrate that the themes in the main instrument of practice analysis (PAM, discussed in chapter 4) have been in existence for over half a century. In other words that GPs see managerialism as a constraint rather than as a means of empowerment.

The dilemmas posed in 1944 by the BMA were resolved by the setting up of the Central Medical Board. Here we see the second theme of this dissertation emerge, with two key questions; whether GPs should be salaried, or self employed and secondly if they should be encouraged to work as individuals or as teams in health centres or work teams. Both these issues are returned to in sections 4.4.4 and 4.4.5. The purpose of the Central Medical Board was to plan and coordinate the provision and control of GPs who were contracted to this central board and paid on a per capita basis. Despite this GPs were encouraged to work together collectively in local authority owned health centers and a move away from competitive pay was encouraged. As the White Paper (**A National Health Service**) states:

> "There is a strong case for basing future practice in a Health Centre on a salaried remuneration or some similar alternative which does not involve mutual competition" (Ministry of Health & Department of Health, 1944:30)

2.2 The structure of the NHS 1944 to 1974.

The outcome of the Act was the establishment of 14 Regional Hospital Boards (later enlarged to 15) responsible for Hospital and specialist services. 134 Executive Councils. They were responsible for the provision of general medical, dental, pharmaceutical and supplementary orthalmic services. Their other responsibilities were to keep lists of patients and pay the fees of contracting Doctors. The third leg of the National Health Service was the institution of 145 Local Health Authorities responsible for health education, prevention and treatment of ill health, health visiting, home nursing, home help, ambulance services and the provision and upkeep of health centers. All these bodies reported directly to the Minister of Health. As well as these the 36 teaching hospitals were outside the jurisdiction of the Regional Health Boards and also reported directly to the Minister of Health. The responsibility for school children was outside the remit of the National Health Service altogether and fell under the auspices of the Ministry of Education, reporting directly to parliament. The structure of the National Health Service in 1948 is laid out below.

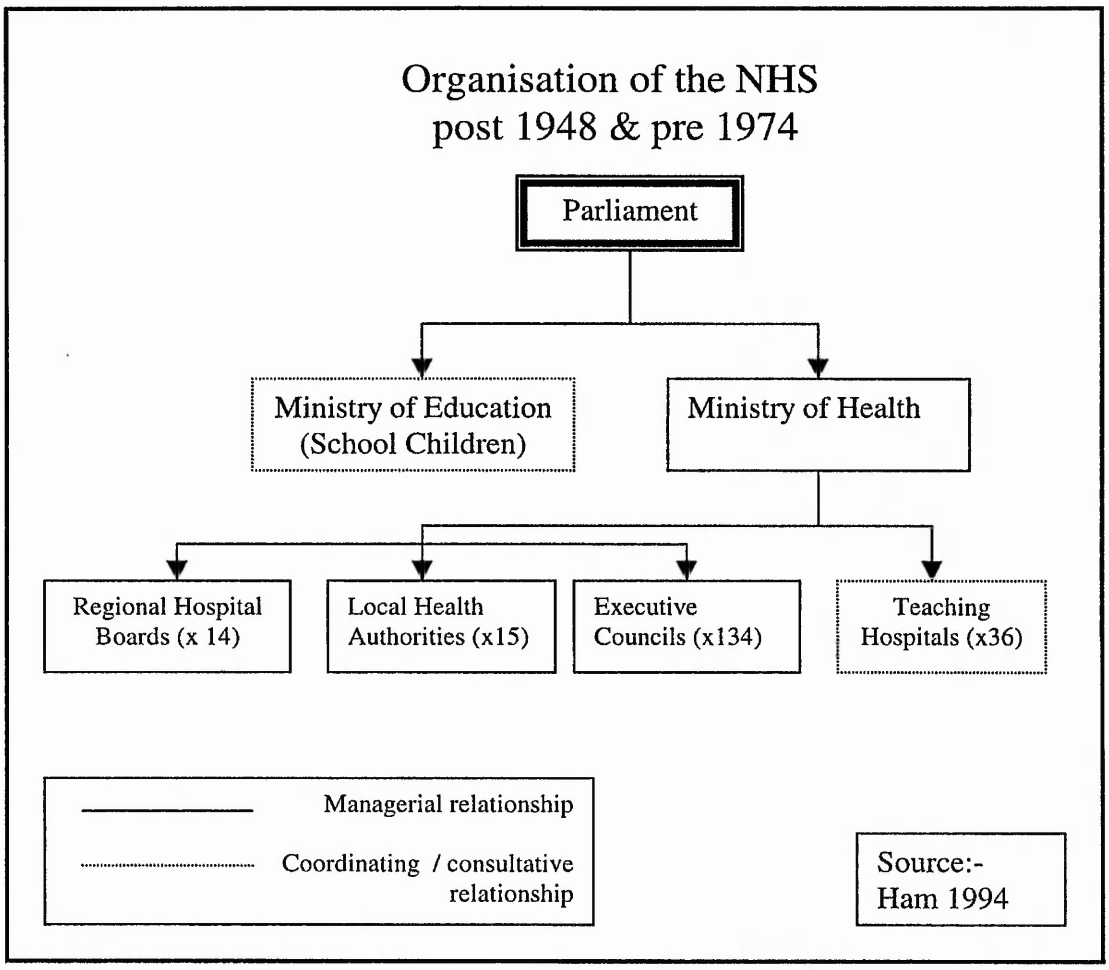

Figure 2.1

The end result of the White Paper was a compromise between the politicians and the medical professions, between the ideals of individualism and collectivism. Implicit in the two Acts of Parliament (1946 England, 1947 Scotland) was the assumption that it was possible to offer a health care service that would provide medical care for all the population. That eventually

> "through human action in the form of social engineering and using scientific knowledge, health could be produced and illness eliminated" (Kelly & Glover 1996:17)

The service provided by the National Health Service was in no way unitary, there was little consistency from one part of the country to the next and local planning was fragmented (Acheson and Hagard, 1984). The tripartite structure was far from perfect. For example the long term care of the elderly was a joint responsibility, shared between the hospital and the local authority, who provided home help and community nursing care. Local authorities were responsible for providing Health Centers but not for the GPs who would use them. Levitt and Wall emphasise this inconsistency:

> "the uneven distribution of services that had existed before 1948 was not eradicated by the creation of the National Health Service, so many inequalities between regions were maintained. Because the administration structure, with bias towards hospital matters, had the strongest influence on policy making in the central department, there was inadequate local liaison between hospital and community staff. This led to a situation where services for the acutely ill and disabled were comparatively neglected" (1984:7)

Furthermore, the structure of the National Health Service accentuated the already existing divide (Stevens, 1966) between general practice and hospital medicine. Approximately 90% of healthcare episodes begin and end with the individual's own GP (Glenister *et al* 1994) and consequently communications between the two are imperative, the new structure did little to encourage this. The first review into the National Health Service structure was made by the Guillebaud Committee in 1956. They recognised some of the problems but decided that it was too early to start a restructuring of the National Health Service (Guillebaud, 1956). Instead it advocated changes to improve liaison and coordination.

By the early 1960s it became apparent that demand for health care was outstripping the ability to pay for it. Indeed there were not enough resources to fund the health of the nation (Klein 1995). Gradually financial reforms were introduced and statistics became more important. New monitoring of hospitals started to emerge, for example a ten year plan for balanced hospital development was produced in 1962 (Ministry of Health 1962) and a similar plan for local authorities was introduced (Ministry of Health 1963). As well as this in 1969 a team of professional inspectors (the Hospital Advisory Service) was brought in to examine long-stay hospitals and report back direct to the Minister of Health. These measures emphasised central control and set the scene for the 1974 reorganisation.

(2.3) The 1974 Reforms.

In 1970 Richard Crossman, who was the first Secretary of State for Social Services, in the newly formed Department of Health and Social Security published a Green Paper **The Future of the National Health Service**. In this three main aims were described. They were:- first, the new health authorities would be independent of local government, only responsible to the central department; second public health and personal services would continue to be the responsibility of local government; and finally the boundaries of the new health authorities would match those of central government. (Levitt and Wall 1984). In 1970 there was a change of government and under Ted Heath's leadership the White Paper **Management Arrangements for the Reorganised National Health Service** was published in 1972. This suggested that there should be maximum delegation downwards matched by comparable accountability upwards. It advocated consensus management, people and departments deciding jointly on outcomes.

> "The aim will be to effect the greatest possible de-centralisation from the Secretary of State to Regional Health Authority, and from Regional Health Authority to Area Health Authority... with corresponding accountability upwards" (DHSS 1972:65)

The White Paper was followed in 1973 by **The Health Service Reorganisation Act** which took effect from the 1st April 1974 (Webster 1988). The new National Health Service was organised into four tiers of management, with the Department of Health and Social Security taking up the top of the hierarchy. The next layer comprised of 14

newly formed Regional Health Authorities, followed by 90 Area Health Authorities and finally by 200 District Management Teams, as Figure 2.2 illustrates.

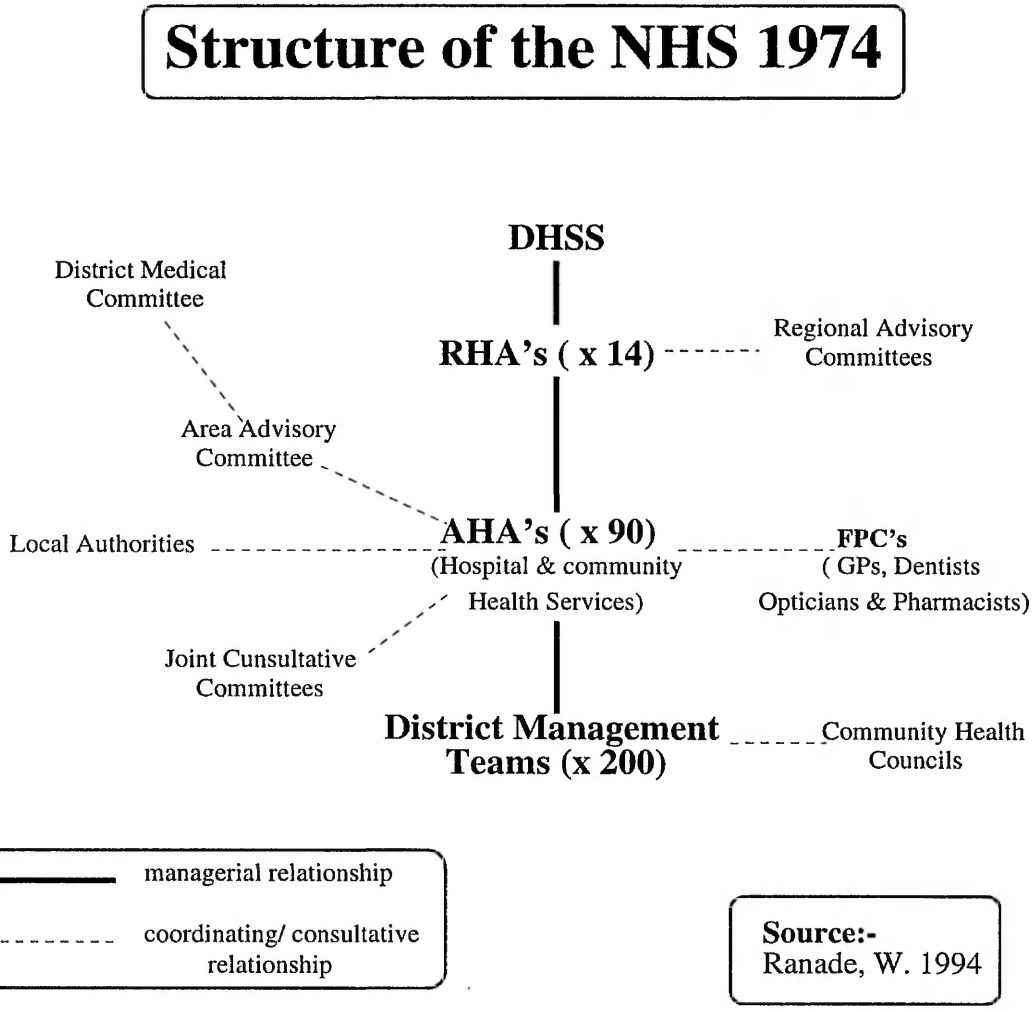

Figure 2.2

The RHAs differed from the old regional hospital boards in two respects. Firstly that they were responsible for supervising all health services, not just the hospitals in their region. This it was felt would enable continuity of care (Rafell, 1984). Secondly they became accountable for the teaching hospitals (with a few notable exceptions in London) that had previously reported directly to the Minister. The RHAs were

responsible for the planning, finance and building of hospitals as well as the selection, appointment and payment of clinicians.

Both the RHAs and AHAs management teams had to include both medical and nursing representatives, a treasurer and an administrator. Management came about through consensus of these and other members of the team (Cox 1991). Membership of the AHAs originally consisted of between fifteen and twenty eight members. This later changed to a range from nineteen to thirty four members; the chairman appointed by the Secretary of State, four members by the matching local authority and the remainder by the RHAs, who largely appointed on the criterion of management ability (Brown 1979). The purpose for the constituency of this membership was to.

> "to provide a better balanced service to, and identification with, the community; the upgrading of professionals ancillary to medical care; the encouragement of consultants and practitioners to take a more active role in planning, and in the economical use of resources; and the provision of units of organisation of sufficient size as to comprise nuclei for capital and revenue spending and resource equalisation, short of total departure from an 'economies of scale' constraint" (Royal Commission 1978:173)

Sir Keith Joseph, the Secretary of State responsible for implementing the Act admitted that his White Paper leant more towards management than the 1970 Green Paper had (Brown 1979).

Several other new bodies were created, one of which was the Family Practitioner Committee. These were responsible to the AHAs. and consisted of thirty members; eight elected by doctors, three by dentists, two each by opticians and chemists, four by

the local authority and the remaining eleven by the AHA. The role of the FPCs was mainly administrative. There were four principal areas of responsibility, these being; the provision of contracts with General Practitioners concerning their services, to compile lists of GPs, to pay for their services and to deal with complaints (Royal Society of Health, 1977).

Professional Advisory Committees were also newly created bodies within the new National Health Service. Their function was to advise and they had the right to be consulted at area and regional levels (Brown, 1979:27). Each Area Medical Committee (AMC) had to consist of equal numbers of hospital doctors and general practitioners. There also had to be representatives of both junior doctors and trainee GPs (again of equal numbers). The AMCs elected their own chairman.However if the chairman was a hospital doctor then the vice-chairman had to be a GP and *vice versa*. For doctors the advisory system was structured in such a way that it could not be dominated by either the hospitals, which was feared (*Ibid*:28) or the GP's interests. Similarly balanced committees were constructed for the other professions (dentists, pharmacists, nurses, and opticians).

Another new body was the Community Health Council (CHC). Their membership numbers varied from eighteen to thirty six, half the membership being appointed by the relevant local authorities, one third by voluntary organisations and the remainder by the RHA, with the RHA meeting the financial costs. There were 207 CHCs in England. They had the right to ask for information, visit hospitals and institutions and

to make representations on the public's behalf to the AHA and be consulted about development plans.

The purpose of these changes and the introduction of new administrative bodies was that

> "Heads of services were encouraged to see themselves more as 'managers' and not just heads or leaders of services... the locus of authority and responsibility (planning and control) was meant to be shifted away from the 'horizontal' management of units or institutions to the 'vertical' management of service functions, coordinated at district level" (Royal Commission, 1979:104)

Until the mid 1970's the amount of money allotted to individual Regional Health Boards/Authorities had been calculated as 'last year, plus a percentage', thus perpetuating the particular allocation of resources decided upon at the inception of the NHS, 30 years earlier. In 1975 a working party was set up to redistribute resources. It assessed the way that funds were calculated by the DHSS for each region. This working party, Resource Allocation Working Party (RAWP)' was set up under Babara Castle (Minister for Health). The objectives were:

> "To review the arrangements for distributing National Health Service capital and revenue to RHAs, AHAs and Districts respectively, with a view to establishing a method of securing, as soon as practicable, a pattern of distribution responsive objectively, equitably and efficiently to relative need, and to make recommendations" (Drury, 1992:29)

RAWP recommended that regions should be allocated funds using a formula that took account of need in that particular area. This was highly complicated, and any changes often took as long as a year to work their way through the system and be reflected in the funding. Some of the criteria the formula took account of were; population, population structure, morbidity, health services and cost-weighting. RAWP generated an ideal resource allocation for each AHA based on the formula. Actual allocations to the AHAs were adjusted annually to converge with the ideal, but gradually, ensuring that no one AHA either gained or lost resources dramatically in any one year. This approach was used to try and remove the inequalities that existed: some areas had been underfunded, whilst others were overfunded. This resulted in a relative diversion of money away from London to the Provinces, based largely on assessment of need rather than geography. In 1976 cash limits were introduced, this illustrates a continuing emphasis on management and accountability

Soon after these changes were implemented it was found that the complex and differentiated system was cumbersome, that the tiered system made planning more difficult than before. The elaborate consultative machinery became highly formal. In short the bureaucracy became dysfunctional. More and more people were becoming employed by the National Health Service that had nothing directly to do with patient care

In 1976 a Royal Commission was set up under Sir Alec Merison to assess the structure of the National Health Service and the effects of the 1974 reorganisation, to:

> "Consider in the interests of both the patients and those who work in the National Health Service the best use and management of the financial and

> manpower resources of the National Health Service" (Royal Commission, 1979:1)

The report's comments concerning primary health care were very favorable (1979:90) and commended the government's achievement in this area. However there were criticisms, notably that there were too many administrative tiers; too many administrators; slow decision- making processes; too many funds wasted; there was low staff morale and too much emphasis on morbidity rather than preventative medicine. The term "morale" was recognised as being too vague a term to be accurately understood in context, so the Commission defined it thus:

> "Assimilated with a general state of content or discontent which might relate to more general feelings about the National Health Service than the feelings of satisfaction with their jobs or working context" (1979:34)

(2.4) The National Health Service 1982 - 1989

The next stage in the reorganisation came about in 1982, largely as a result of the Royal Commission's report, with the government acknowledging many of the criticisms in their paper **Patients First** (DHSS, 1979). The amended structure (Figure 2.3) had new principles underlying it: decision making was to be delegated downwards and the AHAs were to be abolished. This meant that power was given to the smaller units with decisions being made at two hundred DHAs rather than the ninety AHAs, as had formerly been the case. The essence of the decentralisation philosophy is well illustrated by Patrick Jenkins in his paper **Patients First**. He states the aims of the proposed reorganisation as:

> "we are determined to see that as many decisions as possible are taken at the local level - in the hospital and the community. We are determined to have more local health authorities, whose members will be encouraged to manage the service with the minimum of interference by a central authority, whether at regional or in central government departments" (DHSS, 1979:2)

It might be argued that the title of this paper was an indicator of thoughts to come, that of consumerism, which was influential in the National Health Service reforms that came after.

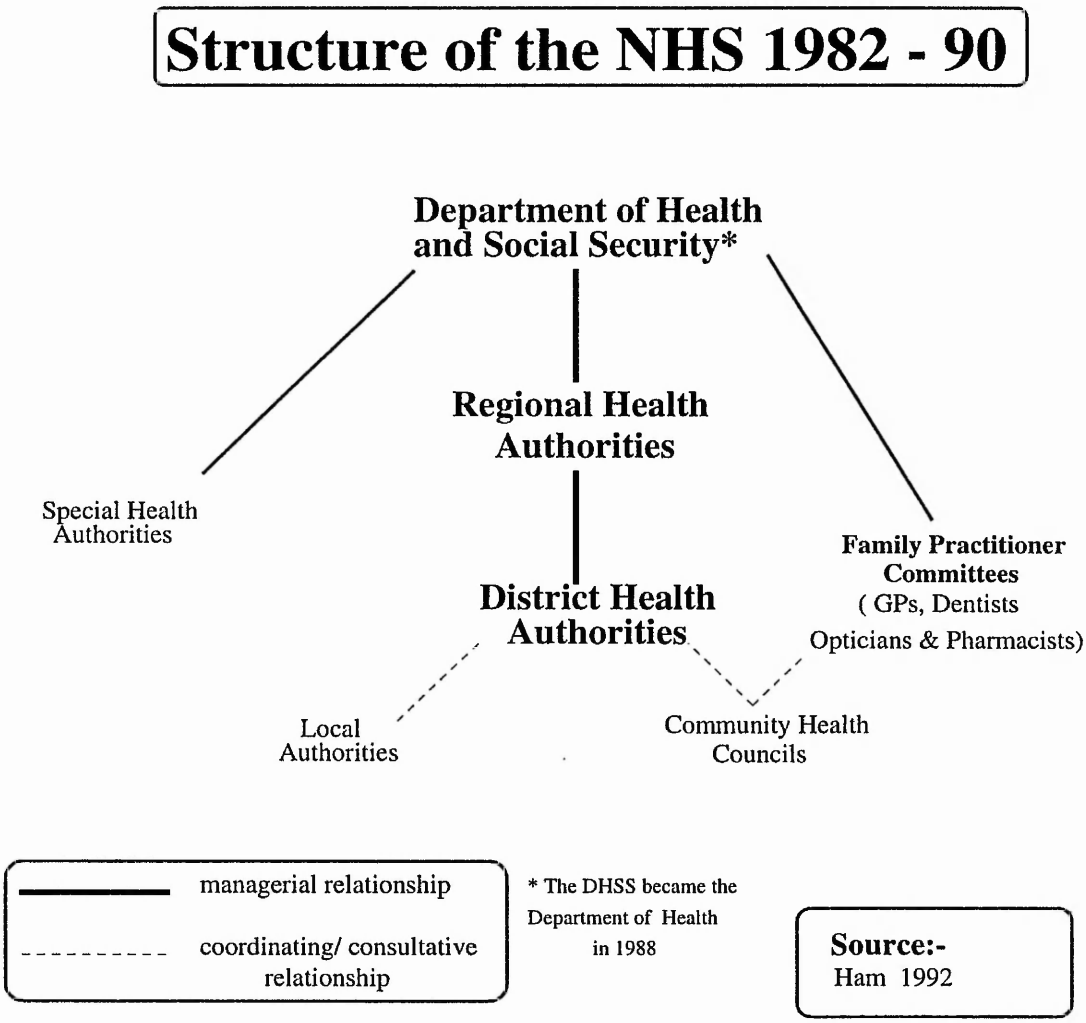

Figure 2.3

In this move from centralisation to decentralisation, doctors and nurses were still being made responsible for decisions relating to the use of resources. A system was introduced that reviewed manager's objectives on an annual basis. Sir Roy Griffiths set up a team to look at management in the National Health Service. This appraisal was published in 1983 called **The National Health Service Management Inquiry**, (DHS 1983) but better known as *The Griffiths Report.* Sir Roy was Deputy Chairman and Managing Director of Sainsburys Plc and he brought the managerial values of industry to bear on the National Health Service. He found evidence of variations in efficiency and lack of quality which he sought to address through the introduction of general management principles (Ham 1994)

The Griffiths report identified a poorly defined management function, with no one having clear responsibilities. As the report points out:-

> "Absence of this general management support means that there is no driving force seeking and accepting direct and personal responsibility for developing management plans and monitoring actual achievement. It means that the process of devolution of responsibility to the units is far too low." (DHSS, 1983:12)

Several suggestions were made, the main one was the introduction of general managers at all levels of the service, in the RHAs, DHAs and at all hospitals. These managers were responsible for the performance of the organisation. Most of these managers were on three yearly rolling contracts with some form of performance related pay woven into their remuneration package, with their annual performance appraisal also being taken into account. Emphasis was placed on the traditional management values (Fayol 1916), efficiency and effectiveness were to be constantly under review.

The Griffiths review was not popular within the National Health Service and many of the proposed (and subsequently adopted) changes were seen as a direct challenge to entrenched values. In short, the culture of the National Health Service was threatened. It might be argued that there was a move from consensus to hierarchical management. Financial efficiency replaced service considerations as the major concern of those running the National Health Service. Thus Sir Roy Griffiths made sweeping changes to the function of various arms of the National Health Service without altering its structure. As Kelly and Glover (1996: 20) point out:

> "The introduction of General Managers was supposed to facilitate planning, action and control and measurement of effectiveness and efficiency... Griffiths identified a lack of unified planning, implementation and control of performance, absence of direction and the existence of consensus management as the major problems".

The next major change came about with the implementation of the White Paper **Promoting Better Health** (Secretary of State 1987) (appendix VII presents a synopsis), which was first published in 1987, the objectives of which were to raise standards of care, promote better health and prevent illness. It was the first occurrence of consumerism in the National Health Service, and assumed the notion that the recipients of health care were customers, thus implying that health care was a commodity that could be consumed. The White Paper **Promoting Better Health** proposed changing the emphasis from an obligation by the state to provide health care for all the Nation, to the individual taking responsibility for their own health. This would come about by patients changing their lifestyle, thus reducing incidents of

obesity, heart disease, alcohol and drug abuse. The new philosophy is summed up in the White Paper:

> "Much of this distress and suffering could be avoided if members of the public took greater responsibility for looking after their own health. The government fully acknowledges its responsibility for raising individuals' awareness of ways in which they can continue to take steps to maintain good health" (Secretaries of State 1987: 6)

(2.5) The 1990 Reforms

The introduction of a far reaching review of the NHS was announced in a television interview with the prime minister, Margaret Thatcher, on Panorama in January 1988. The Government White Paper of 1989, called **Working for Patients** (Secretary of State 1989 [b]) (a synopsis of which is given in appendix VI) was the starting point of the radical changes to the NHS in the 1990's

There were two areas of concern. Firstly there was a financial focus, suggestions concerning the future financing of the National Health Service. The possibility of introducing an insurance financed (rather than tax based) health care system was proposed (Klein 1995) in an attempt to reduce the financial burden on the State of the National Health Service. Secondly the focus turned to matters of efficiency, the need for structural changes, the more effective use of resources. These ideas were influenced by an American economist, Alain Enhoven. He highlighted the weaknesses of the National Health Service and pointed out the main specific

problems. He found that there was a poor matching of funding to workload, inappropriate incentives for managers and clinicians, a lack of responsiveness to consumers, and finally there were few incentives to innovate. One argument put forward by Enthoven was

> "that by separating the purchase of health care from its provision and management and subjecting providers to an element of competition for contracts, providers would now have an incentive to cut costs, improve quality and be more responsive to what consumers wanted. Purchasers in turn, since they would still be cash limited, would have an incentive to bargain for improved value for money" (Enthoven 1985, cited in Ranade, 1994:58)

He proposed that the DHAs would receive an annual budget, which they would use to purchase health care from both the public and private sectors, on the GP's behalf. Under this proposal the GPs would not have a say in negotiations. An alternative proposal, along similar lines, was suggested by the Office of Health Economics (Maynard 1986). Whilst they agreed about the principle of splitting the provider from the purchaser they advocated that the GPs would be the purchasers with the DHAs responsible for the provision of hospital services. Kenneth Clarke, the Secretary of State for Health, greatly favoured Professor Maynard's approach and envisaged an increasing role for the GPs over time, as the White Paper, **Working for Patients** (Secretary of State 1989 [b]) emphasises.

> "General Practice will play an even greater role in assisting patient choice and directing resources to match patients needs throughout the whole Health Service as a result of the Government's new policies. The Government believes that in order to play this key role to the full, general practice will

Working for Patients (Secretaries of State 1989) was the result of the National Health Service review and was implemented under the National Health Service and Community Care Act 1990 in April 1991. The government adopted some of Enthoven's ideas, but mainly Maynard's and in 1991 introduced the internal market into the National Health Service through these reforms, this brought competition into the service. The purchasers of health care were separated from the providers of health care, hospitals and community services being the providers and DHAs and GPs being the purchasers.

Education was also part of the solution and GPs, through financial incentives, (see appendix VIII) were encouraged to conduct special health promotion clinics. Higher targets were set for immunisation and screening. GPs also had to provide regular and frequent health checks on the more vulnerable sections of the population (the young and the elderly). These changes came into effect with the introduction of the New Contract (Department of Health 1989) on the 1st April 1990.

The main aims of **Working for Patients** were to reduce prescribing costs, change the way GPs were remunerated, extend patient choice and to introduce medical audit. The main changes that were aimed at are laid out in figure 2.4.

The Changes that Working for Patients introduced to the NHS
1) To make the Health Service more responsive to the needs of the patients, by delegating power and authority (including financial) to local levels.
2) To enable the hospitals which best met the needs of the patients to do so, by

allowing hospitals to set up as self governing trusts that could earn revenue for the services that they provided.

3) To allow money to follow the patient (often across administrative borders).

4) To reduce waiting times and improve the quality of service (an extra 100 consultant posts were created)

5) To help GPs improve services to patients. Large practices (initially those with 11,000 or more patients, although this figure was subsequently reviewed downwards, so that by May 1995 the qualifying figure was 5,000 patients) could apply for a proportion (about 20%) of their own budgets. These budgets enabled qualifying GPs to obtain a defined range of services direct from hospitals and other providers, originally known as Budget Holders these became known as Fundholders.

6) To improve the effectiveness of the National Health Service management. Regional, District and family practitioner management bodies would be reduced in size and reformed on business lines, with executive and non-executive directors.The assessment of quality of service and value for money through rigorous audit.

7) To introduce indicative drug budgets.

Figure 2.4

To enable these reforms to take effect, a new management structure was required and the National Health Service structure in 1991 is illustrated in figure 2.5. At the top of the tier is the Secretary of State for Health, who is directly responsible to Parliament. Under him is the Department of Health, with 14 RHAs, (originally) 57 National Health Service Hospital Trusts and Special Health Authorities (consisting of bodies such as London's Post Graduate Training Hospitals, Health Education Authority and the National Health Service Training Authority). Under the RHAs come both the 189

DHAs and the 90 FHSAs (formerly FPCs). GP fundholders received their budgets from the RHAs but the FHSAs were responsible for monitoring their performance against budgets and continued to be responsible for services outside the remit of GP fundholders.

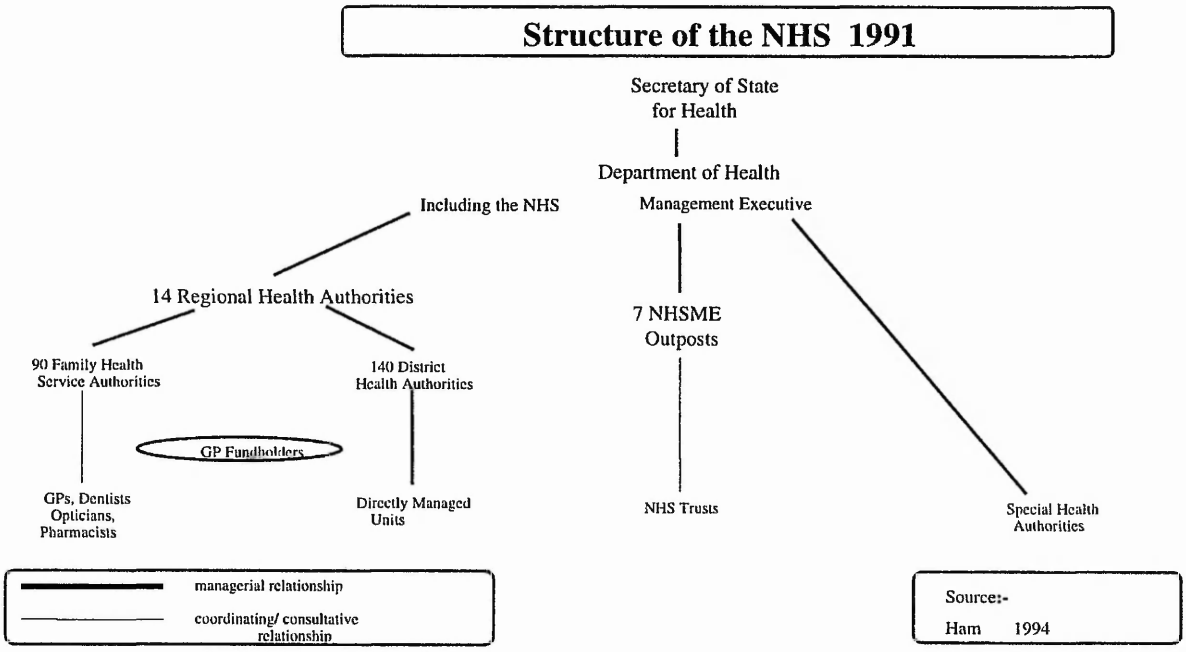

Figure 2.5

In April 1996, further reforms came into existence that were originally announced by the Secretary of Health in October 1993. The 14 Regional Health Authorities were abolished, being replaced by 8 Regional Offices of the National Health Service Executive, also replacing the National Health Service outposts. Also the DHAs and FHSAs merged. This, it was argued, was an attempt to bring about a move to a greater focus on primary care. The main functions of the National Health Service's Regional Offices are outlined in figure 2.6

Functions of the N H S Regional Offices in 1991
1. To ensure compliance with the regulatory framework of the internal market. 2. To manage the performance of both purchasers and providers 3. Arbitration in disputes 4. Approving GP fundholder applications and budgets 5. Aspects of Human Resource Development.

Figure 2.6

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(2.6) Conclusions

This discussion has given an overview of the development of the National Health Service from its inception until 1997. A continuing theme has been the emerging importance of managerialisim and managerial values. These will be explored in greater detail in chapter 3.

Chapter 3

Management and the National Health Service

3.0 Management and the NHS

Historic changes that have taken place within the NHS were considered in chapter 2, with particular emphasis on the changes that affected GPs. This chapter investigates the imposition of "managerial values" by reflecting on the changes that have taken place in the NHS. It then focuses on General Medical Practice and how the status of GPs has changed over time. The next concern is the definition and understanding of management as approached from three different perspectives. Finally the underlying themes discussed previously are explored in the context of my own research.

(3.1) Managerial Values

Until the early 1980's management in the National Health Service (NHS) held a relatively weak position in relation to clinical matters. Harrison (1988) suggests that there were three main characteristics of NHS management at the time; firstly it was reactive, secondly it was incremental and lastly it was introverted. He argues that management were reactive because they did not attempt to shape the organisation's future at the strategic level, but rather responded to day to day issues. They were incremental because the way in which resources were deployed were never seriously questioned, or evaluated, nor was the performance of existing services subject to scrutiny. Planning took no account of redeployment of resources, or savings, but concentrated on how to use incremental additions to the budget, and the size of that increment. Management was also introvert because it focused its attention on influences within the organisation, often ignoring the needs of its users. Management was concerned with maintaining the status quo and stability, with no room for entrepreneurialism or innovative thinking, effectively being administration rather than management.

The reforms of 1974 very much emphasised consensus management, which, arguably did little to aid the smooth running of the National Health Service (Levitt & Wall, 1984). Teams were appointed at regional, area and district level. The problems stemmed from the machinery which meant that each member had the power of veto, but none the power to impose. According to Levitt & Wall (*op cit.*), the results were twofold; decisions were watered down to the lowest common denominator and they also took an inordinately long time to be made. As was discussed in section 2.4, the 1982 re-organisation (DHSS 1981) was an attempt to rationalise and simplify some of the worst complexities by abolishing the area tier and devolving responsibility to unit hospital levels.

Sir Roy Griffiths has been credited, through his 1983 review, with being the major influence in changing the NHS from consensus to general management (Ranade 1994). The assumption of the Griffiths Committee was that the problems of managing the National Health Service were very similar to those of other large service organisations (*ibid.*) and that by applying the rules of commerce the National Health Service could be properly run. Under the Thatcher government, Sir Roy Griffiths criticised the NHS because it

> "Still lacks any real continuous evaluation of its performance against the criteria... Rarely are precise management objectives set: there is little measurement of health output; clinical evaluation of particular practices is by no means common and economic evaluation of those practices very rare." (DHSS 1983:10)

There were two main recommendations to meet these shortfalls. The first was to establish a Health Services Supervisory Board, to strengthen policy direction. The second was to create a general management function throughout the National Health Service, to focus responsibility and give leadership and direction. By general management Griffiths meant **"the responsibility drawn together in one person, at different levels of the organisation, for planning, implementation and control of performance"** (*ibid*:11). As Cox points out a new style and approach was envisaged

> "The recurring themes of Griffith's managerialism are action, effectiveness, thrust, urgency and vitality, management budgeting, sensitivity to consumer satisfaction and an approach to management of personnel which would reward good performance and ultimately sanction poor performance with dismissal" (Cox 1991:94)

As well as the introduction of general management, decision making was devolved down to units, with Doctors and General Practitioners expected to take more managerial responsibility for their activities for the first time

> "Their decisions largely dictate the use of all resources and they must accept the management responsibility which goes with clinical freedom. This implies active involvement in securing the most effective use and management of all resources. (DHSS 1983:19)

The impact of the Griffiths report were immense. Evans and Maxwell's evidence to the Social Services Committee concluded that its most far reaching and radical aspects were its proposals for the central management of the service with a change from passive to active management. From the evidence this seems to be widely agreed.

> "In just five years the National Health Service has been transformed from a classic example of an administered public sector bureaucracy into one that increasingly is exhibiting the qualities that reflect positive, purposeful management" (Best 1987:4).

However, in practice financial imperatives prevailed and balancing the budget became the prime concern. Harrison *et al* (1988) and Strong and Robinson (1990) argue that with short term contracts, performance review and performance related pay being the norm for managers they had little option but to accept finance driven agendas.

These issues were addressed in the 1990 reforms. Hood (1991) suggests that the developments taking place in the National Health Service were paralleled by much wider trends in public management. He argues that there were two schools of thought responsible for this: First that the economics of the new right led to greater competition, user choice and the break up of multi-functional bureaucracies into decentralised units. The second was a new wave of business type 'managerialism' in the public sector, premised on an updated version of 'scientific management'. Ranade (1994:90) suggests the components of this new mangerialism are as follows:

Management tasks in the public and private sectors are essentially the same. Management is an expert activity which requires appropriate training; it is not the province of amateurs. Management is an executive activity, which requires considerable discretionary freedom to lead the orginasation and achieve change. Managers should have clear goals and objectives against which their performance can be monitored, and payment and reward structures should be geared towards the attainment of results. Performance measures should be quantifiable as far as possible.

Managers should be outward looking, trying to satisfy the demands and needs of the organisation's 'customers'.

Unlike Ranade, Pollitt (1993) is very critical of 'new managerialism' being applied to any public service arm and suggests that transposing a managerial model developed in the private sector does not work, because public sector management is different on several grounds. Firstly in that the public sector has a different role and purpose, that does not leave it the freedom to manage. Secondly the public sector is unable to define who the 'customer' is. Thirdly there are uncertainty of goals and the relationship between demand, supply and revenue differ from the private sector.

Pollit argues that there is a political dimension which is not mirrored in the private sector, that is accountability to elected representatives. He illustrates this by suggesting that there are no analogies that work when comparing the two sectors. For example, directors are usually appointed, whereas politicians are elected on the basis of party inspired manifestos. He points out that, in the private sector, there is no situation where a company has to function in a climate where there is a permanent alternative board of directors bent on discrediting that company and constantly suggesting alternative strategies. Relationships between senior managers and politicians are seen as both critical and unique to public services.

> "The political process can be seen as an incidental feature of management in the public domain or more seriously it can be considered as a constraint... as though it is a special difficulty to be overcome, rather than a basic condition expressing the purpose of the public domain" (Local Government Training Board, 1988:5)

Pollitt goes on to suggest that there are multiple goals and priorities. If one takes a rationalist explanation of what management is, in an unsophisticated way, success might well depend on the following process: first to define mutually agreed goals; then to translate these into limited sets of objectives; obtain the relevant management skills and information to achieve these, in the most cost efficient manner; and to monitor the achievement of those targets. An alternative account is offered by more contemporary organisational theorists who argue that 'problematic goals, unclear technologies, fluid participation, shifting and contradictory performance criteria and conflicting stakeholders characterise *all* complex organisations' (Reed, 1988:43). Even taking account of the latter approach Pollitt suggests that public service organisations still differ greatly from private sector companies. He argues that objectives are set, often, by political, rather than economic, rationality. This view is also shared by Aaron Wildavsky.

> "But why, you ask, do governments set objectives they cannot achieve?... these objectives (improve health, reduce crime) all seem terribly attractive and politically seductive" (Wildavsky, 1979:47)

These objectives are frequently unachievable, and often expressed in vague and ambiguous terms. By doing this it is easier to argue later that the aims have , at least in part, been successfully achieved. Broadly based statements leave politicians more room for maneuver, it allows them to defend, evade and innovate in the arena of political debate, as well as taking the credit for any successes. Because of these complications, Pollitt suggests, that unlike business corporations, there is never any 'clear steer' from above. Political decisions can differ from 'good management'. An example of this (Ranade 1994) might be the decision taken in 1991 that no one would have to wait for more than two years for an operation, irrespective of clinical needs.

To comply with this managers were sometimes forced to expend resources on the most trivial of complaints.

Another area where there are differences is the supply and income relationship in the NHS compared to outside business (although the 1990 reforms did much to alter this). Within the public sector increased throughput does not necessarily increase 'income' but may only increase costs. Accordingly there may not be the incentive to increase throughput. Often (especially in the case of health care provision) politicians may want to divert media attention from their rationing roles:

> "Public service managers, instead of focusing on stimulating the public's demand for their 'products' find themselves *de facto* searching for politically acceptable ways of limiting demand and rationing what they provide" (Pollitt 1993:124)

Another constraint on the public sector is that it is often cash limited by politicians, in that there is a finite amount of cash available in the system, so that if one provider significantly increases their share of the market, then of necessity, another provider will shrink its market share. This is not always the case in the private sector where in emerging markets, by employing sophisticated marketing techniques, it is sometimes possible for several companies to do well without being detrimental to the others. An example of this is the growth of financial services and associated products over the last decade.

The final distinction that Pollitt makes concerns the freedom of public sector managers to manage. For example managers do not have the option to exit 'unprofitable markets'. Often managers are unable to determine terms and conditions of employment for employees, as these are set down by the local health authority. This is a constraint that all non-fundholding GP practices suffer from, in that the health authority will only reimburse wages to doctors for employee positions that they have sanctioned and at the rate of pay they dictate. The health authorities usually refer to recommendations laid down by the Whitley Council, which determine the salaries of administrative and clerical staff employed by the health authorities. These are published annually in a complex table, which divides the pay structure into 9 grades with many sub-divisions. When commenting on the national, inflexible pay awards and gradings with regard to the UK public sector Sir Frank Cooper observed that "**the ability to offer incentives, award penalties or give rewards is negligible**" (Cooper, 1983:15)

Pollitt's analysis is useful in helping us understand "managerial values" in the context of the NHS. Nevertheless Gunn (1988), argues that some of the differences discussed are overstated and it is still legitimate to use some of the evaluative tools of management to analyse and better understand the issues and dilemmas affecting the NHS. This has been attempted, particularly in the second dimension of **PAM "Concern for Operational Efficiency and Income maximisation"**

(3.2) General Medical Practice

The preceding arguments have been concerned with the whole of the National Health Service but it is necessary to look in more detail at General Medical Practice (GMP). The subject of management in GMP is extremely ambiguous. A doctor's practice is unusual in that it is a privately run, self contained business, owned by a doctor, or several self employed partners. However their terms and conditions of payment are determined by Parliament, and to some extent the working conditions are determined by the Health Authority (via the cost rent scheme, remuneration of staff etc.). In some respects a GMP resembles a franchise. Nevertheless, there appears more autonomy for the proprietors than is usually the case with a commercial franchise. However this autonomy, it might be argued, stops with clinical issues, but the administrative procedures might well be as tightly controlled as those of a business franchise.

Taking the concept of a franchise might well be an appropriate vehicle by which to examine the relationship between the government and GPs. There are some similarities between franchises and GMP, which serve to illustrate the elements of power and control. In the previous chapter a conflict was identified between GPs and the state which centered around issues of GP autonomy versus control by the state. The equilibrium point that was reached was something akin to a franchise agreement. This "franchise" structure removes any strategic power from GPs and only allows them operational power, which fits well with the concept of fee maximisation. As we can see from Mendelsohn's (1987) definition of the franchise the analogy can only be taken so far.

> "The franchise format is the grant of a license by one person (the franchiser) to another (the franchisee), which entitles the franchisee to trade under the trade mark / trade name of the franchiser and to make use of an entire package, comprising all elements necessary to establish a person in the business and to run it with continual assistance on a predetermined basis." (Mendelsohn 1987:1)

The relationship between franchiser and franchisee is not equal, the contract is one of adhesion rather than negotiation. In other words the applicant accepts the conditions as they are, or does not sign up at all. This emphasises the fact that most of the power lies with the franchiser. As Forward and Fulop point out

> "Various commentators have expressed concerns about the bias of the contract in favour of the franchiser. This, it is believed, causes the franchiser to easily hold the balance of power within the relationship and hence have full control over its workings. This control may be considered to produce conflict within the relationship because it inhibits the actions of the franchisee" (1993:37)

Figures 3.1 and 3.2 set out the legal positions of both the franchisee and franchiser

A Franchisee's Legal Obligations

1) To carry out no other business besides the franchise business.
2) To observe the agreed opening hours.
3) To promptly and properly equip and shopfit the premises and only make alterations approved by the franchiser.
4) To operate the system properly and strictly in accordance with the operations manual,
5) To pay a franchise fee
6) To maintain adequate business insurance cover.
7) To maintain the highest standards, not to do anything to bring the system into disrepute and comply with all statutory and other legal requirements.
8) Not do anything that might result in either the franchiser or franchisee being liable to conviction of any offence.

Acheson and Paul 1991:5

Figure 3.1

These are the basic minimal requirements of a franchise agreement to satisfy the law. Obviously most contracts will have considerably more detail, for example the franchisee may be required to have their shop fitted in a certain way with a specific colour scheme, the staff to wear particular uniforms and telesales to strictly follow a script. Whilst 1 & 5 clearly do not apply to GMP there are elements of *all* the other conditions that could be seen in the relationship between the GMP and the Health Authority.

A franchiser's Legal Obligations

1) To provide the franchisee with initial training
2) To provide the franchisee with continual training and issue them with an up to date manual.
3) To provide guidance to the franchisee on the marketing, administration, and development of the franchise.
4) To provide continual product development.
5) To provide knowledgeable and experienced field support personnel and persons at head office to enable franchisees to deal with operational problems they may encounter.
6) Franchisers may wish to grant exclusive territory to prevent franchisees trespassing on each other's territories (The Restrictive Practices Act 1976 makes provision for this, although EC Law will soon mean that we fall in line with the rest of Europe when regulation 4087/88 is implemented).

Acheson and Paul 1991:5

Figure 3.2

There are certain ingredients for a franchise that apply to GMP, these elements of control are backed up by statute. For example, the Authorities had control over: whether a new GMP may set up in business and its rough location; how much is spent on the premises; whether an annual business plan must be submitted; and when various reports have to be submitted. The government also exerts control, in that it dictates the percentage of cervical smears to be completed and immunisations to be

administered within a defined population. Until recently, control was exercised over the types of clinics that *had* to be run.

In the commercial setting the franchisee may enjoy relatively little autonomy, depending on their particular field. Doctors, it has been argued, do command quite high levels of autonomy. Tolliday identifies four kinds of claim that doctors make, each described in terms of freedom:

> "The right to practice free from hierarchical management; the right to refuse an individual patient; the right to lead and co-ordinate other health professionals; and the right to regard medical knowledge as over arching that of other disciplines" (1978:42)

In 1986 Schultz & Harrison published the results of a survey amongst a group of doctors and asked them in what ways they perceived that they had autonomy within their work. The following were alluded to most frequently:

> "Choice of specialty and practice location; control over earnings; control over the nature and volume of tasks; acceptance of patients; control over diagnosis and treatment; control over evaluation of care; and control over other professionals" (1986:338-340)

In the light of the 1990 reforms it might be argued that some of the above have been eroded. This has recently been ephasised by the debate surrounding Viagra, where there have been overt actions by the state to restrict one of these freedoms on financial and not clinical grounds. Doctors do see themselves as being apart from other professions for a variety of reasons, some historical, some current. For a greater understanding of this it is useful to examine the origins of the General Medical

Practitioner and the constraints placed upon them. The state played a major role in the founding of the medical profession by the granting of a Royal Charter and the subsequent Act of Parliament in the late sixteenth century. Initially, control of the profession was based on class (membership was restricted to graduates of either Oxford or Cambridge Universities) and certification was the direct responsibility of the church. (Macdonald 1995). The first state initiated regulation came in the guise of the Apothecaries Act in 1815. The next regulative mechanism was the Medical Act of 1858, but the state left the initiatives and regulations largely to individuals within the profession, rather than state officials, as had been the case on the continent (*Ibid*). The strength of the profession was demonstrated in 1945 when the BMA was able to secure major alterations to the proposed National Health Act

Another reason why the medical profession might argue that it is different is that doctors are involved in some of our more basic cultural rituals, in that they are people that sign death certificates and are usually present at the birth of a child. Often absence from work due to ill health may only be sanctioned when the person is given a sick note signed by a doctor. Apart from these legitimised forms of power doctors are also in a unique position of trust (similar to that of a priest) in that they are allowed to transcend some of our social taboos. Some examples of this are that they can see us with no clothes on and that we confide in them by allowing them to know the details of our private life. For instance a woman patient will implicitly let the doctor know that she is sexually active, if she asks for a prescription for the pill, or an alcoholic may confide in the doctor if they have a drink related problem. Friedson summed up the special position of the medical profession thus:

> "Professional occupations are especially distinguished from others by their orientation to serving the needs of the public through the schooled application of their unusually esoteric knowledge and complex skill" (1983:19)

These comments were made over a decade ago and until recently the doctor's position *was* firmly established and they *were* well respected and trusted people in the upper echelons of society. People's perception of "the Doctor" had remained unchanged for decades. Over recent years, especially under the Thatcher administration, this status has gradually been eroded, culminating in the imposition of the 1990 reforms. The populous at large is being encouraged to question the value for money that they get in a variety of contexts and the medical profession is no exception. The Patient's Charter clearly sets out doctor's obligations and the public's rights. Couple this with increased awareness, and education (via the media) of the public and the mystique of the profession is disappearing. It might, therefore, be argued that the traditional position of the GP is currently being threatened as never before with greater GP accountability both to the Area Health Authority and to their patients.

Given the preceding remarks the GP is still in a unique position in that they are an entrepreneur running their own business (often in conjunction with similarly qualified partners), in complete charge of the day to day details. For example they have control over when they go to work, how much they spend on the general ambiance of the practice, the control and motivation of the staff. In contrast at the same time they are in a position of comparative weakness concerning the government, with many aspects of their working life being dictated by legislation (the New 1990 Contract).

Reflections in section (3.1) have suggested that from the early days of the NHS's inception the government wanted to directly employ, and thus control, GPs, but was unable to do so and GPs effectively took on the role of subcontractor. It might be argued, especially in the light of the 1990 reforms, that the relationship between GPs and the government more closely resembles that of franchisee and franchiser. If that is so and we accept the relative positions of power discussed earlier then a case might be made that what the government failed to achieve in 1944 has now been brought about by applying the principles of franchising.

(3.3) Management

Setting aside the uniqueness of general practice, there is considerable debate about what is meant by the term "management". On the one hand classicists have defined management in terms of functions Planning, Organising, Command, Co-ordination, Control (Fayol 1916), however even these do not neatly break down into observable tasks. Various studies (Burns 1955, Carlson 1951, Dalton 1959, Kotter 1982 Pettigrew 1973, Stewart 1976 and Watson 1977,) have shown that managers do not scan their environment, dispassionately analyse data and make decisions based on this analysis. Many studies argue that they spend much of their time in verbal communication, they rarely spend more than half an hour on any one item, a typical day contains hundreds of brief interactions, which include highly variable tasks. This analysis was made by Carlson (1951), in his study of Swedish managers. This was the first research using the diary method (this method of research involves the subjects filling out a diary of their activities themselves). Later on in 1967 Rosemary

Stewart studied British managers using the same method. Her impression of the management function was:

> "The picture that emerges is of someone who lives in a whirl of activity, in which attention must be switched every few minutes from one subject, problem, and person to another; of an uncertain world where relevant information includes gossip and speculation... it is a picture, too not of a manager who sits quietly controlling but who is dependent on many people, other than subordinates, with whom reciprocating relationships should be created; who need to learn how to trade, bargain and compromise" *(Stewart 1983 p96)*

It has been argued that the diary study method of research is not rigorous in that it does not elicit valid and objective data as may have been implied. Mintzberg (1973) studied American managers using direct observation rather than relied on the subjects interpretation of events. Perhaps unsurprisingly, Mintzberg found that managers greatly exaggerated the time they thought they spent on activities such as scrutinizing reports, assessing special projects and making thoughtful and reflective decisions.

Matters are further complicated when one considers the importance and meaning the subject associates with various actions, so that whilst a researcher may record actions that are indisputable "facts" they are still open to interpretation. For example a manager makes a five minute telephone call to the FHSA (fact). Upon being questioned they say the purpose of the call was to gain information on their A&E admissions for the month. However, from your observation you know that only one minute was used to illicit this information (fact). The rest of the time was spent remarking on the local football teams results last Saturday, discussing another Practice Manager, recalling events at the last course both parties attended and talking

about who the next chief executive at the local provider unit might be. If pressed, the manager might justify the additional four minutes spent on the phone, as legitimate management activity. The grounds might be that they were gathering useful information (interpretation) that may come in handy for the practice, building up essential contacts with the FHSA that would smooth the path at a later date and accumulating facts about a rival practice.

Watson (1994) suggests that

> "Human actions, in the managerial context, or any other, have patterns to them which arise from an interplay between deliberate choice, or purpose and the social, political, economic circumstances in which they find themselves - circumstances which involve a constant struggle to cope and survive." (p.25)

He suggests that central to all human interaction is the practice of exchange, that all human activity is carried out either consciously or subconsciously in the context of the individual's world with reference to that individual's aspirations, ambitions, goals and constraints. This leads us to the notion that part of the management function is a process of exchange. Watson articulates the "strategic exchange perspective" concept. He suggests that whilst an exchange is an act of reciprocal giving and receiving, in this context an exchange should include not only the material and concrete, but also the abstract and symbolic. These actions are strategically orientated because they are related to a broader purpose, to the projects and interests of the individual. In the earlier example, the manager may have talked about the local football team as they knew the FHSA clerk had a passion for football. Implicit in this aspect of the conversation was a) I take an interest in you and remember your hobbies

and passions b) I'm not just an arrogant manager demanding my figures, I'm a decent person just like you, with similar interests

To further complicate matters, the meanings and interpretation we put on our actions are not consistent, they depend partially on influences beyond our control and sometimes on very trivial matters such as the temperature in the office, what we had for breakfast, or if we have a cold.

From the preceding discourse it can be seen that there is considerable debate as to how we define management. We can't unequivocally state that management is a set of specific actions. There can be no absolute definition that excludes all other attempts at the "truth". If we can't define management activities with any clarity, everybody's actions are determined by their own individual agenda and there is no consistency to our actions, how then can anyone make sense of management in general practice? The solution has to be to make some assumptions and state them. To select some aspects of "management", explaining that these actions and observations are some of the constituents that make up some management functions, that they are not a definitive and closed list. These may well be termed "**management values**". This is the belief that the process of delivering health care must be seen in the context of other facts, which are explored fully in chapter four. Explanation should then be given to justify why they have been chosen and to look at various stakeholder's perspectives of that selection. If we take Appleby's definition of a stakeholder

> "various groups, both internal and external that can affect or be affected by the accomplishments of the organisations objectives. Each of these groups has a 'stake' in the survival of the enterprise" (Appleby 1991:56)

We can deduce that in the context of general practice there are several stakeholders that may have divergent and conflicting agendas and subsequent differing interpretation of various actions. The prime groups would be; the doctors, professions allied to medicine, office staff, reception staff, seconded medical staff, the practice manager, the FHSA and the patients. The aim of this research is to examine some aspects of management from the manager's and doctor's perspective, which was the driving force behind the development of the Practice Audit Matrices (PAM), explained in the next chapter. However the manager's and doctor's perspective will not be looked at in isolation. Where appropriate, the other stakeholder's perspective will also be discussed.

(3.4) Dilemmas and Tensions

Since before the formation of the NHS in 1948 there have been dilemmas and tensions in the provision of primary health care that have not been solved to this day. The themes appear to be a conflict concerning the power and autonomy of doctors, and these often manifest themselves in matters of doctors' pay. We see that prior to the enactment of the National Health Insurance Act, as long ago as 1911, the BMA was fighting hard to preserve the financial position and autonomy of their members, eventually forcing several hard concessions from the government (Macdonald 1995)

In 1944 when considering proposals for the White Paper (**A National Health Service**) the government wanted doctors to be directly employed by the local authorities, such was the opposition of the BMA that they refused point blank even to

discuss the mater. As the NHS has evolved since 1944 various attempts have been made at greater control and accountability of doctors. In 1950 the minister of health appointed a senior civil servant (Sir Cyril Jones) to study the workings of the NHS. In the findings of his report he challenged the doctors right to autonomy arguing for more uniformity. Amongst other things *"he challenged the doctor's right to prescribe for his patients as he wishes*" (Klein 1995:49). The 1974 reforms did much to increase the power of GPs (and also nurses) in that they were allowed to sit on area and regional boards and in most cases had the right of veto. As well as this, half the members of the newly formed Family Health Services Authorities were elected by the professions themselves. However, these reforms were an attempt to satisfy the needs of all interested parties. They were a political exercise in trying to satisfy everyone, to reconcile conflicting policy aims and to promote managerial efficiency but also to satisfy the professionals (Klein1995:99). Apart from slowing down the time decisions took to implement they did little to redress the balance of power. The 1982 reforms swept away layers of control in the NHS but did not, despite its stated aim of allowing as many decisions as possible to be made at local level (DHSS 1979), place any more power or autonomy in the hands of the GPs. The 1990 reforms, by allowing the money to follow the patient, arguably did much to empower the GPs. However with that increased autonomy came very direct accountability, with a large proportion of their own remuneration being influenced with meeting government dictated targets (see Appendix VIII).

(3.5) Conclusions

This chapter has summarised the NHS managerial reforms and how these have affected GPs, including the dilemmas and tensions between government reforms and local practices. It has also given a definition of management and an overview of why

management in the public sector is different from other management models. The following chapter outlines the methodology undertaken to analyse and compare a number of practices, taking into account these different managerial values.

Chapter 4

Methods

4.0 Methodology

The focus of this research is to examine how GPs are addressing the demand for a stronger managerial role. Within this are a number of objectives: firstly, to establish the managerial values important within a GP Practice; secondly, to establish some measure or means of comparison within different practices and, thirdly, to collect data about a number of different practices and compare them.

This chapter will initially examine the philosophy that underpins the research methods used, then consider a methodology for collection and comparison of data, including the use of a pilot study, definition of a tool for analysis, and definition and collection of case study material. The actual methods of research are then described and analysed in the context of both reliability and validity.

(4.1) Philosophy of Method

It is important to understand the epistemological view point that informs the approach taken to the research project. Easterby-Smith *et al* propose that there are three reasons why the approach is important. Firstly they suggest that you will be able to make more informed decisions about the design which is

> "more than simply the methods by which data are collected and analysed. It is overall configuration of a piece of research: what kind of evidence is gathered and from where, and how such evidence is interpreted in order to provide good answers to the basic research question" (Easterby-Smith *et al* 1992:21)

The second point is that you will be able to determine particular approaches that will and will not fit with one's philosophical stance. Thirdly a knowledge of different research methods will help you adapt and take account of constraints. Having established the importance of determining the approach I will now consider the distinction between the terms epistemology and methodology. The term epistemology comes from the Greek word episteme, their term for knowledge. Epistemology is the philosophy of knowledge of how we come to know. Methodology is also concerned with how we come to know, but is more orientated to the practical than the philosophical. Jary & Jary define it as "the techniques and strategies employed within a discipline to manipulate data and acquire knowledge" (1991:394).

Methodology is focused on the specific ways, the methods that we use to gather information to try to understand our world better, for example interviews, questionnaires, and analysis of the literature.

> "Epistemology and methodology are intimately related, the former involves the philosophy of how we come to know the world and the latter involves the practice". (Trochim, M. K. 1998)

Before describing my own epistemological stance it would be helpful to consider the background and review the arguments that lie behind the opposing epistemological views of positivism and phenomenology.

August Comte is the man generally credited as being the father of the social sciences. He argued that the evolution of society followed invariable laws, that behaviour in the social world is governed by laws in the same way as behaviour in the natural world. If this statement was proved to be correct then, indeed, the methods of the natural sciences would be equally appropriate to the study of people. Haralambos suggested that:

> "Auguste Comte argued that the application of natural science methodology to the study of man would produce a 'positive science of society' that would reveal that the behaviour of man was governed by principles of cause and effect which were just as invariable as the behaviour of matter, the subject of the natural sciences". (Haralambos 1987:.493)

From this came the school of thought that is termed positivism. When describing positivism Gill and Johnson point out that:

> "According to many commentators two of the most significant characteristics of positivist epistemology contain claims that warranted science is concerned with:
>
> 1) only directly observable phenomena, with any reference to the intangible or subjective being excluded as being meaningless; and
>
> 2) the testing of theories, in a hypothetico-deductive fashion, by their confrontation with the facts of a readily observable external world.".
>
> (Gill and Johnson 1997:131-132)

Positivism has been criticised because it assumes that society can be described and understood in terms of what is empirically evident and quantifiable. Bilton suggests that:

> "the meanings and consciousness of the social actor are not seen as a problem to be overcome by a strict adherence to quantitative methods that measure social behaviour. Rather, sociology must treat meanings, values, beliefs and hopes of individuals as its principle data, its primary subject matter". Bilton (1985:639)

Hughes further endorses this view:

> "Human beings are not 'things' to be studied in the way one studies rats, plants, or rocks, but are valuing, meaning attributing beings to be understood as subjects and to be known as subjects... To impose positivistic meanings upon the realm of social phenomena is to distort the fundamental nature of human existence." (Hughes 1986:.25)

To further complicate matters consideration must be given to the fact that not only are the observed humans but so are the observers. Because of this it is not possible to analyse observations in a vacuum isolated from our own humanity and so by our own selective processes we will interpret and give meanings to our findings. As Habermas contends:

> "even the simplest perception is not only performed pre-categorically by physiological apparatus - it is just as determined by previous experience through what has been handed down and through what has been learned as by what is anticipated through the horizons of expectation". (Habermas 1974:199)

The alternative view to positivism is the phenomenological perspective, so called because it is based on the way in which people experience social phenomena. It focuses on meanings, what and why events happen. This rejects many of the assumptions of positivism. A useful definition is given by Saunders, Lewis & Thornhill.

> "The phenomenological approach to research is so called because it is based on the way people experience social phenomena in the world in which they live... Phenomenology is characterised by a focus on the meanings that research subjects attach to social phenomena; an attempt by the researcher to understand what is happening and why it is happening".
>
> (Saunders, Lewis & Thornhill 1997:P.72)

Martyn Hammersley draws attention to the differences between the opposing epistemologies, referring to phenomenologist camp he states:

> "All these thinkers reject the methodological monism of positivism and refuse to view the pattern set by the exact natural sciences as the sole and supreme ideal for a rational understanding of reality." (Hammersley 1993:11)

It is argued that the subject matter of the social and natural sciences is fundamentally different. As a result of this the methods and assumptions of the natural sciences are inappropriate to the study of people. For this reason objective measurement is not possible, because meanings are constantly negotiated in on-going interactionary circumstances simple cause and effect relationships cannot be determined.

Whilst leaning towards the positivist view, in that I believe that generally behavior can be objectively measured and quantified and to a certain extent predicted, I consider that some of the positivist methodologies, for example the presentation and analysis of observations are legitimate. On the other hand I do not believe that human behavior is clear cut and unambiguous. Because we are all human beings, each and every action and interaction is unique to that moment. There is an obvious dichotomy here and because of this I think it is only possible to describe oneself as having leanings towards a specific epistemological view. As Easterby–Smith *et al.* point out

> "When one looks at the practice of research...even self confessed extremists do not hold one position or the other...occasionally an author from one corner produces ideas that belong more neatly to those of the other corner" (Easterby–Smith *et al* 1992:22)

Influences other than the researcher's methodological and epistemological philosophies may well determine the actual method(s) used for information gathering. There are practical questions that have to be addressed: the time allocated for the research; the cost of obtaining information in a certain way etc. Set out below is a model produced by Gill and Johnson (1997, p.152) that lays out the impact upon research of philosophical, social, political and practical dilemmas.

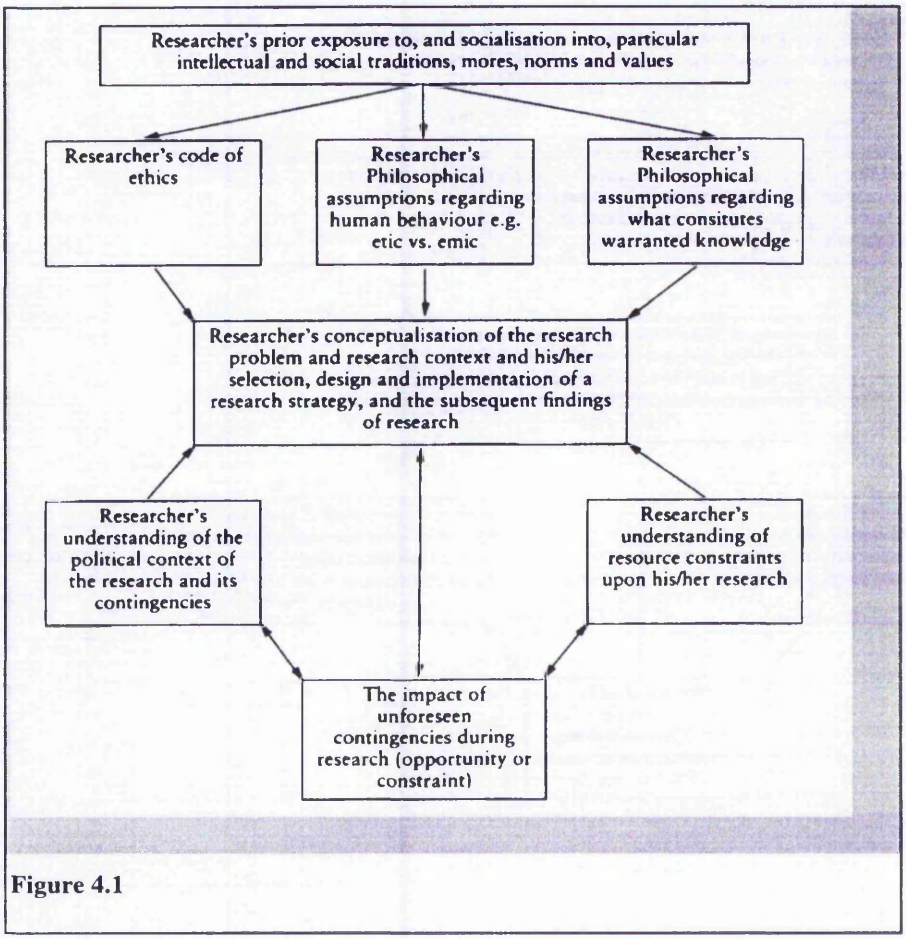


Figure 4.1

I have used both qualitative and quantitative methods, sometimes using one method traditionally associated with a specific epistemological school and analysing it "borrowing" a method associated with the "opposing" school. It is not realistic to suppose that if the researcher uses one method of data collection they are in some way excluded from using another method (of opposing epistemological origins) to support and illuminate the findings of the first. Laurie and Sullivan comment:

> "We suggest that the tendency to see qualitative and quantitative methodologies as mutually exclusive and antagonistic paradigms is a misleading representation of the reality of social research practice." (Laurie and Sullivan 1990:113)

This view is further endorsed by Denzin, who advocates a multi method approach of triangulation:

> "By combining multiple observers, theories, methods and data sources, sociologists can hope to overcome the intrinsic bias that comes from single method, single observer, single-theory studies". (Denzin 1978:307),

Given this stand point I decided to conduct the research using case studies, Robson (1993:40) defines case study as the "**development of detailed, intensive knowledge about a single "case", or a small number of related "cases" ".** Yin (1984:78-98) suggests that there are six sources of evidence relevant to case studies. I use all but one of these (in italics), documents, *archival records*, interviews, direct observation, participant observation, and physical artifacts.

I believe that inevitably all quantitative data is based upon subjective judgments; and all qualitative data can be described and manipulated numerically. This is illustrated in Figure 4.2 .

Sample Population	Collection Method	Presentation of results	Perspective	Interpretation
Representative	Un-structured	Narrative	Subjective	Phenomenological
random				
Non representative	Structured	Tables & Graphs	Objective	Positivist

Figure 4.2

As in the creative thinking technique known as morphological analysis it is possible to construct a research strategy combining random choices from each column in figure 4.2. I believe it is possible to use techniques from one philosophical school, say data collection, and then employ a technique from another "opposing school", say interpretation. The questions that I wish to answer are primarily positivist in orientation. Because my material is qualitative and ethnographic the interpretation of the material and the drawing of conclusions has to be done with the care associated with a phenomenological approach. An example of this is that I used a non representative group of doctors, conducted a series of structured interviews with them, presented some elements of these interviews in tabular form, whilst others took a narrative form

For instance (given accurate recording). the number of patients coming to a surgery and their stated reasons for doing so are observable and "indisputable facts". A pragmatist might argue that the *actual* reasons for coming to the surgery are far more complex than we can extrapolate from observation, that the reasons are probably unknowable, thus not

"indisputable facts". However there are elements of observation that could be described as "indisputable facts", for example the numbers of patients who visit the surgery and who they see. When these observations are recorded as numbers then they can be manipulated so that certain ratios can be computed and analysed in a manner associated with the positivist paradigm. An example might be that the proportion of patients seeing the nurse as opposed to the doctor, could be expressed as a ratio, which might be compared with observations made at another doctor's surgery: again, cast iron facts.

Without interpretation these will remain facts but of no significance. If some comment is made regarding the skill mix in the practice a qualitative judgment has been made. Conversely when information regarding GP's activity is elicited by interview, this could be entirely a subjective view made by the GP. However this would be dependent on several things, for instance if the answer is biased, or even a lie, or whether the question was dichotomous with a yes/no answer. For example "do any of the GPs carry out private non NHS work?" or an opinion "How many hours do you think, on average, you spend doing paperwork per week?" There is ample evidence that managers are poor estimators of their own time allocation (e.g. Burns, 1955; Warmington & Lupton, 1977; and Mintzberg 1973), it is reasonable to assume that this is also the case for doctors. Yet such subjective measures can be numerically represented so as to make comparisons between the time doctors spend face to face with their patients. I believe that this method of eliciting information is entirely legitimate, providing when reporting or analysing the findings, the researcher "comes clean" with their reader. Also that they explain what steps were taken, for instance, to make the doctor's estimate as accurate, or consistent

with each other, as was possible. Alternatively the data can be used but the potential limitations of the method must be born in mind when drawing conclusions

I understand that the researcher cannot totally remove all their influence over what they are researching. This is an inevitable consequence of our humanity. An example can be given that happened during the course of my own research, whilst outside a doctor's consulting room timing patients coming in and out. As one of the doctors came rushing past me he said "I don't usually have a break. It'll spoil my average I know, but nature calls!". Clearly here I was influencing my subject's behavior, in that they had been aware of my presence outside for the whole of the surgery and saw me as some how judging them. This really did surprise me, as I thought that once underway, the doctors would be so engrossed in their consultations that they would have completely forgotten about me. So I do accept that each incident is the blend of a unique set of circumstances, actions and reactions that can never be absolutely replicated. That in itself doesn't invalidate the measurement of (for instance) consultation times, because the same set of variables applies to each similar set of circumstances.

All of the observations and findings of the research, both "factual" and subjective were represented and analysed using numerical methods of analysis. There is a well established tradition for inclusion of anecdotal evidence to support the "hard" data. As Mintzberg observed of his own research:-

> "The research, in its intensive nature, has ensured that systematic data are supported by anecdotal...we uncover all kinds of relationships in our "hard"

> data, but it is only through the use of this "soft" data that we are able to "explain" them and explanation, of course, is the purpose of research...the researcher who collects quantitative data from a distance without anecdote to support them will always have difficulty in explaining interesting relationships". (Mintzberg 1973:587)

I think that most people draw too hard a distinction between positivist and phenomenological positions. In the past this distinction has led to protracted discussions, each camp arguing the superiority of their kind of material over that of their opponents. It is argued that quantitative data is hard, rigorous, credible and scientific. Qualitative data, it is argued, is sensitive, nuanced, detailed and contextual. By looking at figure 4.1 it can be seen that it is possible to mix the tools for collecting, presenting and interpreting information.

My research has been within the positivist paradigm; in that it breaks things down to their elements; it involves observing contemporary events as they happen; the results can be categorised and counted to produce general conclusions. I have used quantitative methods, mainly, but with some descriptive anecdotal evidence also taken into account. To summarise my own position then, I believe that a great deal of what we see in the world is quantifiable,. This allows the manipulation of these observations to help us make sense of them. The world is a very complex place and every event has a slightly different cause and effect, however we can allow for that in our observations. When we see something that we feel might slightly influence our findings we state it and carry on. We never will find the absolute truth about anything. I refer, again, to Mintzberg.

> "All theories are false, because all abstract from data and simplify the world they purport to describe. Our choice, then, is not between true and false theories, so much as between more and less useful theories" (Mintzberg, 1973:584)

(4.2) Focus of the research

So it is with my own research. Management is a multi-faceted thing, more complex than commonly believed by GPs. It is not just about strategic thinking,- mission statements, objectives, administrative audit, planned growth and such matters. This is only one aspect of "management" and for the purposes of this research I have called this element "strategic management values". It is possibly this aspect of management that most doctors strongly objected to. Greenfield and Nayak found from their research that:-

> "Responses to the questionnaires showed that general practitioners did not view the prospect of having to adopt business methods at all positively. They felt first and foremost this was not part of their professional role".
>
> (Greenfield and Nayak 1996:61)

It is the central theme of this thesis that strategic management is only one aspect of management, but there are other areas, which GPs may pursue, such as operational efficiency, which also fits well into descriptions of *occupational standards for managers* (MCI 1991).

> "In other words, GPs may criticise the management role for making accountancy more important then clinical judgment... but they can also, as independent contractors to the National Health Service (NHS) and as people running a small business, be very concerned with cutting costs or maximising their income." (Fisher & Best 1995:48)

The view under examination is that GP's reaction to management are highly complex. They may espouse anti management values, but at the same time display good management housekeeping practices. I decided on a series of in depth case studies to consider this. In these case studies I took a positivist approach.

The case study is distinctive from other means of empirical inquiry and has been criticized by academics as lacking in rigor in which biased views have influenced the direction of the findings and conclusions (Yin 1984:21). But bias *can* enter into other research strategies as well (see Rosenthal, 1968, Sudman & Bradburn 1982). I have tried to ensure that I entered into my research with an open mind and that I have not introduced an element of bias. Another criticism of using the case study is that you cannot generalise from the findings taken from a single (or small number) of case(s). When facing the question "how can you generalise from a single case", Yin suggested

> "The short answer is that case studies, like experiments, are generalisable to theoretical propositions, not to populations and universes" (Yin 1984:21)

Earlier I stated that the central theme of this thesis is that strategic management is only one aspect of management that applies to GPs, but there are other areas that they may pursue. From this it is possible to construct the following proposition. "GP practices can be described as managerial, or not". Utilising Karl Popper's notion of falsification it would then be legitimate to use a case study to refute this hypothesis. In this case through the results it is possible to say "I have found a practice where it is NOT possible to state if it is managerial or not, because it display some of the attributes but not others"

The focus of this research was to identify how GPs are addressing the demand for a stronger managerial role. Figure 4.3 illustrates the development of the research was an iterative process through data collection..

Development of the research process, through data collection

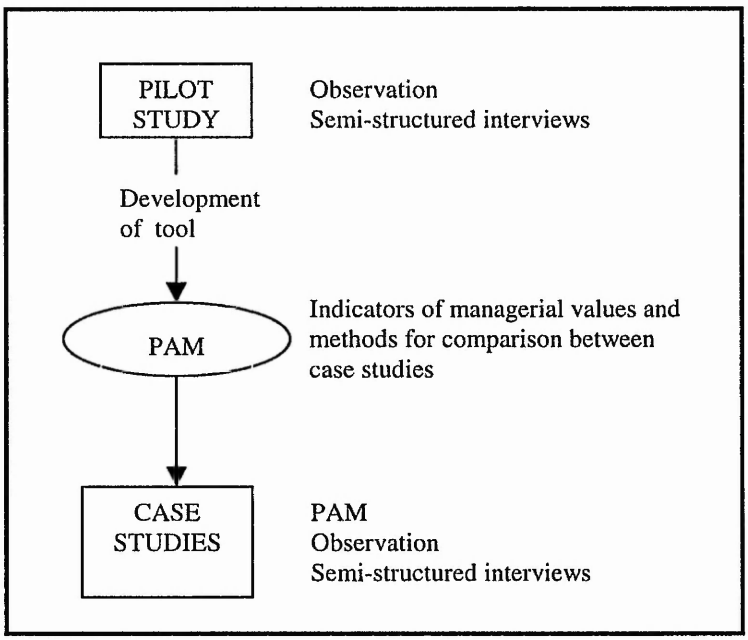


Figure 4.3

This called for a comparison of a number of General Medical Practices, in order to assess the approaches taken to management in different circumstances. Because a pluralist view of management was taken, a number of 'indicators' needed to be identified in order to compare practices. To this end, a pilot study was undertaken to identify important themes which might be used as indicators of managerial stances. This led to the development of an audit matrix for comparison of stances between different practices and was used in the assessment of four such case studies.

The research started with a small pilot case study in a city centre practice. After that, four more in-depth case studies were conducted at various practices, described in more detail in chapter 5.

(4.3) Access

Access for the researcher can often be problematic (e.g.. Easterby-Smith, 1992; Gill and Johnson 1997; Silverman, 1995; Hammersley 1993 and Strauss and Corbin 1990) and my access was no different, often the result of a "contract". The pilot practice was recommended to me by the surgeon who carried out my back operations. Given the balance of power that existed in 1994 between surgeon and family doctor, the fact they

had been recommended to me by a leading surgeon meant that I had no problem being granted an interview at the practice.

The negotiated agreement was similar for the other four practices with a few minor variances so I shall only describe the arrangement that was agreed upon with the pilot surgery. The doctors believed that whatever the intentions, my being there would cause some disruption. I agreed with this concern and in little ways this was borne out. One illustration is my interrupting staff to clarify a procedure. Another is that the receptionists agreed to fill out analysis forms for patient activity, an example of which can be seen in appendix XIII. The doctors also argued that to interview both of them for an hour, if costed at BMA rates, would be worth £160 as well as £12 for an hour of the practice manager's time, so there would be some quantifiable (if only notional) cost involved. In return for access I promised to design and undertake any administrative audit that they might want conducting and provide them with a consultancy style report, complete with suggested solutions to any problems I perceived that the practice had. The audit that they required, which I had not intended to do, was an analysis of their incoming phone calls. The negotiation at the pilot practice was the only one where an explicit contract was articulated. At all of the others I asked for the help and access I required and offered the report and audit in return.

The issue here is that positivist research usually uses large sample surveys and takes great care concerning representativeness. I was doing four case studies within a positivist framework.

(4.4) Selection of Practices

The practices were selected in the following manner. The first one was referred to me by a colleague who had, himself, carried out a small research project there. The lead partner was obviously sympathetic towards research and allowed me access with no strings attached. I had previously decided that I would conduct the research in the same Family Health Service Area (FHSA) as they exerted the same influence over some "management" activities. For example some FHSAs made every practice fill out a proforma type business plan. By staying in the same area I would have continuity of that influence.

Contact was made with the other surgeries in the programme by the author making a public appeal at a conference for practice managers and doctors. This method of selection might throw some doubt on the reliability of the research, if we take Easterby-Smith's definition.

> "Will the measure yield the same results on different occasions (assuming no real change in what is to be measured)? (1992, p.42)

The weakness might be that these were a self selecting group, whose very attendance at the conference (about practice management) might be interpreted as disposing them towards "management". If this were the case and if I had been able to recruit two

practices outside the conference then my findings might have been different. In mitigation I feel that my chances of access would have greatly diminished in this group. Taking aside access, which was the main problem, the other constraint was that of geographical location. The surgeries had to be within a radius of fifty miles of where I lived for practical reasons. Two rural and two city practices were deliberately chosen as it was thought (wrongly, as it turned out) that there might be significant differences in the problems and the way these were tackled. Four practices were chosen as it was thought this would be enough to establish a pattern, if there was one, or, in the light of Yin's argument to establish whether there were any differences rather than a pattern of similarity. For practical reasons more than that number would have taken far too long to investigate.

(4.5) Pilot Study

I decided to conduct a pilot study because it allowed me to explore issues that, from my reading, I felt were important. I discovered other areas that I hadn't thought about before, for instance the level of harmony between clinical principles. In fact the surgery where the pilot took place was staffed by a husband and wife "team", who regularly had rows in front of the staff, who used to take sides. This was an aspect of managing GMP that I had not considered, which later became one of the four dimensions I proposed as some of the component parts of "management".

The study was also useful in that it helped me to plan a systematic approach to the research. One example is that it quickly became apparent that forms would need to be

designed to record consultation times in a busy surgery. I understood the make up of a working day far more. This helped me when approaching other practices to ask them to be part of the research programme. In the introduction letter (appendix I) I realised that I needed to emphasise not only the confidentiality aspect, but also that I would try not to cause any disruption.

The pilot was also helpful in that it identified ambiguities in some of the questions and highlighted the need for a written interview schedule (appendices II and III) for interviews with both the senior partner and the practice manager. These schedules made sure that I was not side tracked too much and that I remembered to ask all the questions.

Another very important point was that I didn't record the first two interviews. The result is that I spent a lot of the time writing instead of paying attention to the interviewees. Also when I looked at those notes two months later they didn't make much sense. All subsequent interviews I recorded and I am especially glad that I did this and would urge any new researchers to do the same. When writing up the findings some two years after the interviews were conducted, I found playing back the interview an invaluable *aid memoir.*

I was apprehensive about using a tape recorder, especially when such delicate matters as "how are working relations between the partners?" were on the agenda. I felt sure that either the respondents would refuse to be recorded, or they would feel so inhibited that the richness of their replies would have been diluted. What I found was that once the

the tape would be turned off at any time they wished, they quickly forgot about the tape, until it needed to be turned over. To help the process along I deliberately scheduled the "easy" questions at the beginning (see appendix III)

The other thing conducting the pilot did was to force me, at an early stage, to consider just how I was going to analyse the data from the case studies (section 4.4). To this end I devised a fairly involved spreadsheet. Excluding the pilot, I analysed 18,782 patient visits, 16,586 incoming 'phone calls and over 4,250 consultations. To attempt such analysis using any other method would have taken considerably more time.

(4.6) Practice Audit Matrices (PAM)

The two White Papers responsible for most of the changes to General Medical Practice were Working for Patients (Secretary for State, 1989[a]) and Promoting Better Health (Sec State, 1987) these were discussed in chapters 2 and 3. The new requirements for GPs meant that doctors altered their perception of the service which they offered their patients. Practices became more reliant on list size for their remuneration. In addition there was the introduction of health promotion and clinic payments together with a range of new fees (see Appendix VIII). The fixed element of practice income (practice allowance) was decreased by about 25% and seniority allowances were also reduced. The effect of this was to make practice profits, and thus GP's remuneration, dependant on workload and efficiency (for comparison of average GP income before and after the 1990 reforms see appendix IX). The relative importance of just "being a GP" in general

practice (Handysides, 1994 [a]) was greatly reduced. These changes and other external pressures (Ellis, 1994) obliged GPs to take managerial matters seriously, one study (Warry & Waters, 1994) claims that there has been a 98% increase in the time GPs spend on management and administrative tasks between the years of 1987 and 1994.

The aim of this section is to introduce the concept of the Practice Audit Matrices (PAM). It is an inventory, based on a model, that analyses General Medical Practice (GMP) in the context of general management. PAM was developed as a direct result of observations from four in depth case studies, of general medical practices in Nottinghamshire. It is suggested that the managerial stances taken in General Medical Practice can be assessed on four dimensions: Firstly; management values and methods; Secondly; concern for operational efficiency and income maximisation; Thirdly; the focus of service delivery; and finally; clinical standardisation and the relationship between clinical principals. In this section each of these four dimensions will be examined.

(4.6.1) Stages in attempting to interpret material

Initially the research was based not on four dimensions but one, a model that placed a practice within a single continuum, concerning managerial matters. Only later did, this single dimension became four. First thoughts indicated that it would be possible to identify the more managerial practices in terms of "efficiency", which was conceptualised using a tick list as displayed in table 4.1

EFFICIENT		INEFFICIENT	
Low admin. hours per GP		High admin. hours per GP	
High number of patients per GP		Low number of patients per GP	
Quick GP consultation time		Slow GP consultation time	
Low proportion of Nurse hours per patient		High proportion of Nurse hours per patient	
Low staff costs per GP		High staff costs per GP	
Below average drugs expenditure		Above average drugs expenditure	
Regular practice meetings		Few practice meetings	
Regulated drawings for GPs		Random drawings for GPs	
Positive use of the Business Plan		Reluctant use of the Business Plan	
Evidence of marketing		No evidence of marketing	
Low tensions between GPs		High level of tension between GPs	
Evidence of long term planning		No evidence of long term planning	
Commitment to staff training and development		No commitment to staff training	
Established protocols for disease management		No established protocols	
Staff uniforms and name tags		Absence of staff uniforms and name tags	
Suggestion box for patients		No suggestion box for patients	

Table 4. 1

However the issues are far more complex. To label an activity "efficient" was presumptuous. For example, is it fair to say that a short consultation time is better than a long one? A shorter consultation time might have been less thorough, resulting in a patient returning after a short period of time with the same symptoms (or worse) and needing a further consultation. Is it fair to suggest that the practice is not committed to

staff development and training just because there appears to be no need for staff to go on courses?

A more useful analysis could be to look at several measures and plot each practice's tendencies along a continuum and eventually plot that practice on a grid. Below are three boxes that identify various attributes of a practice in an attempt to analyse it according to the three different sets of criteria that might plot the practice's tendencies in certain aspects of general practice. Having identified the "efficiency" rating of a practice in the above table the purpose of the following 3 tables is to identify the strategic direction the practice might take

Clinical Tendency		Management Orientation	
Clinical admin. high in relation to management		Clinical admin. relatively low	
Little GP time spent on management matters		GPs involved in management	
Patient notes updated & summarised regularly		No summary of patient notes	
Regular medical audits conducted		Few and haphazard medical audits	
No marketing tools used		Marketing orientated	
Opposed to fundholding		In favour of fundholding	
Closed list - consolidation		Plans for increase in list - expansion	
Grudgingly drawing up Business plan & not using		Strategic use of business plan	

Table 4. 2

GP Individuality		Team Orientation	
GP's level of autonomy & independence		Emphasis more on clinical team not GP	
Low number of patients per GP		High number of patients per GP	
GP's own recipe for disease management		Protocols for disease management	
Variations in number of patients each GP sees		Consistency in number of patients each GP sees	
Variation in each GP's consultation times		Consistency in each GP's consultation times	
Tensions over workload		Balanced fairly distributed workload	

Table 4. 3

GP centred		Primary team centred	
High ratio of patients to staff		High ratio of staff to patients	
High ratio of GP s to patients		Low ratio of GP s to patients	
Many hours spent on call out		Emergencies "managed"	
GP's name plates on doors, photographs in lobby		Photographs of all the team & staff name tags	
Poor on skill mix		Good on skill mix	

Table 4. 4

While these three lists were helpful in identifying areas of importance, in their present form they did not accurately measure any of the criteria. They were subjective judgements. Some more tangible and quantifiable measures were required. One of the problems when devising measures that profile a practice is that it might be seen that they could be used to create league tables that would improve information available to patients. Indeed an article in the BMJ suggested that publicised league tables for general practice would soon be the norm.

> "Some family health authorities may wish to make performance indicators available to the public... we already have league tables for schools, hospitals, and the publication of league tables for general practices may be inevitable" (Majeed & Voss 1995: 209)

It is not the view of the author that league tables should be introduced into general practice, as they only measure certain aspects of performance and nothing about the appropriateness of some of the actions.

It is the intention of PAM to enable the practice to conduct an organisational diagram and to identify if they deviate from the norm (and by what amount) and to show where there is scope for further investigation or audit. It may also identify priorities for improvement and help in monitoring how well they have addressed those areas for improvement. This would be similar to a personality profile, but for the practice instead of a person. This is a concept explored by Belbin.

> "The concept of the firm's personality is worth considering in a general way in relation to their performance" (1997: 81)

In the final version of PAM it was decided that the instrument should assess practices against four dimensions, or managerial stances and that these dimensions would be measured using observable data.

The first dimension concerns management values and methods, here the focus is on how resource allocation decisions should be made. It also is concerned with the priority given to managerial concerns and activities within the practice. It also considers the importance given to management as a strategic (and not simply an administrative) activity.

The second dimension is about concern for operational efficiency and income maximisation. Consideration is given here to the priority the practice puts on matters of economy and efficiency, with the provision of services of an appropriate standard as cheaply as possible.

Another area in which the managerial orientation of a practice might manifest itself is the focus of service delivery to its patients. This third dimension is called "The focus of service delivery" and is concerned with the emphasis that the practice puts on the notion of a team, comprised of various health professionals, providing patient care, rather than individual doctors alone.

The final dimension is called "clinical standardisation and the relationship between clinical principals". This is a further area in which GPs may take a managerial stance without necessarily embracing a wholly managerial ideology. Here the management of clinical practice and the management of relationships between the partners within the practice are examined. Dimension four is concerned with the extent to which GPs emphasise their clinical autonomy and diversity as opposed to offering a uniform and standardised service to their patients.

Once these four dimensions and their constituents had been defined a scoring system had to be devised that could allow comparisons between practices. It was decided that each section of the dimension would be scored at either 1, 2, or 3, with three showing the highest inclination towards the relevant dimension. There were seven topics in each dimension and so a maximum score of 21 was achievable. Because the practices being researched were to have a copy of their scores it was decided to ascribe a value of 1 as the minimum score. This meant that a practice that scored the least possible score for a section would indicate a score of 7 instead of zero, the reasons for this were diplomatic. The specific scoring for each element of each dimension and the reason for their inclusion will now be discussed

(4.6.2) **Dimension one: Management Values and Methods**

In 1990 the FPCs were replaced by new FHSAs who were charged with improving the quality of primary health care in their areas, with particular regard to general practices. This new role entailed adopting a less administrative and more 'managerial' position. The mandate for this was the White Paper Working for Patients (Secretary of State 1989[a]). The introduction of fundholding, might well be seen as further evidence of the state encouraging GPs to become more concerned with management values and methods. This underpinned the state's management philosophy. Fundholding was at first viewed as being of little importance, on the margins of the reforms (Judge, 1992).

> "At the start of the reforms many commentators and managers saw fundholding as an experimental side show. However, it provoked a lot more interest than most health managers expected" (Glennerster et al. 1992:5)

However between 1990 and 1997 there was growing interest in fundholding and, under the new Labour government, aspects of it promised to become an increasingly important part of the governments strategy for managing part of the NHS in the guise of commissioning. However upon being elected the government has abandoned fundholding altogether in favour of the newly formed Primary Care Groups

The notion of patients being viewed as customers, rather than patients with symptoms who have needs that have to be satisfied, is endorsed and encouraged by the Patients Charter of 1992. This charter applies to all patients of the NHS and there is a section dedicated to GP services. Handysides, when reviewing morale amongst GPs, remarked

> "General practitioners I talked to in Sheffield expressed frustration at the rising expectations of patients encouraged by the Patient's Charter... the general practitioners face increasingly strident and inappropriate demands for their services" (Handysides 1994[b]: 2)

Dimension One looks at measures that might indicate the practice's disposition towards managerial values (some of which were referred to in chapters 2 and 3). It examines how resource allocations are made. Managerial values are concerned with cost effectiveness and efficiency. A useful definition of these terms is made by Gardner.

> "Efficiency measures the relationship between input and output and involves maximising useful outputs (services) from a defined and quantified level of resource input, or minimising the quantity of resources consumed in producing a defined output. Effectiveness is the measure of output or impact." (1998: 170)

The clinical position, which might be described as the opposite of the managerial view, is that the provision of health care is a principle and should be given on the basis of need. The management perspective, on the other hand, is that health care provision is a matter of policy, of how to effectively account for a finite resource (management accepts that one procedure may be carried out at the expense of another). The distinction between the

two approaches was graphically illustrated in 1995, by a case involving Cambridgeshire Health Authority. They refused to spend £75,000 on bone marrow transplants for a young girl suffering from leukaemia. They viewed it as an unjustified treatment, arguing it had to set priorities. Their argument was that such a large sum of money could provide care for a great many people, rather than one individual (Independent March 1995). Legal action to force the Authority to treat the patient failed. The Appeal Court found that

> "Difficult and agonising decisions over the use of limited resources had to be made" (Independent; Law Report 1995)

Gudex (1986) describes a managerial methodology to help make clinical decisions in terms of cost effectiveness. To enable managers rank decisions the notion of a QUALY is introduced. This is the measure of improvement in the quality and longevity that can be expected as a result of a specific medical procedure. The purpose of this measure is to enable maximum well being of a population.

We will now look at each section and measurement included in this dimension of **PAM.** *Section 2.1* asks GPs to report the percentage of time they spend attending to management affairs, thus indicating their commitment to managerial goals, which is the main purpose of this dimension of **PAM**. It seems reasonable that the more time GPs spend on management matters the more orientated the practice is towards management. Management activities are identified as: practice accounts; training; meetings concerning

the strategic direction of the practice, or with the practice manager and time spent compiling the business plan. As with all of **PAM,** respondents are asked to discount activities that are dedicated purely to fundholding, to enable comparison between non and fundholding practices. This information is elicited by interview and the replies are recorded on a form, an example of which is shown in figure 4.3. This does, however, rely on the GP's recollection of the proportion of their working week dedicated to management and as such is a very subjective measure. The precise method of eliciting this information and the measures taken to obtain "reliable " answers are described more fully in section 4.5

Doctor "A"'s weekly activities

Patient Contact		Clinical Administration		Management	
Surgery	17.75	Patient Paperwork	3	Accounts	5
Visits	6	Reading	2	Training	4
On Call	3	Training	1	Meetings	1
Anti-Natal	1	Meetings	1	Other	
Specialist Clinics		Yearly up-date of notes	0.38	Other	
Private Medicals		Script Signing	1.5		
Other		Other			
Sub-Total	27.75	Sub-Total	8.88	Sub-Total	10

Total Hours per week 46.63

Figure 4. 4

The calibration of this measure is quite "tight", as only a relatively small amount of time is spent on management. Therefore a 1% variation when put in the context of a total of 4.5% represents 22% of the total and so becomes a significant proportion of the population that potentially could attract the medium score. From the case studies it was found that the practice which appeared to be less "managerial" had 3.3% of GP time spent on this activity. Two others scored 5.5%, whilst the other practice scored 6.6%, so a score of 1 for under 4%; 3 for more than 5% and 2 for between 4% and 5% seemed

be a reasonable measure. According to the Financial Pulse 1992/93 survey (Wunder, J. 1995) GPs spent an average of 8.5% of their working week (excluding on-call time) on practice administration and management. This seems very high compared to the findings in the case studies. The only explanation is that the Financial Pulse do not say how they define "management activities". If they had included "clinical administration" as well, then that might reflect the case study findings

Section 2.2 of PAM asks for a calculation of the practice management hours per GP, this is arrived at; by adding up the weekly hours of the practice manager, their assistant and any one else directly employed on the management side. To this sum add the total time GPs spend on "management" matters each week and divide the total hours between the number of GPs (again excluding fundholding activities). By having this measure in PAM it compensates practices that may, as a team, spend considerable time on "management" activities. When applying this measure to the case studies there was a large range, as can be seen in figure 4.2.

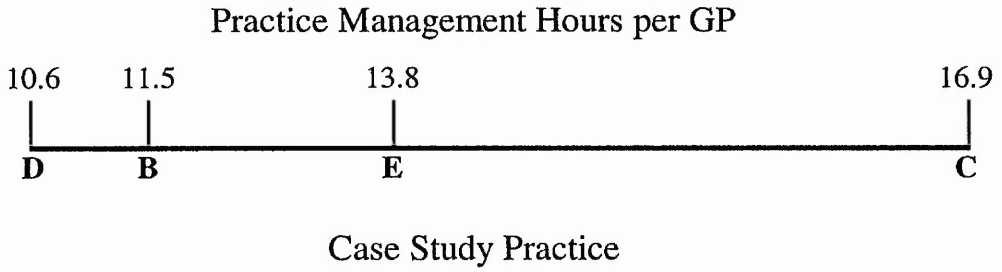


Figure 4.5

From these figures the calibration was chosen that is shown in **PAM.**

According to a survey published in the BMJ (Leese and Bosanquet 1995) 88% of practices employ a practice manager compared with 61% in 1987. So largely due to the influence of the two White Papers, **Promoting Better Health** and **Working for Patients** the management function in general practice has increased

Section 2.3 deals with the question of being in touch with their "customers". It asks how recently they conducted a patient satisfaction survey (an example can be found in appendix XI). In their book, *Total Quality in General Practice,* Brooks and Borgards (1994:IX-X) describe how, in 1991, the Hereford and Worcester Family Health Service Authority initiated a pilot scheme, called *pathfinders for excellence,* in which four practices became involved. One of the ways these participants identified some of their strengths and weaknesses was to conduct a patient satisfaction survey. If practices

conduct some such survey on an annual basis it is fair to deduce from that that they are managerially aware and likely to be planning and thinking strategically.

Section 2.4 In this section the respondent is asked if the practice has a policy of consolidation or of growth. If a practice is aiming at growth they must actively be attempting to attract patients. If this is so, it might be assumed that the practice is aiming to provide a better service than its rivals or to differentiate itself in another way. To do this they must give priority towards managerial values and concerns.

Section 2.5. The questions in this section deal with mission statements, objectives and long term strategies. If the practice concerns itself with the tools of strategic management and doesn't just pay lip service to them, it can be taken as a measure of commitment towards managerial values

Section 2.6 The area of priority setting is addressed here with emphasis being put on managerial values versus clinical values, as was mentioned earlier. Here there are two straightforward questions. The first question asks whether the practice has considered the ethics of refusing "expensive patients". If the answer to this is yes, then the practice might be said to be concerned with management issues. The second part of the section asks whether this has actually been put into practice. It is recognised that it is unlikely that any practice would tell the truth if this had been the case, for legal reasons.

Section 2.7 This part further explores the issues raised in section 2.5, asking if there is a regularly updated area needs document. If the practice has one then it demonstrates awareness of their environment and a marketing orientation.

The higher the total points for this dimension, the greater the practice's orientation towards managerial concerns, as illustrated in figure 4.6.

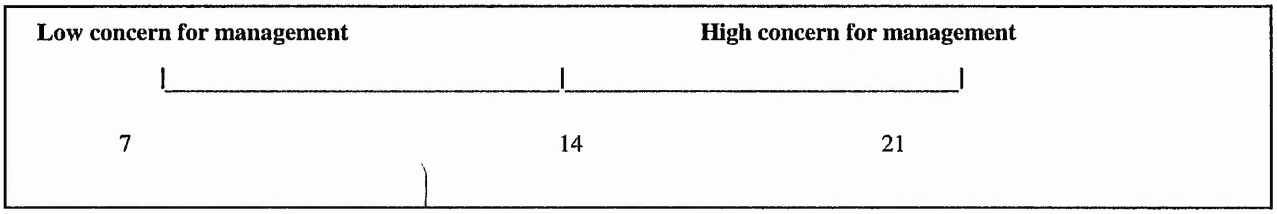


Figure .4.6

It is thought that the measures and topics covered in this dimension encompass most of the practical aspects that enable a practice to determine its orientation towards management concerns

4.6.3 Dimension two: operational efficiency and income maximisation.

The Public Finance Foundation's Report of 1988 suggested that GPs were inefficient, especially in their referral rates to hospitals and in their prescribing patterns. The inference was that they were prescribing and referring different amounts and at different

rates, without a logical justification. Clinical characteristics of patients would not vary sufficiently to warrant the differences (Butler, 1992). The Report suggested that:

> "there can be little doubt that further increases in efficiency are possible, and these will need to be realised to make the best use of expenditure"
>
> (Public Finance Foundation, 1988:5)

The New Contract (Departments of Health for Great Britain 1989) made clear the Government's intention regarding efficiency and income.

> "Making terms of service more specific to reflect clearly the requirements of good general practice, that better practices meet in serving their patients... amending the Statement of Fees and Allowances (SFA) so that the remuneration system becomes more performance related, enabling GPs who provide high quality services to get better paid" (*Ibid*:5)

It has been argued that the effect of this New Contract was to give GPs all the rewards of private business but entailing none of the risks, effectively becoming a publicly subsidised business (Huntingdon, 1993). By directly linking the GP's pay to efficiency (appendix IX) it was thought that GPs would become more aware of the implications of using finite resources. The NHS Executive suggested that Fundholding GPs should be

> "properly accountable for the services they provide and their use of resources"
>
> (NHS Executive 1995:7)

It can be seen from the preceding discussion that one of the main aims of the NHS reforms was to increase efficiency and one of the ways of achieving these objectives was through General Medical Practice. The second section of PAM relates to criteria that can be applied to measure the efficiency of a practice. Specifically these are:

Section 3.1 Asks for the ratio of patients to GPs. This takes into account part time GPs pro rata but not trainee or student doctors. The regional average for this is 2,003 per doctor (Faley 1994:33). A central band of 200 (10%) was chosen to represent an "average" practice, whilst those who had less than 1,900 would score as less efficient and those who had more than 2,100 patients per doctor would be identified as more concerned with maximising income. This criterion was included because the most significant change the New Contract brought about was remuneration via capitation fees.

> "in placing a greater emphasis on capitation in the remuneration system is to reward GPs who give a high priority to attracting and keeping patients by providing a high quality, comprehensive service. More money will follow the patient than has been the case in the past (Department of Health, 1989 p. 8)

This sentiment was later further endorsed in **Working for Patients**, which stated more overtly:

> "The Government remains of the view that GPs have a stronger incentive to satisfy their patients if a greater proportion of their income is attributed to the number of patients on their list" (Secretaries of State 1989 p.54)

Section 3.2 Looks at the average consulting time. This measure was included because by implication the quicker a doctor sees their patients the more they will attend to per surgery. This statistic might confuse efficiency with effectiveness. For example if a GP has an average consulting time of 5 minutes but their patients return more frequently then is that GP more efficient? However, for the purposes of the research, and from anecdotal evidence gathered in interviews, it is clear that the GP's own interpretation of speed of consultancy is that the quicker the consultation, the more efficient the doctor (Colin-Thome 1997). Accordingly the scoring was geared to reflect this with higher marks for speedier consultations.

From the four in-depth case studies it was found that the average consultation time for patients, that is the time from when the patient enters the consulting room to leaving it, was 6.75 minutes. From the four case studies 3,115 consultations were analysed. The 1992 GMP Workload Survey (Faley 1994), however, found that the average consultation lasted 8.4 minutes. Their information was elicited from the GPs by getting them to record their activities for each half hour period for a week. This could endorse the view that managers are poor estimators of the time they spend on specific activities, thus introducing error into the estimate. In this instance I would suggest that my figures were more accurate than the workload survey. The reason for this is that their figure relied on the GPs own perception of how long they spent on consultations, whereas mine was derived from over three thousand observations. From my observations 6.75 minutes was

taken as the average time, a band of between 6.25 and 7.25 minutes was taken to represent the average practice.

Section 3.3 Considers annual prescribing costs as another measure of efficiency, as this was identified in Working for Patients as being an area that needed addressing. In 1991 indicative drugs budgets were introduced. This came about as there was a need to control expenditure, as was explicitly spelt out in a Working Paper, *Indicative Prescribing Budgets for General Medical Practices:*

> "The objective of the new arrangements is to place downward pressure on expenditure on drugs in order to eliminate this waste and to release resources for other parts of the Health Service" (Secretary of State 1989:3 [b])

The purpose of this document was to attempt to increase the GP's awareness of the costs of their prescribing. This was done against a background of large variations in prescribing behaviour that could not be accounted for by the differences in populations that GPs were serving. The introduction of PACT (Prescribing Analysis and Costs) was recommended in **Promoting Better Health** (Secretary of State 1987) This scheme was piloted in 1989/90 and was integrated into **Working for Patients** (Secretary of State 1989[a]). PACT reports are sent to all GPs every three months. PACT provides information on all items prescribed and dispensed on the FP10 (this is the doctors prescription script book) by GPs , not only the quantity but also the costs involved. Comparisons are made between the individual GPs and the FHSA and regional

prescribing averages, and also the practice averages are compared. This data can help GPs find out what they are doing and assist in monitoring change.

This clearly is an area where the Government felt that there were efficiency gains to be made, the Audit Commission (1994) observed that GPs could still reduce expenditure and improve the quality of care through more rational prescribing. In 1996, the Audit Commission, whilst broadly critical of fundholders, praised them on their prescribing activities, showing that fundholders prescribed 9% less per unit and showed 3% less growth in expenditure than their non fundholding counterparts.

In **PAM** a practice is determined to be average if it falls within 2% of its FHSA average.

Section 3.4 asks how frequently the practice conducts an administrative audit. The rationale behind this is that the more often an audit is done the greater the level of concern for control and efficiency is likely to be.

Section 3.5 looks at the average hours GPs spend on home visits per week. Interviewing some thirty doctors gave an average of 4.5 hours. However the November 1994 GMP Workload Survey 1992 - 93, found that the average time spent on visits per week was 4.08 hours. The average visit time, for the purposes of **PAM**, was deemed to be between 4 and 5 hours, more than 5 hours indicated less concern for efficiency, while less than 4 hours indicated more efficiency.

It is possible to assume that doctors spending less than four hours on home visits, far from being efficient may be giving their patients less attention. But this not necessarily so, as the following example will illustrate. One of the practices being observed only spent an average of 2.4 hours per GP per week on visiting because of an innovative approach to managing their visits. The elderly and infirm, as well as potential home visit patients are offered a door to door collection service. One of the receptionists doubled up as a "taxi driver". From the patient's perspective, they are encouraged to stay with the same practice. They perceive the service as both friendly and personal (especially the elderly) and they enjoy the attention and getting to know the receptionist. From the practice's perspective it is cost effective (the doctor's time is used more effectively), it increases patient satisfaction, retains patients that might go elsewhere and differentiates them from the competition. From the doctors' perspective the patients are seen in the best environment, it reduces the amount of house visits from what had formerly been 3 or 4 visits per doctor per day, to only a handful.

Section 3.6 The next two sections are concerned with Item of Service Payments (IOS). This is the main source of income for GPs, is heavily dependent on the list size and relates to most NHS activities the doctors might conduct. A full list of these is displayed in table 4.5. Section 3.6 asks the respondent to calculate the IOS income as a ratio of total staff costs, as an indicator of efficiency, the closer the IOS income comes to covering the staff wages the more efficient it should be judged. Medeconomics, (Slinsby 1995:73) found that in 1994 the average ratio was 0.75:1. If the figure is lower than this then either the practice is employing too many staff, and are not eligible for sufficient IOS

payments, or they are not proficient at claiming these back. In any event a poor ratio would tend to indicate a low concern for efficiency.

Section 3.7 Asks the practice to calculate the IOS income per patient for each payment type and to compare these with regional averages, excluding payments that the practice has no control over (temporary residence and emergency treatment). It is necessary to weight this measure to make it meaningful. An average practice would have a weighted total difference of zero. For the purposes of our measurement we have allowed a differential of + /-.05 for "normal".

The weighting works thus: calculate the IOS income per patient; compare each payment, with the regional average and log the difference (Column 4, table 4.5 over). Multiply this by the weighting (to compute the weighting take the specific total [e.g. CHS, 12,750] divide it by the whole IOS income for the practice [199,541] and multiply it by 100. This gives a % weighting [6.39%]). Add up the weighted difference column as per the example in table 4.5. In the example we have a plus figure of £0.36

Item of Service Payments Analysis

	Practice Total	Practice per Patient	Regional per Patient	Difference per Patient	Weighting	Weighted Difference
Child Health Survey	12750	0.59	0.54	0.05	6.39%	0.0032
Registration Fees	4593	0.21	0.43	-0.22	2.30%	-0.0051
Temporary Residence	**5871**	**0.27**	**0.22**	**0.05**	**2.94%**	**0.0015**
Emergency Treatment	**770**	**0.04**	**0.02**	**0.02**	**0.39%**	**0.0001**
Minor Treatment	11800	0.54	0.49	0.05	5.91%	0.0030
Maternity	30542	1.41	1.5	-0.09	15.31%	-0.0138
Children's Imms & Vaccs		1.48	0.59	0.89	16.10%	0.1433
Contraception	18590	0.86	1	-0.14	9.32%	-0.0130
Health Promotion	48510	2.23	1.21	1.02	24.31%	0.2480
Other	11040					0.0000
Total Annual IOS income	**199541**					**0.3655**

Table 4.5

When calculating the score for this section, the higher the points the greater concern the practice has for operational and financial efficiency.

4.6.4 Dimension three: The focus of Service Delivery

This dimension is concerned with the way in which the practice delivers health care to its patients. Whether the emphasis is on GPs as individuals, who employ staff to assist them. Or whether the practice is viewed as a team, made up of different professionals such as counselors and nurses, who each contribute to the patients needs. It is argued that managerially orientated GPs would tend to the latter view. This managerial focus echoes the government's intention (never realised) in the 1970s to provide a seamless service with the introduction of Health Centers, where GPs from different practices would work side by side with other professions allied to medicine. These two opposing approaches can be better informed by referring to Charles Handy. He describes a 'person culture' where the individual is the central point, as well as introducing the notion of a Task/Team culture

> "If there is a structure or an organisation it exists only to serve and assist the individual(s) within it... The culture seeks to bring together the appropriate resources, the right people at the right level... it is a team culture, where the outcome, the result, the product tends to be emphasised, obliterating individual objectives and most status and style differences." (Handy 1995: 188-190)

It is contended that these two opposites are often found in general medical practice, with the team/task culture aligning with a more "managerial" approach. To enable a practice to determine where it's orientations lies the following measures were introduced to **PAM**:

Sections 4.1 & 4.2 These are straight forward measures based on direct observations within the four practices studied. 19,000 patient visits were analysed to determine the reason for the patient's visit. The more patients seeing the nurse in proportion to the Doctor, the greater the skill mix and empowerment to staff and thus team orientation. From observations it was found that three practices had between 27% and 29% of visits to the doctor, whilst the other had 42%. A score of 1 was decided upon for more than 32%, with the mid-range being 28% - 32% and less than 28% being awarded 3 points.

The visits to the nurse were treated in a similar way. The practice that had 42% of patients visit the doctor only had 4% see the nurse compared to between 10% and 20% for the others. The measures decided upon were less than 8% score 1, between 8% and 10% was the mid range, whilst those having more than 12% visit the nurse scored 3 points

Section 4.3 This was a calculation to determine the ratio of hours that professions allied to medicine (nurses, councillors, physiotherapists, speech therapists, chiropodists, physiotherapists, osteopaths etc.) were engaged compared to the total GP hours. Such a measure, it was thought, would be an effective gauge of the practice's commitment to a team approach. The four case studies showed a large variance ranging from 24% up to 77%

Section 4.4 Here we calculate the number of hours the doctors spend actually face to face with their patients as a proportion of their working week. The lower the proportion of

time the more likely the practice is team orientated, because the inference is that the patients see another practitioner allied to medicine instead of seeing their GP.

Section 4.5 This takes into account the rest of the team, the clerical staff and asks for a ratio between them and the GPs.

Section 4.6 These are six straight observations that indicate inclusion of all staff as a team. They are: the frequency of meetings; the presence of an annual staff appraisal scheme; the existence of training and development schemes; the provision of a staff pension scheme; the provision of a uniform and name badges; and finally if photos, names and job descriptions of all staff are on display for the general public to see.

The essence of the measures are, that the less time the patient spends with the doctor and more with others, the more likely a practice is to have a team orientation. As well as this the less status seeking the GPs are (for instance pictures of ALL the team in the foyer, not just the Doctors) and the more involved in staff welfare, the more inclined they are towards a team philosophy. The higher the score, in this section, the more team orientated the practice is.

4.6.5 Dimension Four Clinical Standardisation and Relationships between Clinical Principals

The theme underlying this dimension is the extent to which GPs retain their clinical autonomy. The assumption is that a practice that lays down formularies and has regularly reviewed protocols for specific clinical procedures will favour clinical uniformity and a

consistency in the way patients are treated. This, it is contended, is another vector of management.

Section 5.1 asks the practice to compare the number of patients per GP with the regional average of 2,030 (Faley 1994). The assumption made is that if a GP has less than the average they are likely to look after their own patients rather than work a "pool" system within the practice. The measure is that "normal" is within a 10% band of the average, 5% less than that scores 1 and those GPs with over 5% above the average score 3 points.

Section 5.2 asks if there are clearly stated protocols and procedures for disease management. If there are none the practice scores 1 point, between one and five 2 points and five or more scores the maximum 3.

Section 5.3 Relates to the frequency these protocols and formularies are reviewed. No review scores 1 point, once every eighteen months or more gains 2 points, more frequently is awarded 3 points.

The subsequent four sections ask questions concerning the relationships between GPs within the team and measures some comparative performance measures. These sections clearly do not apply to the single handed GP practice (11% of principals in 1993). In these instances it is assumed that the GPs in question elect to be on their own, in part, because they will be "free agents" unencumbered by the clinical views of their colleagues. If this assumption runs true then those single handed practices filling out **PAM** score the minimum of one point per remaining section.

Section 5.4 Requires the standard deviation of consulting times. If there is a great disparity it might highlight a "freeloader" or more likely emphasise a more individualistic and autonomous approach to holding clinics. From over three and a half thousand observations taken at the four case studies it was found that the actual consulting times ranged from 9 to 5 minutes. From this figure it was decided that it was reasonable to expect less than 1.5 minutes deviation for a good practice. Between 1.5 and 2 minutes for an average practice and over 2 minutes would score 1 point.

Section 5.5 asks for the frequency of medical/clinical meetings between principals. The inference is that the more frequent the meetings the greater the consensus of opinion and higher the standardisation.

Section 5.6 Asks if any of the partners carry our any private, non NHS work, and if so if that income is paid into the pool, or kept. The rationale behind this is that if private work is carried out, and the proceeds kept, the partners tend more towards autonomy, rather than team membership.

Section 5.7. This asks for a direct observation concerning the GPs attitude and behaviour towards each other, since if relations between the GPs are harmonious then there will be a tendency towards standardisation.

(4.7) Interviews

Now the actual methods of data collection will be described. Two hour-long interviews were held with the practice manager and senior partner respectively. As discussed earlier, these interviews were recorded on tape. The purpose of interviewing the practice manager was to establish general information about the practice and its surrounding area: a brief history, the cost of any recent improvements, the depravation rating, a little about the patient mix etc. At that interview we filled out the practice profile proforma, (see Appendix XII) that recorded the number of staff, the annual costs as well as a break down of Item Of Service payments.

Next the questions were orientated towards each of the four dimensions of management that were described in detail in chapter 3. Briefly these were orientations toward strategic management concerns. Here I ascertained if the practice had a mission statement, long and medium term objectives, an area needs document, if the practice had recently carried out a patient satisfaction survey and also how they viewed the production of the annual business plan.

The next dimension was concern for operational efficiency. The question here for the practice manager was; how frequently was an administrative audit carried out? The penultimate dimension reviews the focus of service delivery. Here the questions asked were to describe the frequency, purpose and procedures for meetings held in the practice. Also the Practice Manager was asked if the practice had a staff pension scheme, if staff appraisals were held annually and what the policy was concerning staff development and

training. The final section investigates the relationship between clinical principals. The two questions here were to inquire how relations were between the partners and ask if any non NHS work was carried out by the partners.

The hour interview with the lead or senior partner followed a similar pattern. Some of the questions were the same as those that the practice manager was asked. The purpose of this was to fill in any gaps that the practice manager had left and to confirm information. For example, in one practice the practice manager stated that there was no mission statement (indeed none of the staff were aware of it either). However the lead partner could recite it verbatim and told me that it had been discussed at a staff meeting. Furthermore it was to be found on the front page of the practice leaflet. These two conflicting answers told me much about the practice. Firstly, although they did have a mission statement, because the staff were unaware of it they scored no points in section 2.5 in the section of PAM that deals with orientation towards management concerns. Secondly it told me that, despite their claim to be team orientated, there was very much an "us and them" application to managerial matters with the doctors viewing the staff as their employees. This was reflected in section 4.6 of PAM, which dealt with the focus of service delivery. In the next stage of the interview questions were posed that related to section 2 of PAM, that of Orientation towards strategic management and values.

Patient Contact			Clinical Admin.			Management		
	Surgery	20		Paperwork	3.5		Accounts	1.5
	Visits	1		Reading	1		Training	
	On Call	3		Training	1		Meetings	1
	Anti Natal			Meetings	1		"Reps"	
	CHS Clinic			Notes			Other	.5
	Private			Sign Scripts	1.5			
	Other			Other				
	Sub Total	24		Sub Total	8		Sub Total	3
			Total hours for	week	35			

Figure 4.7

During the interview with the lead partner, and their colleagues a form similar to that displayed in figure 4.7 above was filled in, to ensure that I got a return from every doctor. Secondly it enabled me to "jog their memories" and explain what I meant in each category. I would sometimes talk them through a typical week and we would agree what proportion of their time was spent on what. For example, explanation was often required to differentiate between a management meeting and a clinical one.

Next, various areas were explored that related to other aspects of the PAM section. Did they measure the quality of service that they provide to their patients (2.3)? Does the practice have a policy of consolidation or growth (2.4)? What are the objectives of the practice and where do they see themselves going in the next few years (2.5)? Have the practice GPs ever discussed the ethics of accepting "heart sink" patients?. This was

followed up with probing follow-up questions (2.6). Does the practice have an area needs document (2.7)?

The next section of **PAM** that of operational and financial efficiency, was not discussed in the interview. There were only two questions that were relevant to the next section, that of the focus of service delivery. These concerned the practice's training policy and if they measured the performance of their staff on a regular basis.

The final section of **PAM** reviews the clinical standardisation and the relationship between clinical principals. The first question was did the practice have any formal written formularies, or protocols for disease management? If so what was the frequency of review (5.3)? What was the frequency of formal meetings to discuss medical cases (5.5)? Did any of the partners conduct any non NHS work? If so what happened to the money (5.6)? How were relations between the doctors (5.7)? The final question asked them for their opinions on fundholding. The purpose of this was to further explore how they felt about strategic management.

As has been previously discussed, all the doctors were interviewed. The main purpose was to ascertain how they spent their working week and how they apportioned their time between patient contact, clinical administration and management. As well as exploring this issue, other matters were discussed, such as what motivated them to go into general practice, how they perceived their attitudes towards management. I drew up a short profile for each doctor, including age and how long they had been qualified (appendix V)

(appendix V) This was done with a view to establish if there was any significance in age, length of service to consulting times or attitude to management. There was none. In total I conducted 19 hours of doctor's interviews

(4.8) Observations

The next method of information gathering was direct observation. As well as "ticking boxes" a great deal of other information was gleaned by just sitting in the surgery. Initially both staff and doctors were acutely aware of my presence at the surgery, as I described earlier in this chapter. However, the longer I was there the less I seemed to be noticed, or the more the staff trusted me. I kept a careful log of anything that I felt was important (for an example see appendix IV). Whilst at practice "C", which scored the highest in the strategic management section of PAM and appeared to be very concerned with staff morale and staff development, as well as teamwork, two conversations with staff threw doubt on those assumptions. The first member of staff was very resentful at lack of recognition of her commitment and the long hours she worked. She felt that her good nature was being abused. The second person did not feel part of a team at all but only identified with her specific surgery.

I was also able to tell a lot about the atmosphere and patient's perceptions versus the "official line" regarding the service that was being offered. Also I was able to observe how relations really were between the doctors. Anecdotal evidence of this has already been discussed earlier. Direct observation allowed me to comment on other aspects of

the practice, for example whether there were photographs of staff and doctors on display (4.6 v) or whether the staff had a uniform and wore name tags (4.6,vi). The two main purposes of my staying, on average, two and a half weeks at each surgery were firstly to ensure that staff were correctly recording the reasons for patient's visits (4.1), and secondly to observe the doctors' and nurses' consultation times (3.2 & 5.4).

Date:- 29/03/95

Doctor 3

IN	OUT	TIME
08:21	08:31	00:10
08:33	08:38	00:05
08:42	08:46	00:04
08:47	08:51	00:04
08:54	09:00	00:06
09:02	09:06	00:04
09:08	09:11	00:03
09:18	09:26	00:08
09:29	09:31	00:02
09:40	09:44	00:04
09:47	09:51	00:04
10:02	10:08	00:06
10:10	10:13	00:03
10:27	10:30	00:03
10:32	10:39	00:07
10:44	10:49	00:05
10:50	10:57	00:07
11:01	11:05	00:04
11:08	11:11	00:03
11:22	11:26	00:04
11:39	11:46	00:07

Total Consultations	21
Total Time	01:43
Ave. Consultation	00:04

Figure 4.8 shows an example of the form used to record the doctors' consultancy times. A similar form was used for the nurses Observations were made during the course of a fortnight. The reason for such a long observation time was to observe every single surgery that was held twice. I felt that this would smooth out any idiosyncrasies there might be between days of the week or times of the day.

Figure 4.8

A total of four thousand three hundred and twenty four observations were made.

Patient activity was monitored. Each visit that a patient made during a fortnight was monitored using the form displayed in Appendix XIII. Altogether, eighteen thousand, seven hundred and eighty two (18,782) such visits were recorded and analysed.

(4.9) Conclusions

This chapter has presented the ways and means by which data was collected. Consideration was also given to the philosophies underlying the selection of collection method. A description and evaluation of the primary tool of analysis (PAM) was made, including its role in the collection of data. Access and selection of the case study practices has also been discussed and is further explored in the concluding chapter (6). From these case studies, I analysed 18,782 patient visits, 16,586 incoming 'phone calls and over 4,250 consultations, the results of which can be found in Findings (Chapter 5).

Chapter 5

Findings from the Case Studies

5.0 Introduction

The research was initiated by carrying out a pilot case study in a small two doctor practice in inner city Derby, to familiarise the researcher with the issues facing GMP. The other purpose of the pilot was to test out various data collection processes and to refine and fine tune the types of questions to be addressed.

Then, over a period of two years, four in depth case studies were conducted in different GMPs, which varied considerably in both their size and geographic location. Selection of the GMP was largely determined by issues of accessibility (dealt with in section 4.3 of chapter 4)

In this chapter the findings from each of the four case studies are examined. The format for each is the same. A description of the practice building, equipment and personnel, is followed by an analysis of the findings, with discussion of the evidence, mirroring the order in which PAM looks at each issue. Next to be tackled are any puzzles, or conundrums that might be applicable to the practice, the final session assesses the management orientations of that practice. In the last section of the chapter comparisons between practices and conclusions are made.

5.1 Practice "B"

(5.1.1) Description

The Practice is located in a semi-rural market town in Nottinghamshire, which has a population of about 45,000. There are two other practices in the town, a two doctor practice, which closed its list 12 months prior to the case study being conducted and a three doctor practice that was a 5th wave fundholding practice.

The practice is a well established one, having been in existence since before 1948. For the past 22 years it had been located a few hundred yards from its new purpose built premises that were opened in October 1993, at a cost of approximately half a million pounds. The premises are light and airy. All 10 consulting rooms lead off one central 'J' shaped corridor with natural light from the roof. All the rooms can be seen from the reception area, which has a glass frontage approximately 45 feet long. The waiting area, on the other side of reception, is well furnished with comfortable chairs and a television. Leading off from there is a large family clinic area and a further two nurse/health visitor consulting rooms. Patients are called through to reception by a tannoy system, where they collect their notes and are given directions to the appropriate doctor's consulting room.

The reception and office area are open plan, being broken up by library style shelves that house the thirteen and a half thousand Lloyd-George envelopes (containing patient's medical records). Here there are four computers and printers and four windows opening out to the reception area. It is difficult to describe the atmosphere in the reception room. The place 'buzzes'. There is so much activity going on that it almost, but not quite,

quite, seems that things are out of control. None of the staff have any time for 'idle chat', or even gentle banter. One or two members of staff are constantly taking patient notes from the shelves either to update them, place them in trays for the next surgeries, or replace them as doctors drop in the notes of patients that have been seen on that day. During surgery hours there are always two receptionists on the main desk. One calls through patients whilst the other makes appointments and gives out repeat prescriptions. Doctors communicate that they are ready for their next patient via a panel that flashes a strobe light and issues a continuous shrill 'Beep Beep' until acknowledged by the receptionist.

What also gives the impression of constant activity is the fact that there are three different telephone lines into the office area: one for appointments and general enquiries; one for repeat prescriptions; and the other for emergencies and out of hours visits. One of these phones rings at least once every minute or so and sometimes all three ring at the same time. It is surprising, then, that the impression from the waiting room is, in contrast, that of quiet caring competence. The muted tones of the television only being interrupted by the loud-speakers calling patients through to see the doctor, the patients then being ushered through an empty corridor to the doctor's consulting room.

The practice has a list size of 13,400 patients, with an annual patient turnover of about 1,000. There are 6 full time male doctors and 1 part time female doctor as well as a full time trainee GP. This gives a ratio of 1,675 patients to each doctor. Three of the doctors have been with the practice for more than 20 years, whilst the last one to join the practice was appointed last year.

The practice employs 19 part time staff and 5 full timers. These staff all wear a uniform and wear name tags. At the main entrance to the building there are a series of large coloured photographs in frames of every single member of staff with their names and job titles, to enable patients and visitors to identify every one in the team.

The practice manager has worked for the practice all her working life, starting out as a part time receptionist. This earlier experience has stood her in good stead, as recently, due to staff shortages, she has had to work two full shifts per week 'front of house', which has resulted in her frequently having to take work home. She has had some management training, having successfully completed her Diploma of Practice Management.

All the doctors and the Practice management are of a single mind, in that none of them want to become fundholders. Their reasons range from ethical to practical:

> "Fundholding would take me away from clinical work, as well as my colleagues. We're interested in being General Practitioners, not negotiators for contracts. Basically I can not see any benefits for my patients by our becoming a fundholder." (doctor "B")

> "a lot of extra work for no extra pay... a real government con trick."
>
> (doctor "E")

(5.1.2) The findings at practice "B"

The research was conducted during an intensive two week period as well as three supplementary visits. Each of the six full time and one part time doctors were interviewed, using an administered questionnaire (appendix II). The purpose of the format of this interview was to ensure consistency, when eliciting doctors' evaluation of just how they spent their working week. These interviews also gave insight into how relationships were between doctors.

First we consider the practice's "orientation towards strategic management and values".

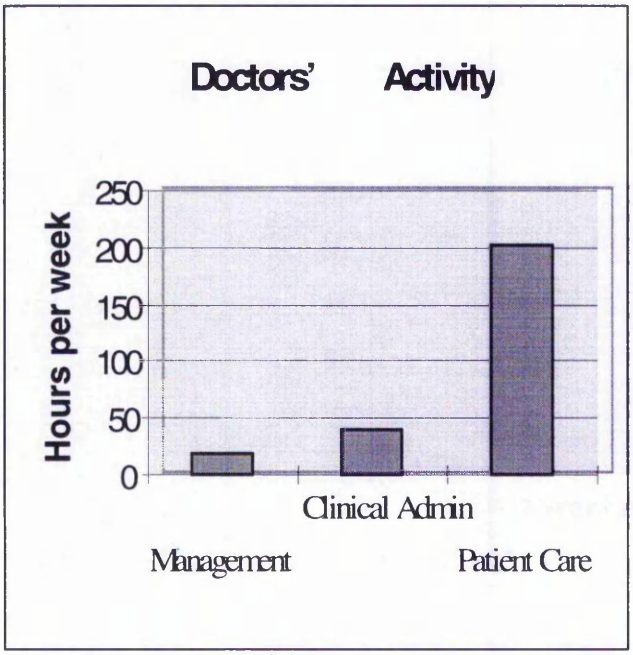


Figure 5.1. 1

Figure 5.1.1 shows that GPs reported that about two thirds of their time is taken up with patient care, whilst almost a third is concerned with clinical administration and only a very small amount of time is dedicated to management.

The main reason for the majority of management time is the time doctor "F" dedicates to payroll and management accounts. This could be reduced by greater delegation to the

practice manager, but would mean appointing an assistant PM, or increased PM hours.

The practice has 11.5 management hours per GP. This is surprising as the practice only has one person, the practice manager, dedicated to management matters. The amount of clinical administration is high due to the high standards set with regard to the update and annual summary of patient notes. This additional work is a requirement of being a training practice for doctors.

The doctors reported that between them they spent just 24 hours per week on emergency visits and call out, out of a total of 238 hours of patient contact time. This is a relatively low figure. This is not due to partners refusing to visit patients, but due to practice policy on what constitutes an "emergency". At the end of every surgery there are usually a dozen or more patients waiting who have not made appointments who loosely fall into the category of "emergencies". By agreeing to see these patients the doctors believe that they reduce the subsequent number of call outs. This practice, to some extent, allows patients to abuse the system so that they can be seen at a more convenient time, or without making an appointment. The usual waiting time between making an appointment and being able to see the doctor of their choice is two working days.

The practice has not carried out any form of patient satisfaction survey over the last twelve months. They do not have a policy concerning attracting new patients, but concede that their list size has grown firstly due to one practice in the town closing its list and also because some patients like to move to the practice with the newest premises. The lead partner says that very soon they may also close their list (when it

reaches 13.5 thousand patients) as they are getting too large. Past experience suggests that patients would find it hard to make an appointment and they would be far too busy, in those circumstances the practice would only take on patients that had just moved into the town. The lead partner would not consider employing other full time partners. He did not think that it would be "a good idea". This remark was not fully explained, but the general view of all the partners was that communication was a big enough problem between the existing ten doctors, without exacerbating matters by introducing another person.

The practice doesn't have a mission statement. When pressed the lead partner said the practice's medium term objectives would be:

> "to keep our heads above water. How can you plan if you don't know your staffing allocation from one year to the next? We can't plan, for instance, to extend our services without taking account of the human resource implications can we?"

At the time the research was carried out there was considerable frustration with the FHSA over funding. Senior partners and the practice manager believed that the practice was entitled to more money for administrative and management functions. Their bid for additional funds was still being considered. This tended to overshadow their thinking and might, in part, explain their negative attitude towards strategic planning, mission statements and practice objectives.

The doctors have never discussed the ethics of keeping "heart sink" patients on their lists, that is to say costly patients who require sustained and expensive treatment that could be a considerable drain on the practice's budget.

The practice does not have an area needs document, nor does it have plans to acquire one, arguing that even if it were more aware of local trends and plans it wouldn't make any difference to the way in which they would conduct their business.

Practice "B"

Low concern for Management High concern for Management

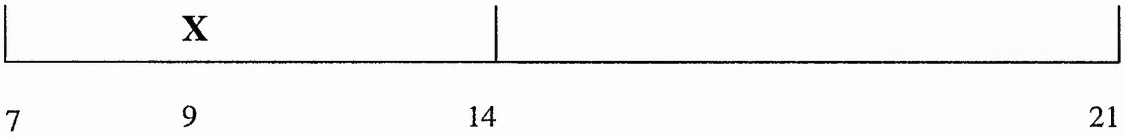


Figure 5.1. 2

Practice "B", from the above analysis, has a very low orientation towards management concerns, scoring just nine points on the PAM matrix.

Now we will consider the practice in terms of their "concern for operational and financial efficiency".

There are just over nine percent more patients per doctor than the national average of 1,892. The practice has 2,062 patients per doctor. This, it seems, is a direct result of the recent increase in patient numbers and the reluctance of partners to take on another

doctor to accommodate the increase. This reluctance is mainly due to the feeling that communication is hard enough between the number of doctors that there are currently without introducing another. The partners believe that introducing just one more doctor would "de-personalise" their working environments, that somehow they would loose their individuality and autonomy, and that they would become removed from the decision making process. When directly asked if some of the objection was that they were paid (largely) on a per capita basis they emphatically denied any financial considerations.

The average consulting times for the practice were 6.19 minutes, with 790 patients observed entering and leaving the doctors consulting rooms. As the figure below illustrates, there was considerable disparity in the number of patients seen by GPs and also differences in average consultation times.

Analysis of consultancy times for doctors at practice "B"

Doctor	"A"	"B"	"C"	"D"	"E"	"F"	"G"	"H"
No of Consultations	106	92	205	53	35	133	102	64
Ave Consultation Time	5	4	4	7	6	7	10	10
Total Time (Mins)	530	368	820	371	210	931	1020	640
Average Consultation Time	5.19							

Table 5.1. 1

Even when particular circumstances are taken into account, the part time doctor, the trainee doctor and one doctor who was on holiday for some of the time, of the remaining full timers there is a large variation.

The Practice prescribing costs were well below that of the regional and national average, with 76% of items prescribed generically (and therefore more cheaply) compared with the FHSA's 54% and a national average of 52%. Overall the practice,s prescribing costs were 11% below the FHSA average and 13% below the national average. The average cost per patient at the practice was £13.77 compared with the FHSA's £15.39. Although the practice was not a fundholding one, all the partners were aware of the cost of treating patients.

The amount of time the partners spent on emergency visits was very slight, As has been discused earlier.

Comparisons between "B"'s IOS income and national figures

	Practice Total	Practice per Patient	National per Patient	Difference per patient	% Variance
Child Health Survey	8995	0.67	0.42	0.25	59.52%
Registration Fees	4517	0.34	0.38	-0.04	-10.53%
Temporary Residence	583	0.04	0.34	-0.3	-88.24%
Emergency Treatment	349	0.03	0.04	-0.01	**-25.00%**
Minor Treatment	7717	0.58	0.46	0.12	26.09%
Maternity	23176	1.73	1.43	0.30	20.98%
Children's Imms & Vaccs	19500	1.46	0.57	0.89	156.14%
Contraception	12757	0.95	0.91	0.94	4.40%
Health Promotion	18371	1.37	1.49	-0.12	-8.05%
Other				0	0.00%

Table 5.1. 2

As can be seen from Table 5.1.2, a comparison with national figures, the practice is substantially over target (+156%) for children's vaccinations and immunisations. This may well be the result of Dr "G's" introduction of special holiday clinics. Payments for child health surveillance were 59.5% above the national average, and 23% above the regional average, whilst minor treatment was 24.9% above the national figure. The high maternity payments (21.1% above the national average) might well reflect the fact that both the trainee and part time doctors are women and that the practice runs three specialist anti natal clinics per week.

Apart from the health promotion figure (-8.2%), the practice has no influence on any of the other areas that were showing an adverse percentage. For instance temporary residence fees are entirely dependant on the number of visitors who need the surgery whilst on holiday. Not many people visit a depressed ex-mining area, compared, for instance, with a practice in Cornwall and so the figure would be expected to be low.

The practice's IOS figures also compare favourably with the local averages, as table 5.1.3 shows.

Comparisons between "B"'s IOS income and FHSA's figures

	Practice Total	Practice per Patient	Regional per Patient	Difference per patient	Weighting	% Variance
Child Health Survey	8995	0.67	0.54	0.13	7.95%	0.0103
Registration Fees	4517	0.34	0.43	-0.09	4.01%	-0.0036
Temporary Residence	**583**	**0.04**	**0.55**	**-0.51**	**0.52%**	**-0.0026**
Emergency Treatment	**349**	**0.03**	**0.02**	**0.01**	**0.31%**	**0.0000**
Minor Treatment	7717	0.58	0.49	0.09	6.85%	0.0062
Maternity	23176	1.73	1.5	0.23	20.57%	0.0473
Children's Imms & Vaccs	19500	1.46	0.59	0.87	17.30%	0.1506
Contraception	12757	0.95	1	-0.05	11.32%	-0.0057
Health Promotion	18371	1.37	1.21	0.16	16.30%	0.0261
Other				0	0.00%	0.0000
Total Annual IOS income	**112685**					**0.2312**
Annual Staff Bill	**£ 128,163**			**0.879**		

Table 5.1. 3

Here we can see that, when we weight the payments, the average is 0.2312, which is very good as the "average" practice would have scored just 0.00. Also the IOS income as a ratio of staff costs is 87.92 pence in the pound. This means that the practice generates nearly 90% of its staff costs from IOS payments, which would indicate operational efficiency.

Referring to the PAM index practice "B" has a high concern for operational and financial efficiency.

Practice "B"

Low concern for Efficiency High concern for Efficiency

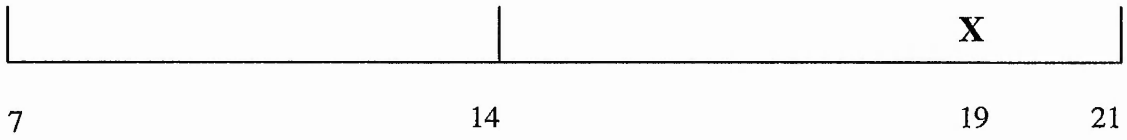


Figure 5.1. 3

Next we analyse the findings in the context of the focus of service delivery

Over three thousand eight hundred observations were made regarding the reasons patients had for visiting the practice, as can be seen from figure 5.1.4 over forty percent came in specifically to see the doctor.

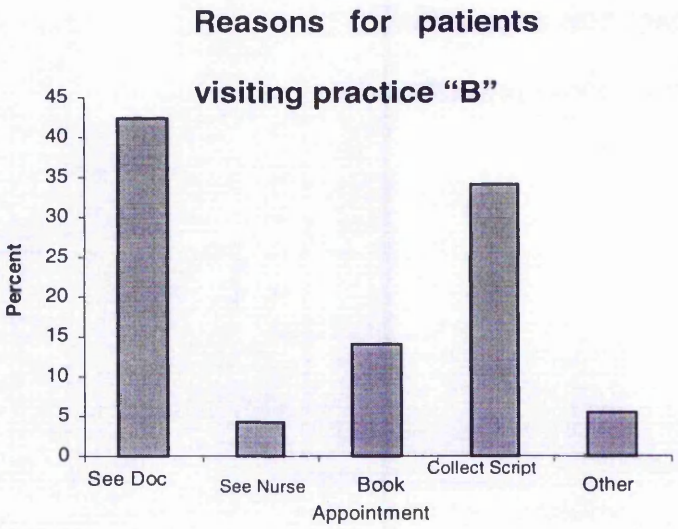


Figure 5.1. 4

This compares with just four percent that come to see the nurse, thus implying that the focus within the practice is orientated towards the doctors. When the ratio of nurses, phlebotamists, chiropodists, councellors (Professionals Allied to Medicine) compared to GP hours worked is computed it is relatively low, further endorsing the earlier comments. The hours doctors actually spend face to face with their patients as a percentage of their total hours worked is seventy eight percent. This further endorses the view that the doctors are committed to patient care and more concerned with clinical matters than managerial ones.

If we take the number of clerical staff hours per GP hour we see that each GP hour is supported by twenty five minutes of clerical time. When we analyse the practice taking the criteria from section 4.6 of PAM we notice that practice "B" scores quite well. An

annual appraisal scheme is in place, administered by the practice manager. She is committed to staff development and training and six staff have successfully completed courses in the past year. She believes the scheme is important as it gives her staff the opportunity for individual feed-back outside the urgent atmosphere of the working environment. She is, however, slightly sceptical about the opportunities that are available and also the funding allocated for training.

Staff meetings are held every six weeks, with sub meetings every two months or so. Photos of all staff and doctors are prominently displayed in the foyer and all staff wear uniforms and clearly identifiable name tags.

The overall impression is that the focus of service delivery for practice "B" is towards the doctor, rather than the team. Applying the findings to the PAM the practice scored just ten points, five of which were under the direct control of the practice manager. There appears to be some conflict here, in that the practice manager understands the need to work as a team, but the doctors, who have more power, prefer to retain their autonomy. The constituent of the PAM matrix in figure 5.1.5 gives us the picture.

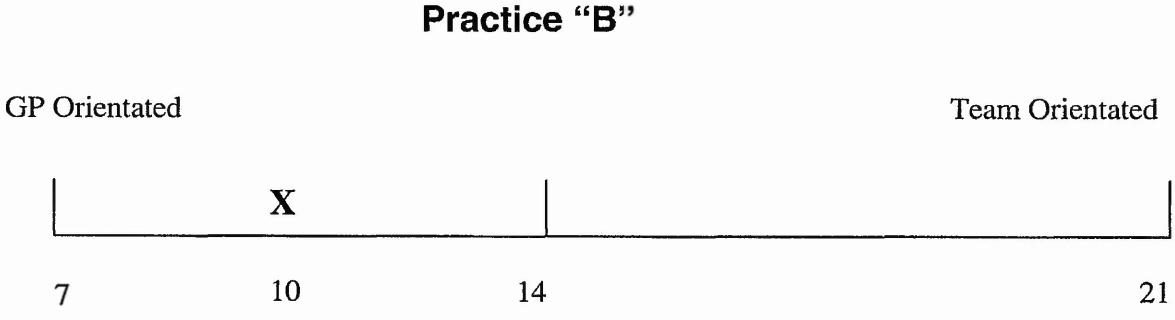


Figure 5.1. 5

We now turn our attention to clinical standardisation and the relationship between clinical principals.

There are two clearly stated protocols for disease management, for asthma and meningitis. These protocols were set in place years ago and there has been no review since that time. This would imply that there is little enthusiasm for standardisation.

We now turn to relationships between clinical principals. The doctors have an average of 2,062 patients per GP. This compares with a 1,892 national average, being some 9% higher. There is a great deal of variation in the consulting times of doctors (see table 5.1.1). When the standard deviation in consulting times is computed it comes to 2.4 minutes. In part this is explained by the special holiday clinics that doctor "G" holds, which sometimes take up to half an hour per couple. The other anomaly is doctor "H", she believes that, because she is the only woman doctor, the receptionists place the more demanding patients onto her as she is "good with the awkward ones". These patients take up more time. Both of these examples emphasise the strain between clinical principals. This is further endorsed when we consider that one doctor carries out non-NHS duties and keeps the proceeds from this work for himself.

The GPs do meet on a monthly basis to discuss medical cases, but this meeting is chaired by the practice manager. Relations between GPs were very strained. During the research period there were several incidents that illustrated this. On one occasion, tempers had become so heated that the practice manager had to shout at two GPs before they stopped having a stand up row in front of some patients. On another occasion,

three GPs refused to see patients and went home because they thought that one of their colleagues was not pulling their weight and had not seen an equal number of patients. This left the remaining GP to see ten emergency patients on their own, keeping some people waiting for over two hours.

By examining these issues we can plot the findings against the PAM matrix for this section thus:-

Practice "B"

Emphasis given to GP autonomy — Clinical Services are Standardised

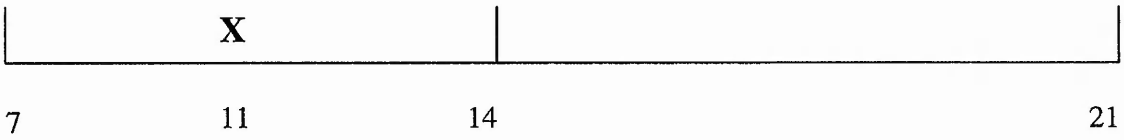


Figure 5.1. 6

5.2 Practice "C"

(5.2.1) Description

The practice has three surgeries (two of which dispense drugs and medications) covering a mainly rural area. One of the surgeries is located in a market town, that is growing as a commuter satellite town of a large city. One is in a depressed mining village in decline; whilst the other serves a mainly professional clientele together with a farming community. The list size for the practice is 21,700. There are 40 staff in total and 9 full-time, 2 part time and 2 trainee doctors. The practice is a first wave fundholder. A more specific description of each surgery follows.

"St. Endors"

"St. Endors" is the oldest established of the surgeries having been started in the 1950s. By 1966 it had a list size of 4,500, being a small market town. In 1975 the "St. Endors" Health Centre was built and "St. Endors", by then, had become a commuter town. The surgery now serves just over 9,000 patients. "St. Endors" continues to grow and a new village is planned on the site of the old "St. Asaph's" hospital, which would certainly place even greater demands on the surgery.

The health center is a two story flat roofed building, shared with the Health Authority and the town's library is adjacent in the same building. Considering the list size, the waiting area is quite small, and removed from both the doctor's and nurses' consulting rooms. Patients are called through using a public address system. The office area is comparatively large. The surgery has a dispensary, dispensing drugs and medications to all patients who live outside "St. Endors", as there is a chemist in the nearby shopping

precinct. The surgery has 3 full time male doctors and 1 full time female doctor. It is not a training practice.

"St.Clements"

The "St.Clements" Surgery was first set up in a Coal Board house in 1966. The coal pit had just opened and miners and their families were moving in from all over the country. It was very much a growth area. By 1975 "St.Clements" Health Centre had opened in a purpose built building housing both doctor's surgeries and Health Authority facilities, located in a new shopping center, where a chemist had also opened. By 1985 it had been extended and refurbished to accommodate an increasing list size. The pit closed in October 1993 and now a high proportion of the patients come from families where there is no wage earner. Most of the patients are working class, taking a deferential view of the doctor. This interestingly was not reflected in a shorter consultation time compared to the other surgeries. One might have thought that this type of patient would spend less time asking for explanations than their middle class counterparts. However when questioned on this point some of the doctors said that they spent longer wit these patients because they thought it was the doctor's duty to ensure that the patient clearly understood treatments etc. Middle class patients grasped the concepts and issues more readily and with less explanation than their less educated counterparts.

The waiting room is large and removed from both the nurse's and doctor's consulting rooms. Patients are called through by the doctor, using a public address system. The doctors have the patient's notes in order on their desks.

The reception area is very cramped and is shared by the office area, with the Lloyd-George envelopes (patient notes) being kept in a "room within a room". These extremely cramped working conditions could, but surprisingly don't, cause tensions in the working relationships. Possibly this is explained by the fact that all the staff have worked together for a long time. One member of staff has been with the practice for 38 years (but only at this surgery for the last 20). The senior receptionist has also been there for the last 20 years.

The Surgery has 3 full time male doctors and two half time female doctors. The Surgery is also a training unit and has one female trainee doctor.

"St.Ewes"

The "St.Ewes" surgery is situated in a picturesque location, with views out over the fields. The administrative center of the practice is to be found here. The surgery has a list size just above 5,000. The catchment area is very rural and the patient base is predominantly professional and middle class as well as serving the farming communities. The surgery started life in the early 60's in the front room of a 'call house'. This was a room in a domestic house where a lady allowed the local doctor to conduct his surgery one morning a week. Patients were also allowed to "call" in for their prescriptions on the remaining mornings.

The surgery and dispensary were built in 1965 next door to the call house. At the time the list size was 800. In 1993 it was completely refurbished and a second floor was added to accommodate the administrative office. The waiting room is compact and

carpeted with modern furnishings away from the consulting rooms. There is a large staff room, looking out over the fields. The consulting rooms are on the ground floor and all lead off a light, bright and airy vaulted area. This spacious, modern building is the only one that is owned by the GPs and not rented from the Health Authority.

(5.2.2) The Findings at practice "C"

The research was conducted in three main phases, these being an intensive three week period of observations and interviews (appendix III as discussed previously) conducted at each of the surgeries. Nine supplementary visits were also made for interviews with lead partners and the practice manger.

The findings will now be considered using PAM as a tool of analysis. The first section examines the practice's "orientation towards strategic management and values"

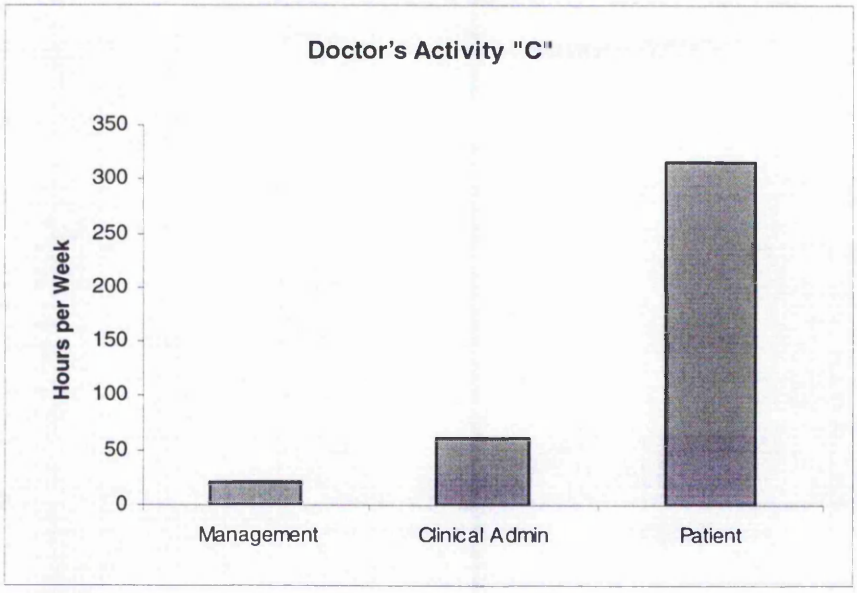


Figure 5.2. 1

As can be seen from figure 5.2.1 the bulk (just over 70%) of the GP's time is taken up with patient care, over 20% with clinical administration and what appears to be a relatively small time

with management activities. However this is 5.5% and is comparatively significant when using the scales laid out in PAM. In consequence this scores a maximum 3 points.

A point could be made that the practice's orientation to "management" is a function of being very large and located on three split sites, that these factors necessitate a more "managerial" approach. However the practice manager is very managerialllly aware, having two masters degrees, one in business administration and the other in human resource management, and she encourages the GPs in these "managerial" activities. Often this is not appreciated, as one doctor articulated:

> "you can be a good clinician - but spend a lot of your time doing other things... chasing the paper... but you have to, as part of your income depends on it. Sometimes that is not recognised and you are not paid for the extra work and responsibility, if this happens people will become disillusioned... that is why morale is so low at the moment... you work harder, achieve results, do a better job and can actually get paid less"

The practice has 16.9 management hours per GP, which is high, possibly for the reasons outlined above. Patient satisfaction surveys are carried out on a regular basis at least once a year at each surgery.

The practice doesn't have a policy of either consolidation or growth, in that it does not actively promote itself to increase its patient numbers but is aware, through an area needs document, of future plans.

Despite the fact that the town of "St. Endors" is set to double in size in the next decade, the surgery is situated in an old building which is itself a constraint on patient numbers, which might naturally hamper growth. One of the plans is to buy the building from the Health Authority and refurbish it utilising part of the first floor, which would use the space more efficiently. The alternative, that of building a purpose built premises has, for now, been rejected on both grounds of cost and location. Currently the surgery is at the center of the town and no properties that would be suitable have been identified in the vicinity.

At "St.Ewes" there is outline planning permission, in the county plan, for four hundred dwellings in the catchment area. This could easily be addressed by employing an additional doctor, which the accommodation would allow. In the long term that is the contingency plan for that surgery.

"St.Clements" is an area in decline, the closed pit having been its main source of employment. Whilst the demographics may change, in that older residents may move in to retire and the remainder of the population that stay will be long term unemployed, it is not thought that the numbers will decline too much. As the building is large enough, with the exception of the small reception and office area, the long term plan is to continue to rent the property but ask the landlord for a refurbishment to enlarge the office accommodation.

Although the practice is not doing anything to actively promote growth it does have medium and long term strategies to compensate for envisaged growth. Due to this they score the maximum for section 2.4 of the PAM matrix.

The practice does have a mission statement, which is translated into specific stated objectives, with an annual review of long term strategies. The mission statement **is "To promote best medical practice, to improve the health of the population, identify their health needs and meet them"**

One of the objectives is to **"continue to upgrade medical skills; to be aquatinted with technological medical advances; for the doctors to regularly attend courses"**

With a view to the increasing elderly population and the growth in the numbers of nursing homes for the elderly another objective **is "to develop a special geriatric orientated team with responsibility towards the elderly, with a view to setting up occasional satellite surgeries in old peoples homes"**

As can be seen from the above example, the practice does have a mission statement that is translated into specific objectives. Various meetings are conducted within the practice each month. The practice manager sees these meetings as extremely important as communication must be at the center of good management particularly when the practice runs from three separate sites.

There is a staff meeting at each surgery, held on a quarterly basis. This involves every member of the team who works at that surgery. A copy of the minutes of these meetings is provided for the practice manager as a means of feedback. The purpose of these meetings is to open up the channels of communications between various departments and give people the opportunity to see potential problems from another person's perspective. Also any new systems are reviewed and the day to day running of the surgery is co-ordinated through these meetings.

There is a monthly management meeting, between the practice manager, the 3 senior receptionists and sometimes staff or GPs that have been specifically invited. The purpose is to implement and co-ordinate practice policy.

There is a monthly practice meeting, that consists of the practice manager, and all the partners (the executive). The purpose is to set the practice policy. Quarterly there is a fundholding meeting attended by the practice manager and all the partners to discuss related financial matters.

Practice strategy is set for the short, medium and long term. Once a month 2 GPs (who have specific responsibility for this area), all the nurses and the practice manager meet to co-ordinate matters concerning the practices nursing requirements. Primary health care meetings are also held on a regular basis; these include the GPs, district nurses, health visitors and the senior receptionists. As well as all these meetings working parties are set up to tackle specific issues (for example dispensary stock control). The practice manager and any interested parties attend these meetings.

.Every year there is an AGM for the partners and the practice manager. Here financial targets and objectives are finalised for the next twelve months, with long term strategic issues being addressed, for example those discussed earlier concerning various buildings. On the **PAM** matrix they score a maximum 3 points for this aspect of strategic management.

As indicated earlier, they do have an area needs document that is consulted and updated on a regular basis. An example of this would be being kept informed about the stage of planning for the new town.

The practice has discussed the ethics of accepting "heart sink" patients onto their list, but decided never to decline acceptance on the grounds of financial cost, but only to accept patients on grounds of clinical need.

As can be see from figure 5.2.2 below, the practice scored 19 points on the PAM scale, thus indicating a very high concern for management.

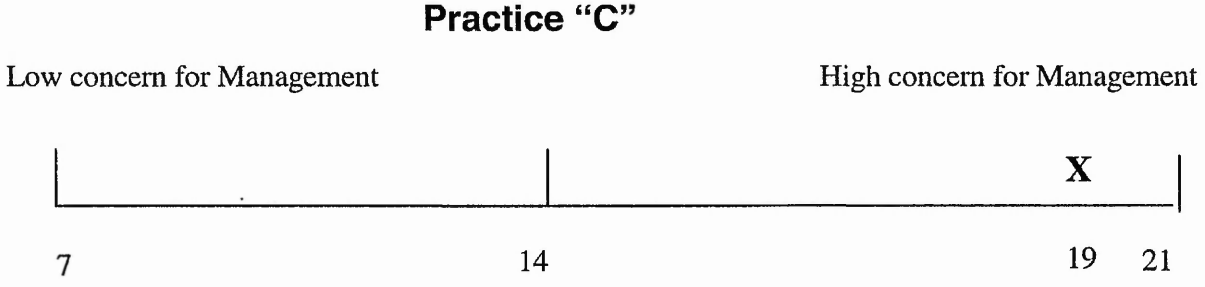


Figure 5.2. 2

Now we will consider the practice in terms of their "concern for operational and financial efficiency".

There are slightly less patients per GP (1,973) than the regional average of 2,003, but this is still 4% above that of the national average of 1,892. Accordingly the practice is in the middle band for section 3.1 of PAM.

As this is a split site, it is hard to give an overview of the practice as a whole as it is almost like analysing three small practices separately. This is because in the rural area of "St.Ewes" the average number of patients per GP is much lower than in the center of "St. Endors". It may well be that this split site model of practice is the way forward, because rural practices that are sparsely populated would not survive economically without the support of the town doctors. Without this support we could witness a startling decrease in the level of services that are available in a rural area, resulting in patients having to travel for several miles and not be allowed home visits. The number of patients and possibly the patient-doctor ratio is set to change over the next decade as both "St. Endors" and "St.Ewes" grow.

The average consulting time was just over 8 minutes (seen table 5.2.1), with 1,269 patients being observed entering and leaving the doctor's consulting rooms.

Analysis of consultancy times for doctors at practice "C"

Doctor	"A"	"B"	"C"	"D"	"E"	"F"
No of Consultations	83	81	84	46	63	**197**
Ave Consultation Time	9.86	10.6	8.8	**13.2**	5.0	6.3
Total Time (Mins)	818	855	738	607	317	1246
Average Consultation Time	8.12					

Doctor	"G"	"H"	"I"	"J"	"K"	"L"	"M"
No of Consultations	153	84	97	47	133	156	**45**
Ave Consultation Time	9.4	7.5	10.8	7.7	**5.6**	7.0	9.1
Total Time (Mins)	1439	627	1049	362	744	1088	409
Average Consultation Time	8.12						

Table 5.2. 1

There was a large disparity in the number of patients seen by each doctor, one seeing 197 patients, another just 45, over the same time period. This might be partially explained by the shift patterns that I was able to observe. Also there was a huge difference in the consulting times, ranging from an average of 13.2 to 5.6 minutes. Some of this can be explained by the differences in each surgery. The average times for each were 6, 7 & 8.5 minutes. As can be seen from the table, no correlation can be made between the busiest doctors and the quickest consultation times. This was by far the largest variation in the research with a standard deviation just under three minutes, which will be touched upon later.

The Practice prescribing costs were below that of the national average, by 6.8%, but above the regional average by 2.8%. Compared with the FHSA's 35.5% and a national average of 36.5% the practice prescribed 38.5% of items generically (and therefore cheaper). Overall the practice's prescribing costs were 2.9% above the FHSA average.

The average annual cost for prescriptions per patient at the practice was £58.60 compared with the FHSA's £56.92. On the PAM matrix this scores the practice a minimum 1. Part of the reason for this poor score is that two out of the three surgeries were prescribing surgeries and there might have been a conflict of interest between the FHSA targets and potential profit to be made from the prescriptions. The practice is very strict on the consistency of prescribing within the practice, with one of the doctors, a qualified pharmacist, overseeing the policy making concerning formularies.

Administrative audits are carried out continuously throughout the year. The results are discussed at the various meetings that are held (which will be examined in the next section dealing with the focus of service delivery) improvements are proposed and means of implementation formulated. Therefore a score of 3 is recorded in section 3.4 of **PAM.**

The amount of time spent on home visits is quite high, being 4.9 hours. This just (by .0.1%) scores as average on the PAM matrix. The reason for this high proportion of time spent on visits could be explained by the wide rural area that the practice covers.

As can be seen from table 5.2.2, the practice is substantially over target (+159.6%) for children's vaccinations and immunisations. This might in part be explained by the practice's approach to administering vaccinations. At the time of this audit patients were being offered flu injections. At one of the surgeries the patients were arranged in queues and asked to roll up their sleeves. 2 nurses, working as a team, proceeded to give the injections. By using this "conveyor belt" technique they managed to give 102 injections in an hour and a half.

Comparisons between practice "C"'s IOS income and national figures

	Practice Total	Practice per Patient	National per Patient	Difference per Patient	% Varience
Child Health Survey	12750	0.59	0.42	0.17	40.48%
Registation Fees	4593	0.21	0.38	-0.17	-44.74%
Temporary Residence	**5871**	**0.27**	**0.34**	**-0.07**	-20.59%
Emergency Treatment	**770**	**0.04**	**0.04**	**0**	0.00%
Minor Treatment	11800	0.54	0.46	0.08	17.39%
Maternity	30542	1.41	1.43	-0.02	-1.40%
Childrens Imms & Vaccs	32127	1.48	0.57	0.91	159.65%
Contraception	18590	0.86	0.91	-0.05	-5.49%
Health Promotion	48510	2.23	1.49	0.74	49.66%
Other	33988	0		0	17.03%

Table 5.2. 2

Payments for health promotion were 49.6% above the national average, and 84.7% above the regional average, whilst minor treatment was 17.9% above the national figure.

Apart from the maternity and contraception figures (-1.4% & -6% respectively) the practice has no influence on the only other area that was showing an adverse percentage with regard to regional averages (that of registration fees).

The practice's IOS figures also compare favourably with the local averages, as table 5.2.3 shows.

Comparisons between practice "C"'s IOS income and local FHA's figures

	Practice Total	Practice per Patient	Regional per Patient	Difference per Patient	Weighting	Weighted Difference
Child Health Survey	12750	0.59	0.54	0.05	6.39%	0.0032
Registation Fees	4593	0.21	0.43	-0.22	2.30%	-0.0051
Temporary Residence	**5871**	**0.27**	**0.55**	**-0.28**	**2.94%**	**-0.0082**
Emergency Treatment	**770**	**0.04**	**0.02**	**0.02**	**0.39%**	**0.0001**
Minor Treatment	11800	0.54	0.49	0.05	5.91%	0.0030
Maternity	30542	1.41	1.5	-0.09	15.31%	-0.0138
Childrens Imms & Vaccs	32127	1.48	0.59	0.89	16.10%	0.1433
Contraception	18590	0.86	1	-0.14	16.10%	-0.0225
Health Promotion	48510	2.23	1.21	1.02	9.32%	0.0950
Other	33988			0	17.03%	0.0000
Total Annual IOS income	**£ 199,541**					**0.2031**
Anuall Staff Bill	£ 270,895		Wages ratio	£ 0.74		

Table 5.2. 3

Here we can see that when we weight the payments the average is 0.2031 which, whilst not as good as practice "B", is still good as the "average" practice would have scored just 0.00 Also the IOS income as a ratio of staff costs is 73.66 pence in the pound. This means that the practice generates just over 70% of its staff costs from IOS payments, which would indicate average operational efficiency.

Surprisingly, given their high "management" score, practice "B" doesn't fare so well when measuring their PAM score for concern for efficiency, with only an average 14 points. The main reason for this was their high prescribing costs and the long consultation times.

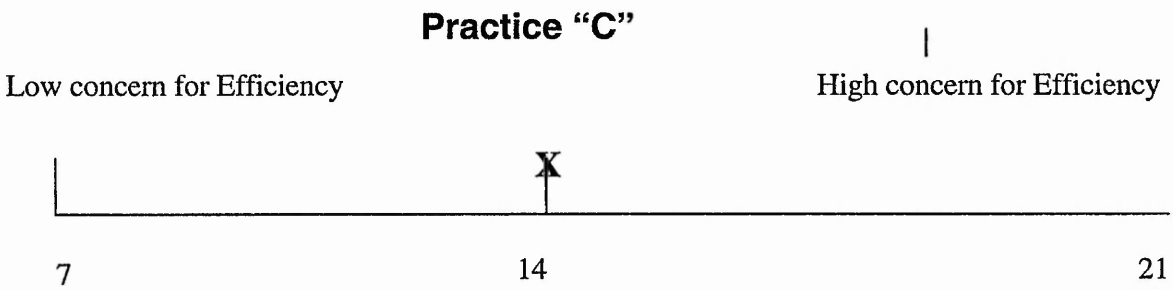


Figure 5.2. 3

Next we analyse the findings in the context of the focus of service delivery.

Eight thousand and two hundred patient visits were recorded and the reasons for their visit analysed. As can be seen from figure 5.2.4, just over 28% come to see the doctor, with 10% to see the nurse. (this figure was adjusted downward, as a further 7% came in for their annual 'flu injections)."Skill mix" is an important issue, that is the extent to which tasks are delegated away from the doctors to members of staff (within their competencies). A good illustration of this is that at one of the surgeries the nurse tests urine samples, weighs the patients and takes blood samples from them before they go in to see the doctor for their anti-natal-appointments.

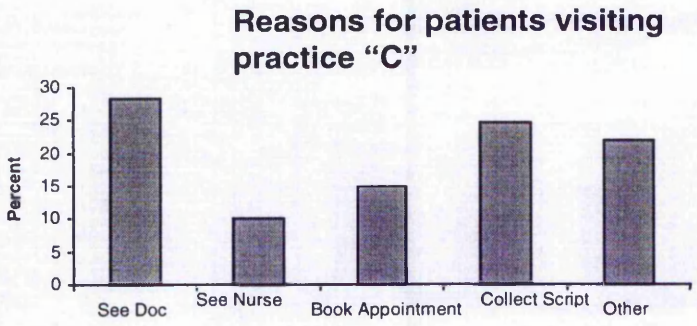


Figure 5.2. 4

The average numbers of patients visiting either the doctor or practice nurse were 28.4% and 10.2% respectively means the practice score an average mark of 2 for sections 4.1 and 4.2 in PAM. This means that more than half the patients coming through the doors come for reasons other than to see a clinician. From figure 5.2.4 it might seem that there is a high proportion of "other". This is because (for the "St.Clements" Surgery) some of the community activities and duties were initially dealt with by practice staff (ie ordering of ambulances, issuing of incontinent pads & hearing aid batteries, returning blood and urine samples, or checking their appointments with the health visitors). Most of these activities and duties should have been carried out by Health Authority staff. Almost 25% of patients came in to collect their prescriptions and nearly 15% to book an appointment.

When the ratio of nurses, phlebotamists, chiropodists, councellors (Professionals Allied to Medicine) compared to GP hours worked is computed, again this falls into the average band of the **PAM** matrix. When the hours doctors actually spend face to face with their patients as a percentage of their total hours worked is calculated it can be seen (Figure 5.2.5) that this is some seventy nine percent. This would tend to indicate that the doctors

are committed to patient care and more concerned with clinical matters than managerial ones.

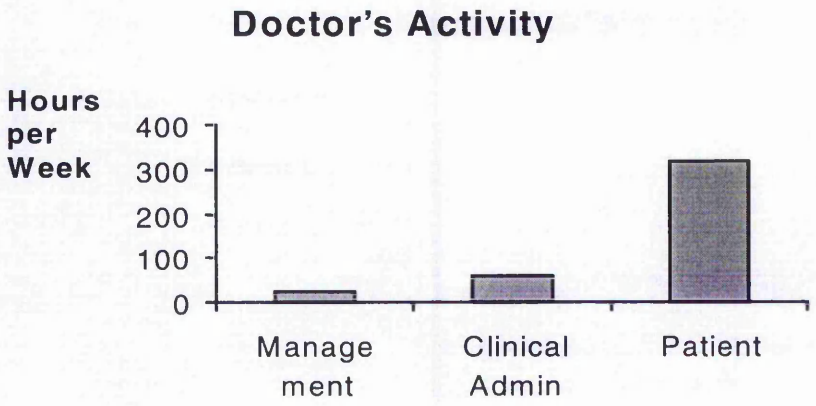


Figure 5.2. 5

Each GP enjoys nearly 51 minutes of clerical support, which falls as a normal score in **PAM**'s section 4.5. In section 4.6 practice "C" tends heavily towards team orientation with the presence of an annual appraisal scheme and a myriad of regular meetings that have been described earlier.

Overall the focus of service delivery is firmly in the center between the GP and team orientation, as figure 5.2.6 illustrates.

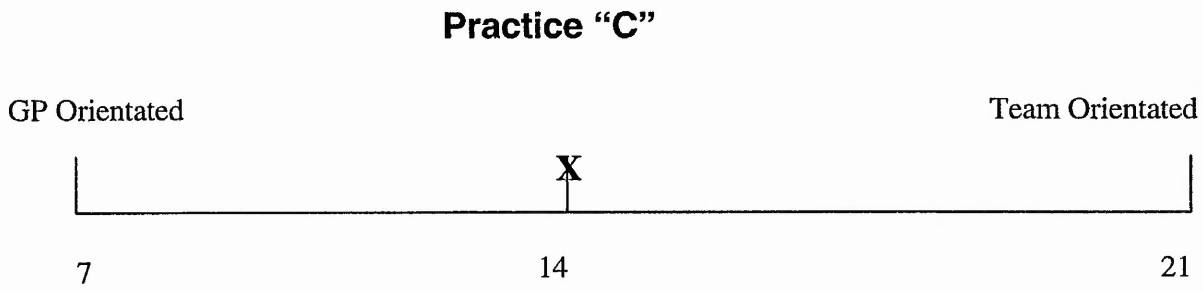


Figure 5.2. 6

The final analysis for practice "C" considers clinical standardisation and the relationship between clinical principals. The doctors have, on average, 1,973 patients each, which compares to a national average of 2,003. When expressed as a percentage it is well within the PAM tolerance of 5%, and scores as average.

There are clearly stated protocols and procedures for disease management and these are reviewed and added to at a meeting held every six months. The same goes for formularies, which are updated at the same meeting. On both sections 5.2 & 5.3 from PAM practice "C" scores a maximum 3.

On section 5.4 the standard deviation in consulting times is huge. This has been discussed earlier and the practice has a standard deviation of 3 minutes, and thus scores 1 point.

The frequency of meetings has been discussed earlier and the practice scores 3 for section 5.5. One of the partners does conduct private non-NHS work, but the financial proceeds go into the practice account. He is a qualified dentist and surgeon and it is considered beneficial to the practice for him to keep his skills up to date. This indicates that relations between clinical principals are harmonious and productive. As well as regularly meeting during their working day, a monthly dinner party is held in one of the partner's houses, so that the spouses can also keep in touch with their opposite numbers.

If we plot practice "C" on the final **PAM** matrix we see that the practice tends towards standardisation. This might be a function of having to survive on three sites.

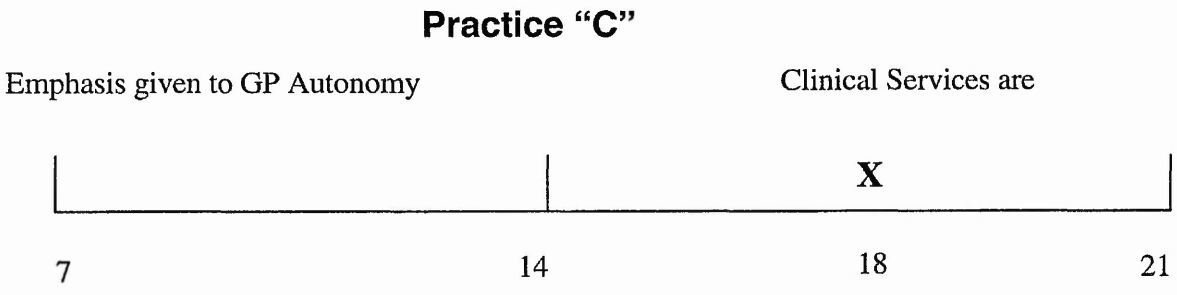


Figure 5.2. 7

5.3 Practice "D"

(5.3.1) Description

The original practice was formed in 1989 when two practices working from the health centre merged. Two of the doctors from those are with the present set up. There are 4 other surgeries in the immediate vicinity with 10 doctors. The population of the catchment area is about 28,000. All the doctors within the practice are strongly opposed to fundholding (on political and ethical grounds). They have a list size of about six and three quarter thousand patients, with a new patient turnover of about ten percent per annum, being served by three male and one female full time doctors. The patient base is 13% Asian and other ethnic minorities, with 62% coming from deprived areas (as defined by the Jarmon index), with unemployment in the district higher than the national average.

The surgery is a modern, light, airy and spacious, purpose built building, set back from the busy main road. It was opened in 1993 at a cost of £300,000 and is situated just outside the city centre, and is considered to be an inner city practice.

The new building is about a mile away from the old surgery, in order to retain their list (there is a doctor's surgery opposite their old premises), and in an effort to reduce the out of surgery visits the practice has pioneered an innovative service. The elderly and infirm, as well as potential home visit patients are offered a door to door collection service, one of the receptionists doubling up as "taxi driver". From the patient's perspective they are encouraged to stay with the same doctor, perceive the service as

both friendly and personal and (especially the elderly) enjoy the attention, getting to know the receptionist. From the practice's perspective it is cost effective, with the doctor's time being used more efficiently. It increases patient satisfaction, retains patients that might have been lost and differentiates the practice from the competition. From the doctor's perspective the patients are seen in the best environment, and it reduces the amount of house visits per doctor from 3 or 4 per doctor per day to only a handful a week. From the receptionist's perspective it makes the job more interesting, getting them out of the surgery. They believe that they really are contributing to the patient's welfare and also they are completing the whole job, thus being a real morale booster.

Patients enter through the main doors, which open directly into the waiting room, which accommodates about 25 patients, has a television and magazines as well as a separate area for little children and toddlers. The reception desk is situated to the left of the main doors

The consulting rooms are reached through a door immediately opposite the main door, two Doctors on the left, the other two being on the right. Beyond this hall the nurses' and treatment rooms are to be found. Patients are personally called through from the waiting room by either the doctors or the nurses. This is a deliberate policy as it encourages personal contact and enables doctors and nurses to communicate any additional waiting times there might be to patients.

Patient's notes are kept in the reception area, these are not stored in the traditional A5 Lloyd-George envelopes, but in A4 folders for ease of use. Although they are not a

training practice all patient's records are summarised at the front. This is a particularly time consuming exercise and usually only done by training practices as it is a requirement of their eligibility to be a training practice. Behind the reception area is a back office which houses two computers, and two full time members of staff. The practice employs 11 part time staff and 6 full timers. These staff all wear a uniform and some wear name tags.

The Practice Manager has worked for the practice for the last three and a half years. His previous experience was as an administrative manager for a life insurance company and he has had some management training, having successfully completed his Diploma of Practice Management. Soon after his appointment a large proportion of his energies were channelled into the commissioning of the new building. Now successfully installed with most of the teething problems behind them, he believes the time is ripe for an evaluation of the management practices at the surgery. One or two points came to the fore during our interview. He candidly admitted that some activities that he had previously instigated had not been attended to since the move. None of the staff have had a performance or appraisal interview for the last eighteen months. Apart from a very small survey amongst a minority group of patients (those clinically depressed), conducted by a drugs company no, "patient satisfaction" surveys have taken place.

All the Doctors and the Practice management are of a single mind, in that none of them want to become fundholders. Their reasons are varied:

"Fundholding devolves responsibility for the under-funding of the health service from the government to individual doctors." (Dr. "C")

"It costs so much money to administer a fundholding practice - the Audit Commission reckon it's £80,000 per practice - this is a waste of resources that **should** be used to benefit the patient. Couple this with the vast costs that providers incur in extra management of thousands of individual contracts and you must agree it is a monumental waste of money that could be spent on the patient." (Dr. "A")

(5.3.2) The findings at practice "D"

The research was conducted over an intensive three week period as well as three supplementary visits. Each of the doctors and the practice manager were interviewed, using the administered questionnaire (appendix III).

Using the PAM matrix as a tool for analysing the findings we consider the practice's "orientation towards strategic management and values".

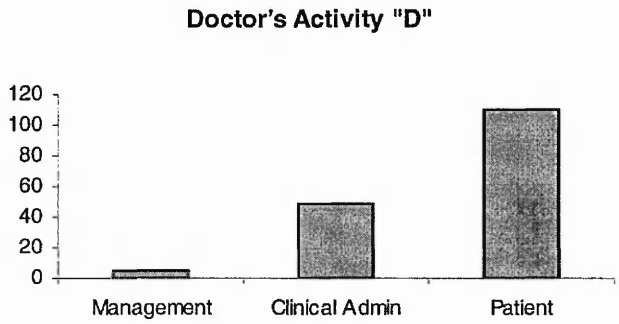


Figure 5.3. 1

Figure 5.3.1 shows that the GPs reported that well over half their time (67%) is spent in direct contact with the patient. Almost a third (30%) is concerned with clinical administration and only a very small time (3%) is dedicated to management. Most of this is due to the time that doctor "B" dedicates to management matters. The amount of clinical administration is high due to the high standards set with regard to the update and summary of patient notes. The practice management hours per GP is just 10.6 per doctor, which is low. The practice scores the minimum score on the PAM index for the first two elements for this section.

The practice has not conducted any form of patient satisfaction survey in the past years nor any form of audit in the same period of time. Before to the move, two and a half years prior to my research being conducted, the partners employed a management consultant company, which on their behalf, sent questionnaires to every one of their patients. The main purpose of this was to gauge the effect that the proposed move might have on their patient population. Immediately after the move, the FHSA sponsored a campaign of canvassing each patient that visited the practice for the first six months. The results showed a very satisfied patient population. Due to the intensity of these audits the partners had not considered conducting any more research. The lead partner

did concede that they had been complacent and stated that he had it in mind to instruct the practice manager to carry out a patient satisfaction survey of 5% of the population every six months. So, whilst the practice scores the minimum of one point for section 2.3 in PAM, both the practice manager and lead partner do appreciate the importance of audit as a management tool.

The practice is aware that the capitation is well below that of the local average. They are still feeling the effects of relocation, and have a policy to actively increase its list. To this end the practice manager has taken advertising space with the two nearby universities. As well as this there has been a recent leaflet drop on a new housing estate. Regarding section 2.4 the score is a maximum of 3 as the practice does have a policy of growth.

The next section is interesting, dealing with mission statements and strategic thinking and planning. The practice manager did not think they had a mission statement and when pressed gave very vague personal objectives concerning the practice. When the same question was put to the lead partner he assured me that there was a mission statement displayed on the front of the practice leaflet. It reads:

> "Taking care, we aim to provide high quality patient care in all aspects of practice activity".

When asked what it meant, the GP said that it was under review and the new proposed mission statement was:-

> "The practice aims to provide a high quality of care to the local community; to meet the aspirations of the public, where reasonable and to educate that public when those aspirations are not reasonable".

The partner believed that this was more relevant and contained less waffle. He gave an example of patients booking an appointment and then not turning up for it on more than one occasion as an example of unreasonable patient expectations. The practice policy in such events was to write to that patient saying that if it happened again they would be taken off the list. If there was a re-occurrence then the patient was written to again and told that if they did not come in and see the doctor within two weeks they would be taken off the list. If matters progressed to this stage a ten minute interview was undertaken with the patient and the doctor, where it was pointed out that it would be impossible to plan a surgery if lots of people didn't turn up also the consequences for other patients were explained. The doctor said that since this policy had been implemented they had not removed anyone from the list and the did not attend (DNA) record had improved from 10% to 2.5% over the last three months. In this example they had educated the patients towards more reasonable expectations.

This section is interesting in that there is clear lack of communication between staff and doctors. Oviously there were no stated objectives nor a formal annual review of long term strategies. The **PAM** score for this section was 1.

The GPs had never considered removal of any "non-profitable" heart sink patients from their list. They stated that on ethical grounds none of them could envisage a time when this ever happened.

The practice manager stated that the practice did have an area needs document, but didn't know where it was. When asked what was included in the document he didn't, know, but was quite aware of local plans for building etc. In consequence of this rather muddled message the practice did score 2 in section 2.7. On balance the practice displayed a poor concern for management, scoring 10 on the PAM matrix as seen in figure 5.3.2.

Practice "D"

Figure 5.3. 2

Next attention is turned to analysing the practice in terms of Operational Efficiency and Income Maximisation.

The practice has an average of 1,683 patients per GP, which is very low indeed, being 11% below the national average. The doctors are quite concerned about this and believe that part of this is due to the move, but in reality they calculate that they lost under 600 patients which still doesn't account for the shortfall. The senior partner revealed that until last year all the partners drew from the practice was £30,000 per year before expenses, these expenses being typically around £5,000. This compared with average

national earnings for GPs (at the time of interview) of £42,000 after expenses. They believed, in part, that this was a function of working in an inner city practice in a deprived area and thought the financial sacrifice worth paying, in the short term.

They are looking to increase numbers so they can afford to employ a part time female doctor. One of the doctors is a qualified surgeon and two of the others have certificates allowing them to conduct certain procedures. Two years ago the practice successfully won a contract from the Health Authority to carry out minor surgery as part of an initiative to reduce hospital waiting lists. This has brought in additional profits of £40,000 per year, so despite a smaller list size the doctors are nearly on parity with their colleagues. The contract is due for renewal in a years time. If, as they are confident of doing, they secure a second larger contract they believe that their earnings will be above that of their colleagues. So whilst on the PAM index the practice must score the minimum 1 point here, the partners are actively addressing the problem of doctor to patients ratio.

As can be seen from figure 5.3.1 the average consulting time was 6.2 minutes, which is very quick. 408 patients were observed entering and leaving the doctor's consulting rooms.

Analysis of consultancy times for doctors at practice "D"

Doctor	"A"	"B"	"C"	"D"
No of Consultations	74	50	130	154
Ave Consultation Time	4.8	5.3	6.0	7.3
Total Time (Mins)	352	266	780	1118
Average Consultation Time	6.17			

Table 5.3. 1

There is a lot of variation in the numbers of patients seen by each doctor, even when holidays are taken into account. The times of different locums were attributed to the doctor they were covering, but this figure was slight. The standard deviation (covered later) is very low, at one minute, and indicates little variation in consultation times.

When we examine the nurses' consultation times we see much less variation in the number of patients seen (except for nurse "C" who was part time) and a conformity of consultation times.

Analysis of consultancy times for nurses at practice "D"

Nurse	"A"	"B"	"C"	"D"
No of Consultations	92	71	48	70
Ave Consultation Time	11	11	9	11
Total Time (Mins)	1012	781	432	770
Average Consultation Time	10.66			

Table 5.3. 2

The longer times might be explained partly because the nurses take on a counseling role (thus freeing up much of the doctors' time) The second reason is that the nurses often spend several minutes at a time waiting in the lobby outside the doctors' consulting rooms. Sometimes this was for advice, but often to ask the doctor to sign patient's prescriptions. For section 3.2 on the **PAM** matrix the practice scores 3.

The Practice prescribing costs were above that of the regional (15%) and national (10%) averages. This could well have been due to the deprived nature of the area, rather than a reflection of the GP's prescribing habits, as the cost per item was 4% and 9% below the regional and national figures respectively. The number of items prescribed, per patient, were dramatically higher than the region (19%) or the nation (20%). 76% of items were prescribed generically (and therefore cheaper) compared with the FHSA's 54% and a national average of 52%. The average cost per patient at the practice was £17.70 compared with the FHSA's £15.39. So although the practice scores the minimum 1 point for this ratio in the context of efficiency, this might be a slightly unfair perception.

The frequency of any administrative audit has been covered earlier. Whilst not having addressed this issue in the last 12 months, both the practice manager and the partners realise the importance of such an exercise and are resolve to institute an audit in the near future.

The average hours each GP spent on home visits and emergency call outs per week was just 2.38 hours. This is very low indeed and needs explaining. This is not due to partners refusing to visit patients, but due to practice policy on what constitutes an "emergency". Patients who have not got an appointment, and who feel they are too ill to wait (often several days) for the next available appointment are encouraged to come to the surgery. They are at first seen by a nurse who determines if the patient needs to see the doctor or if they can treat them. The practice operates a triage system. Couple this with the "taxi service" described earlier and they greatly reduce the out of surgery hours,

effectively "managing" the emergencies. The practice score 3 **PAM** points for efficiency.

Next we look at item of service payments.

Comparisons between practice "D's" IOS income and national figures

	Practice Total	Practice per Patient	National per Patient	Difference per Patient	% Varience
Child Health Survey	2458	0.37	0.42	-0.05	-11.90%
Registation Fees	1905	0.28	0.38	-0.1	-26.32%
Temporary Residence	**828**	**0.12**	**0.34**	**-0.22**	**-64.71%**
Emergency Treatment	**210**	**0.03**	**0.04**	**-0.01**	**-25.00%**
Minor Treatment	4500	0.67	0.46	0.21	45.65%
Maternity	7256	1.08	1.43	-0.35	-24.48%
Childrens Imms & Vaccs	9114	1.35	0.57	0.78	136.84%
Contraception	5250	0.78	0.91	-0.13	-14.29%
Health Promotion	17190	2.55	1.49	1.06	71.14%
Other	16837	0		0	25.69%

Table 5.3. 3

As can be seen from Figure 5.3.3 the practice is substantially over target (+137%) for children's vaccinations and immunisations. Payments for health promotion were 71% above the national average, and 111% above the regional average, whilst minor treatment was 45% above the national figure. The low maternity payments (28.2% below the regional average) and low contraception payments (21.7% below the regional average) might well reflect the fact that there is a high immigrant population in the catchment area.

Apart from the child health surveillance figure (-32.6%) the practice has no influence on any of the other areas that were showing an adverse percentage. For instance temporary residence fees (-45.08%) are entirely dependant on the number of visitors who need the surgery whilst on holiday and this in itself doesn't constitute a large amount of money (£828). Figure 5.3.4 shows that the practice's IOS figures compare favourably with the local average.

Comparisons between practice "D's" IOS income and local FHSA's figures

	Practice Total	Practice per Patient	Regional per Patient	Difference per Patient	Weighting	Weighted Difference
Child Health Survey	2458	0.37	0.54	-0.17	3.75%	-0.0064
Registation Fees	1905	0.28	0.43	-0.15	2.91%	-0.0044
Temporary Residence	**828**	**0.12**	**0.55**	**-0.43**	**1.26%**	**-0.0054**
Emergency Treatment	**210**	**0.03**	**0.02**	**0.01**	**0.32%**	**0.0000**
Minor Treatment	4500	0.67	0.49	0.18	6.87%	0.0124
Maternity	7256	1.08	1.5	-0.42	11.07%	-0.0465
Childrens Imms & Vaccs	9114	1.35	0.59	0.76	13.90%	0.1057
Contraception	5250	0.78	1	-0.22	13.90%	-0.0306
Health Promotion	17190	2.55	1.21	1.34	8.01%	0.1073
Other	16837			0	25.69%	0.0000
Total Annual IOS income	**£ 65,548**					**0.1375**
Anuall Staff Bill	£ 183,691		Wages ratio	£ 0.36		

Table 5.3. 4

When the payments are weighted to take account of their prominence the payment is well above the average of 0.0. IOS income as a ratio of staff costs is 0.36, which given the higher than average payments per patient for the region would tend to indicate higher than average staffing levels. The average IOS to staff wage ratio for the region is between 70p and 75p (Slingsby 1995). Consequently the practice score 1 point in section 3.6 of PAM but three in section 3.7.

The overall picture is that of a practice mildly leaning towards a low concern for efficiency, which is illustrated in figure 5.3.3 below. The practice scored very highly in some areas and if it could address the patient doctor ratio problem, get its prescribing habits under control as well as carrying out a regular audit it could well become much more efficient.

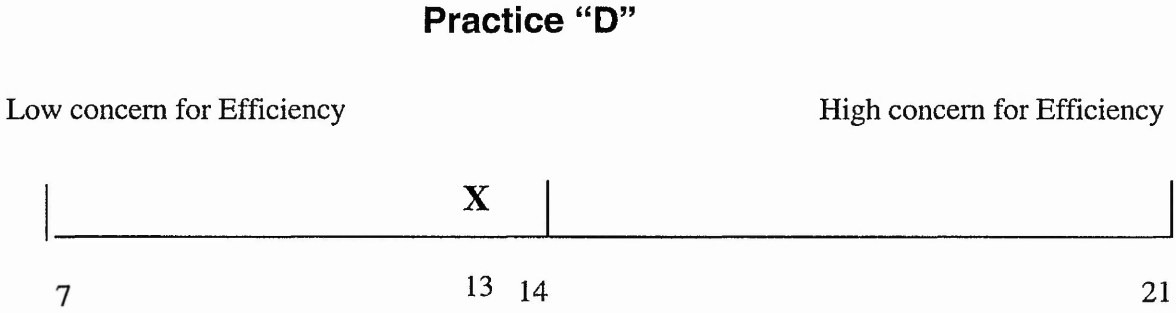


Figure 5.3. 3

We now turn our concerns to analysing the practice in terms of the focus of service delivery.

Over two and a quarter thousand observations were made regarding the reasons for a patient's visit. As can be seen from figure 5.3.4.

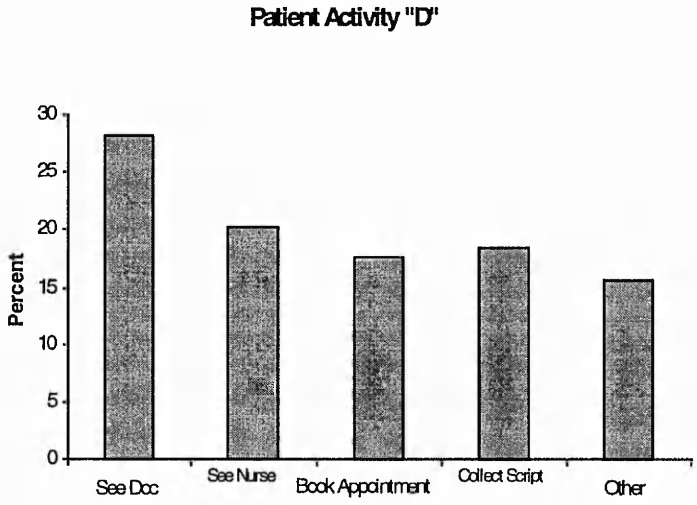


Figure 5.3. 4

The relatively high numbers of patients visiting either the doctor or practice nurse 28.2% and 20.3% respectively underline the emphasis put on patient care by the practice. It also underlines the high number of nurse hours per patient compared to regional averages. This is explained in the way in which the practice approaches the question of Skill Mix, the manner in which various staff members are deployed. For example, by using the triage system for emergencies' the practice is using a nurse being paid about £12 per hour rather than a doctor on about £90 per hour. As long as the clinical outcome is acceptable, this is an efficient use of resources and might well enhance job satisfaction for the nurses.

As might be expected from the preceding discussion, the ratio of professional allied to medicine's hours to doctor's hours is high at 77, scoring a maximum 3 PAM points.

The doctor's hours face to face with the patients as a percentage of total patient care is 67%. This further endorses the view that there is an even distribution of patient care carried out by the team. The clerical hours per GP are also high.

The absence of an appraisal scheme has already been discussed. Various meetings were conducted within the practice on a fairly ad hoc basis. Clinical issues were discussed at an informal level daily between the GPs. A formal clinical meeting was scheduled to take place every other month, but in reality this happened two or three times a year. These were attended by all the partners, practice nurses and community nurses.

Partner's meetings were supposed to take place every week, but at the time of the author's visit it had been eighteen weeks since the last meeting. These were attended by all the partners and the practice manager, who has equal voting rights. The reasons that he had equal voting rights were twofold. If ever the doctors couldn't come to agreement over an issue, with two opposing the proposal and two supporting, it then the practice manager would have the casting vote, thus preventing a stalemate. The second reason was that all the partners believed that if the practice manager was responsible for the day to day running of the practice and all the financial activities, then he was entitled to a vote as much as any doctor. The purpose of such meetings was to facilitate the management of the practice.

There were full practice meetings held about once or twice a year, although they should have been scheduled every 3 months. These involve every member of the team, (except the cleaner and gardener), and are chaired by the Practice Manager.

The practice scored poorly in section 4.6 with just one point out of a potential five. The overall picture of section four is illustrated in 5.3.5, with the practice scoring 15 points.

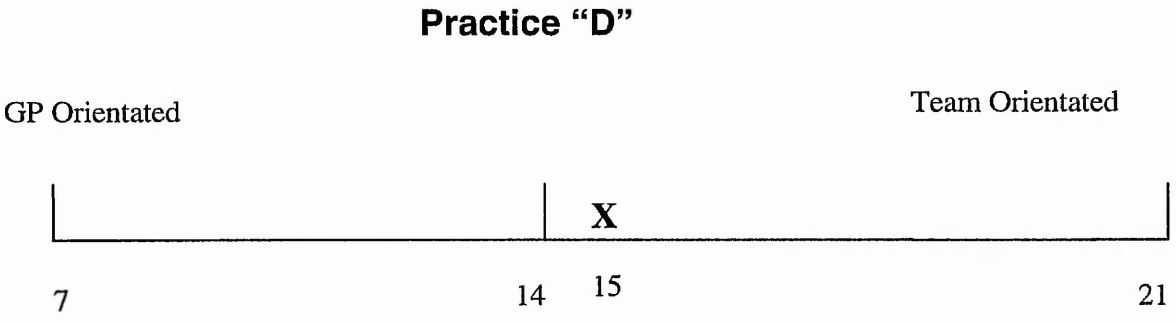


Figure 5.3. 5

Despite the outcome on the **PAM** matrix that places the practice just one point towards team orientation, this is deceptive. The reason for this is inertia rather than intention. In other words if all the meetings that were intended were carried out, along with the appraisal and staff training and development schemes, then the practice would show strong tendencies towards team orientation. From observation it could be deduced that this was the intention. For example' doctors encouraged staff to call them by their first names, and in the past the whole practice, staff and doctors alike had been away for team building weekends.

The senior partner gave an example of staff empowerment, when the head receptionist had been allowed to bid for resources from the FHSA for staff training. This task, by tradition, would have been carried out by the senior partner and the practice manager, with the programme just being dictated to the reception staff. She had to produce the bid document, as well as propose the training programme. It was felt that she would have "ownership" of the scheme if funds were allocated.

The next section relates to clinical standardisation and the relationship between clinical principles.

The doctors have an average of 1,683 patients per GP which, as discussed earlier, is way behind the national average by 11%. There are no formally stated protocols and procedures for disease management. The doctors believe that they see each other a great deal informally during the day and that formal meetings are unnecessary. However, the senior partner does concede the need for formally written down procedures for disease management, even if it is for the guidance of locums during holiday periods. When plotted against the **PAM** matrix the practice scores only a single point for each of the first sections in section 5.

The standard deviation between the doctors is about one minute, which is good as they are consistent in how long they see patients.

The frequency of meetings has already been dealt with. As previously mentioned some of the partners do carry out private work and are supported in this by their colleagues covering for them. The revenue from such activity is pooled and becomes part of the communal drawings. All the doctors get on really well. At no time was any tension observed between them. The practice scores the maximum PAM points for the last four sections giving an overall picture depicted below, which places the practice with fifteen points marginally towards standardisation. This is a fair representation.

Practice "D"

Emphasis given to GP Autonomy

Clinical Services are Standardised

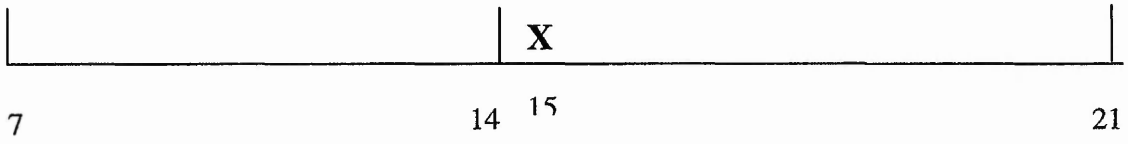


Figure 5.3. 6

5.4 Practice "E"

(5.4.1) Description

The original practice was formed in March 1995 when two practices working near to each other merged. Three doctors from the original merger are with the practice today. It is situated in a suburban area of mixed housing, with a catchment of approximately 75,000 people. The list size is 11,293, and there are five other surgeries in the immediate area with eighteen other Doctors. Just one of these practices is fundholding.

The surgery is a modern light airy and spacious purpose built brick building, set back from the main road, opened in 1985 at an approximate cost of £200,000. Patients come in via the entrance lobby. There is a window to reception, which is well signed, for future appointments, enquiries and collection of prescriptions. Through another door is the main waiting room, which seats thirty people, and a separate open plan area for children and toddlers. There is another window to reception, this is also clearly marked "Today's appointments". It is here that all patients report before seeing either the doctor, or the nurse. The reception office has several doors leading off it and is like the hub of a wheel. There is a central island which houses staff's personal belongings, the top of which is used like a giant desk. A separate little room leads off which is used for the telephonist. The patient's Lloyd George envelopes are housed in this office, with the over 75's records being kept in a separate cabinet. There are two coffee making areas, one of which doubles up as a rest room and doctor's conference room. As well as these rooms, there are two nurse consulting rooms, the clinical support co-ordinator's office and a support "back office" for four staff.

The practice employs twelve part time and six full time staff, that all wear a uniform and display a name tag. All except one of the partners is opposed to fundholding, their reasons ranging from political to ethical:

> "it is not the way forward, it leads to a two tier system. If everyone were to go fundholding, it would enable the government to push the blame onto GPs for rationing health care using the excuse that GPs weren't managing their budgets properly"

The practice is, to some extent, in a state of flux, in that at the time of the study the junior partner had only just been appointed. The partners were conducting interviews for the appointment of another partner and the longest serving GP was hoping for early retirement within a year. Three of the partners were not full time working, and another (the only male doctor) had a large commitment to the LMC, leaving him also with about 2/3 full time hours. This meant that a locum was employed to all intents and purposes on a full time basis.

(5.4.2) The findings at practice "E"

The research was conducted over an intensive two and a half week period as well as supplementary visits to conduct interviews. Both the practice manager and all the doctors were interviewed.

In the context of PAM, first we analyse the practice in terms of orientation towards strategic management and values.

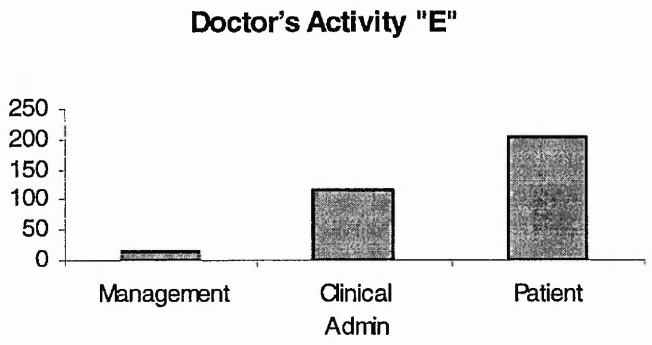


Figure 5.4. 1

Figure 5.4.1 shows that the doctors reported they spent about two thirds of their time on patient care, whilst almost a third is concerned with clinical administration and a relatively small amount of time (5.5%) is dedicated to management. This figure was high due to the practice manager's insistence on holding regular meetings. Because of this the practice scores 3 points on the **PAM** register. The practice has 13.8 management hours per GP per week, scoring it 2 in section 2.2 of **PAM**.

The doctors did not feel the need for a patient survey. Reasons for this varied. The senior partner realised that currently they had huge problems with patients waiting far too long for appointments and also being kept waiting at appointments (this will be discussed later). In consequence she felt that the results of any survey would be extremely negative and conducting such a survey might draw attention to the problem and inflame dissatisfaction amongst the patients. Two other partners agreed that a patient's survey was not needed, but their reasons were at odds with the senior partner. They believed that because the practice enjoyed a good reputation and they had a waiting list of patients from other surgeries in the area that they must be the best. Any survey would be pointless and waste a lot of time administering it. Consequently practice "E" scores 1 point for section 2.3.

Returning to the matter of waiting times, this appeared to be a serious problem at the time of the research. From direct observation in the waiting room it was noted that on occasion patients had to wait nearly one hour past their appointment time to see the doctor. Whilst other emergency "sit and wait" patients waited up to an hour and three quarters. This seems incongruous with the blue practice leaflet, which states ***"we aim to see all patients within 15 minutes of their booked appointment".*** Monday mornings were a particular problem, and often there were nearly 40 "emergencies" at the end of the surgery. On one such occasion there were just two doctors in the surgery who finished seeing patients at 1:45pm. The scheduled finishing time for morning surgery is 12:00.

The earliest appointment patients that could be offered with any doctor was seven days away. If they wanted a specific doctor it could have been up to two weeks away. This was not a function of the doctors being on holidays. Their practice leaflet states ***"If you need a routine appointment, we aim to offer you one with the doctor of your choice within 3 working days".*** The explanation for this apparent failure, given by the front of house manager, was that some of the doctors were part time and didn't work every day, so three working days was in effect one week for some doctors.

The practice manager seemed unaware that there was a problem, as this quote illustrates:-

> "We are a centre of excellence. We take, on a regular basis, patients from all the other practices in the area. Patients vote with their feet. We provide a brilliant service. We're open five full days of the week from 7 in the morning 'till 8 at night and a half day on Saturdays. We don't have half

> days, or lunch breaks. If you want to be seen, you get seen People really enjoy coming here."

Returning to section 2.4 of PAM the practice scores the minimum 1 point as it has a policy of consolidation, partly because to increase their list would exacerbate the problems outlined above. The patient to doctor ratio was 19% above the national average already and they felt that they just could not cope with any more patients. They ruled out appointing another doctor on the grounds that the accommodation wouldn't allow it, although "off the record" they admitted enjoying above average earnings of £54,000 per year and were reluctant to reduce this.

The practice doesn't have a mission statement, despite being urged to by the practice manager. The general (but not unanimous) consensus was that mission statements were dreamt up by business consultants and were pure rhetoric, an amalgamation of meaningless words. The senior partner said that all the doctors got on really well, the only two occasions that there was any dissent were when becoming fundholding was discussed and when producing a mission statement was on the agenda for a meeting. On those occasions the lead partner said:

> "When we discussed having a mission statement we ended up having such appalling rows that we've never written a single sentence".

The practice did not have any stated objectives and only one doctor out of six, when pushed, could articulate any objectives, and they proved to be quite instrumental.

> "To earn more money than our less fortunate colleagues. To sustain the lifestyle that we have been accustomed to. Oh, er yes, to practice good medicine and provide a good service within a pleasant working environment".

However the practice does produce an annual business plan, initially in response to the FHSA's request, but now at the instigation of the practice manager. This document is produced mainly by the practice manager then the first draft is circulated amongst all the other doctors for their comments, amended to reflect these and then processed. Before being implemented it is discussed at a full Practice Meeting to confirm that everyone is in agreement with the contents. The purpose of the business plan is viewed positively, by the practice manager, who fully understands the strategic importance of formulating a business plan and regularly referring to and amending it:

> "It is the only way to go forward, unless you plan for the future you spend all your time fire fighting".

The senior partner had previously had her reservations:

> "My feelings about management are fairly negative, because I was brought up before general practice had to be a business... I leave the business plan to other people, but I do concede it is a good thing."

The GPs had never discussed the policy of "expensive patients" and as long as their pay was not penalised believed it unethical to consider this. The practice did not have an area needs document, nor did they see the purpose in having one.

When plotted against the PAM matrix the practice is shown as having a very low concern for management.

Practice "E"

Figure 5.4. 2

The practice as a whole scores a very low orientation towards management, which is not surprising as the senior partner admitted management was an "anathema" to her, as she was of the generation that qualified as a doctor long before they were expected to run the practice as a business. The practice manager was clearly frustrated that the doctors were unwilling to allow him to set in motion such matters as a mission statement and clearly stated objectives.

Section 3 of PAM focuses on "concern for operational and financial efficiency". As has been discussed earlier, the practice has a large list size, averaging 2,259 patients per GP compared to the national average of 1,892, or 19% above that average. This came about in

1988 when the building was still new and a two partner practice retired. There was an influx of about 2,000 new patients, which the practice has retained. The turnover of patients is roughly 5%, much lower than the other practices in this research. For 2.1 the score is 3 points.

The average observed consulting time was 7.9 minutes which was really very slow, being 1/6th more than that of the national average, 645 patients were observed visiting the doctors. This slow consulting time resulted in attracting the minimum score of 1 in section 3.2 of **PAM.**

Analysis of consultancy times for doctors at practice "E"

Doctor	"A"	"B"	"C"	"D"	"E"	"F"	"G"
No of Consultations	90	72	114	110	91	112	56
Ave Consultation Time	7.4	9.2	7.5	7.2	7.5	7.4	10.7
Total Time (Mins)	666	664	860	790	687	825	597
Average Consultation Time	7.89						

Table 5.4. 1

As table 5.4.1 shows, with the exception of doctor "G" who had only just been appointed and was finding her feet, there was consistency in both the number of patients seen and the average consulting time. There was a standard deviation of 1.3 minutes for the practice, but if we ignore doctor "G" this drops to a very small 0.75 of a minute, which allowing for six doctors is very close indeed.

Analysis of consultancy times for nurses at practice "E"

Nurse	"A"	"B"	"C"
No of Consultations	122	105	114
Ave Consultation Time	12.0	12.0	10.0
Total Time (Mins)	1464	1260	1140
Average Consultation Time	11.33		

Table 5.4. 2

As can be seen from table 5.4.2 the situation is similar to that of the doctors, with 341 patients being observed entering and leaving the nurse's surgeries.. Although the consulting times were longer, there were consistencies.

The practice prescribing costs were well above both the national and regional averages, 6.5% and 5.5% respectively. Most of this was explained by the doctors' aggressive treatment of asthma, of which there was a high incidence in the area. Generic prescribing for the practice was 55%, which compares favourably with the FHSA's 54%. The average cost of treating each patient at the practice was £16:23 compared with the FHSA's average of £15:39.

Some form of administrative audit was carried out at least once a year, this being an analysis of the clinic support co-ordinator's job. This is an innovative appointment and figure 5.4.3 outlines her role.

Role and responsibilities of the clinic support co-ordinator

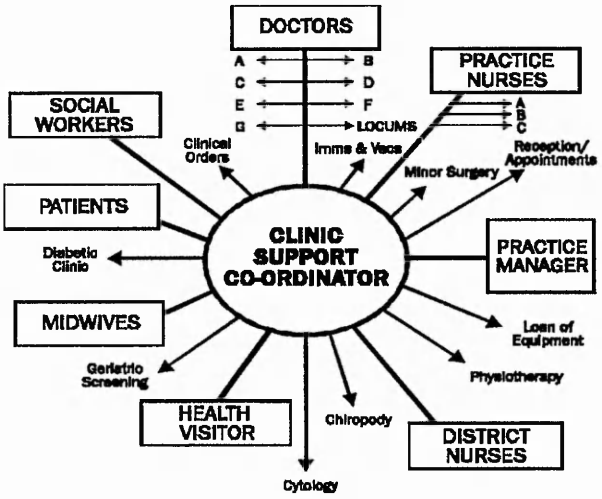


Figure 5.4. 3

She was responsible for the practice meeting all its targets for cytology, immunisation and vaccinations for children and dealing with all the support agencies. For example she was be responsible for liasing with social services if an elderly patient needed to be admitted into a home. Because she was dealing with these people on a daily basis not only did she know the correct procedures but also quickly built up a network of contacts. Projects like that used in the example above usually would take two or three days to achieve, but because the clinical services co-ordinator could focus on the problem until resolved the time she took was just a few hours.

By making such an appointment the practice has created a centre of excellence, greatly reducing the time doctors spend liasing with support services, benefiting the patients by offering a better service. The only flaw is that all the experience and expertise is concentrated in one person. The implications of that person going on holiday or going long term sick are obvious. Another way in which the practice was planning to benefit from the skill mix was by appointing a phlebotomist, to collect bloods from patients, which will in turn free up more of the nurse's time.

Comparisons between "E"'s IOS income and national figures

	Practice Total	Practice per Patient	National per Patient	Difference per patient	% Variance
Child Health Survey	7224	0.65	0.42	0.23	54.76%
Registration Fees	2338	0.21	0.38	-0.17	-44.74%
Temporary Residence	3412	0.31	0.34	-0.03	-8.82%
Emergency Treatment	453	0.04	0.04	0	**0.00%**
Minor Treatment	3800	0.34	0.46	-0.12	-26.09%
Maternity	17373	1.56	1.43	0.13	9.09%
Children's Imms & Vaccs	14.21	1.26	0.57	0.69	121.05%
Contraception	13231	0.86	0.91	-0.05	-5.49%
Health Promotion	11250	2.23	1.49	0.74	49.66%
Other	11996				0.00%

Table 5.4. 3

As can be seen from table 5.4.3 the practice is substantially better than the national average (+121%) for children's vaccinations and immunisations, child health surveillance (54.8%) and health promotion (50%). This, possibly, might have been one of the benefits of appointing the clinical support co-ordinator, who has been responsible for obtaining 100% of the practice target. The only large negative figure is minor treatment, which is 26% below the national average. This may well be a function of there being such a large list size. Maternity payments were higher than the FHSA average, perhaps a side effect of having a high level of female doctors. The only other adverse figure was registration fees (45% down). However, with a closed list policy, not much could have been done about this.

As can be seen from table 5.4.4 IOS income as a ratio of staff costs is 0.43, which is relatively low indicating higher than average staffing levels. The practice manager is aware of this and plans to reduce the administrative staff by two. However the weighted average is excellent at 0.2642. This indicates that whilst the staff wages are high, there is a great deal of efficiency (26% better than average) in meeting targets and claiming for them.

Comparisons between practice "E's" IOS income and local FHSA's figures

	Practice Total	Practice per Patient	Regional per Patient	Difference per Patient	Weighting	Weighted Difference
Child Health Survey	7224	0.65	0.54	0.11	8.49%	0.0093
Registation Fees	2338	0.21	0.43	-0.22	2.75%	-0.0060
Temporary Residence	**3412**	**0.31**	**0.55**	**-0.24**	**4.01%**	**-0.0096**
Emergency Treatment	**453**	**0.04**	**0.02**	**0.02**	**0.53%**	**0.0001**
Minor Treatment	3800	0.34	0.49	-0.15	4.47%	-0.0067
Maternity	17373	1.56	1.5	0.06	20.42%	0.0122
Childrens Imms & Vaccs	14021	1.26	0.59	0.67	16.48%	0.1104
Contraception	13231	0.86	1	-0.14	16.48%	-0.0231
Health Promotion	11250	2.23	1.21	1.02	15.55%	0.1586
Other	11996			0	14.10%	0.0000
Total Annual IOS income	**£ 85,098**					**0.2548**
Anuall Staff Bill	£ 197,513		Wages ratio	£ 0.43		

Table 5.4. 4

Despite the better than average earnings the doctors enjoy, the practice has a poor showing on the PAM matrix for operational efficiency, scoring just 12 Points

Practice "E"

Low concern for Efficiency High concern for Efficiency

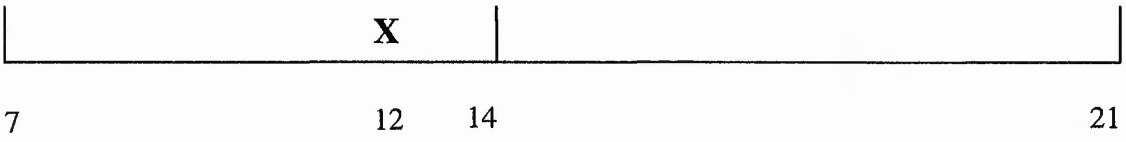


Figure 5.4. 4

The next section in PAM deals with the focus of service delivery.

During one fortnight over the research period over four and a quarter thousand patients visited the surgery. Their reasons for doing so were analised and are shown in figure 5.4.5.

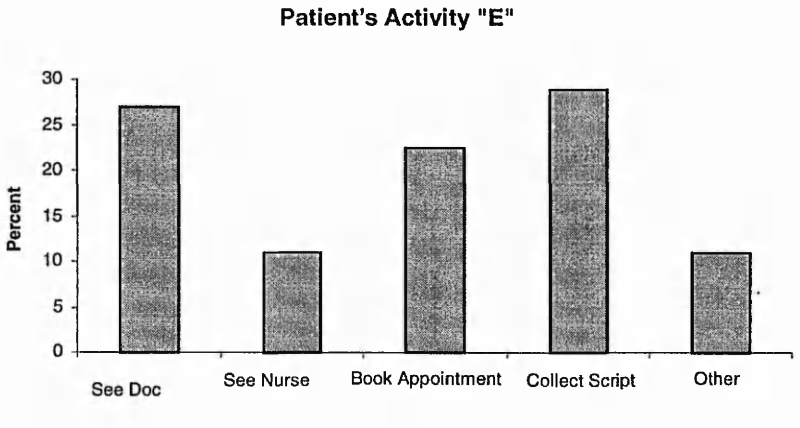


Figure 5.4. 5

The relatively low numbers of patients visiting either the doctor or practice nurse 26.9% + 11.3% respectively mean that more than half the patients coming through the doors come for other reasons. Most (28.8%) come in to collect/order their prescriptions and 22.4% to

book an appointment. This scores 3 points for section 4.1 and 2 points for section 4.2.on the PAM scale.

When the ratio of nurses, phlebotamists, chiropodists, councellors (Professionals Allied to Medicine) compared to GP hours worked is computed it gives a figure of 0.22 and scores just one point. This is an area that the doctors had looked at, with a view to employing a senior nurse to conduct a triage. However, when this was discussed the majority of doctors did not think that a nurse had the clinical knowledge to decide who should be seen by a doctor and who by a nurse, so the idea was shelved.

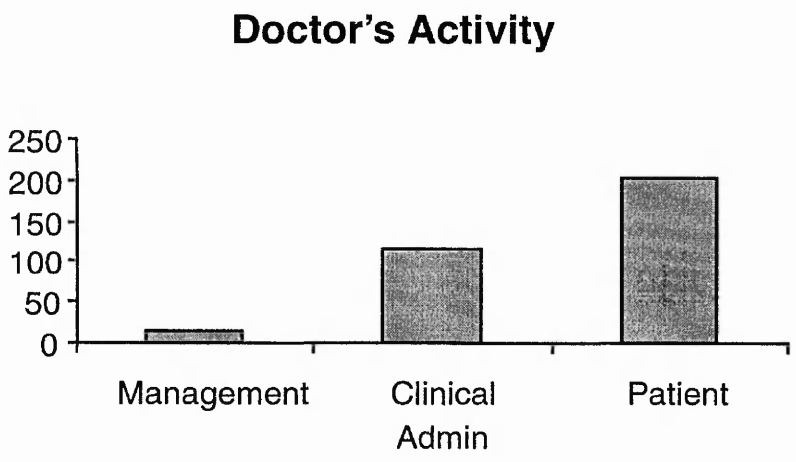


Figure 5.4. 6

Figure 5.4.6 shows GPs reported that about two thirds of their time is taken up with patient care, whilst almost a third is concerned with clinical administration and only a very small amount of time is dedicated to management. The main reason for the majority of management time is the time doctor "D" spends in meetings with the practice manager.

The amount of clinical administration might seem high, but is a reflection of current trends, although with the appointment of the clinical services co-ordinator one might have expected this to be slightly reduced.

Most (79%) of the doctor's time is spent directly face to face with the patients, which scores 1 point in section 4.4 of PAM. The number of clerical staff hours per week supporting each GP is right in the middle of the range, being 49 minutes. This is surprising as the practice employs a clinic support co-ordinator and someone else employed for 20 hours a week specifically to summarise the patient notes. Both these appointments are unique to this practice and expectations would have been that this would have inflated the ratio to above the norm.

All the staff have an annual appraisal and performance review, with stated targets and objectives to be met over the coming year. Various meetings are conducted within the practice on a regular basis, all having agendas, minutes, action lists and being chaired. These were as follows: **Section Heads**, held every week attended by Practice Manager, Senior Partner, front of house manager, back office manager and the senior nurse; **Partners**, planned to be held every month (the reality being every three months), three hours in duration; one hour management, two hours clinical, attended by all the partners and the practice manager; **Section**, held every two weeks, attended by all staff working in that section; **Full Meeting**, held bi-monthly, attended by all staff; **Liaison**, held biannually, attended by all the nurses, midwife, health visitor, all attached unit staff and two partners. As well as these meetings there is a meeting between the senior partner and the practice manager every week for half an hour.

There are staff development and training schemes in place. Over the last year the practice manager has been on a pensions administration course (despite there not being a staff pension scheme). One of the secretaries had been on an RSA course whilst the other attended a word processing course. Two nurses had been on asthma and diabetes courses. All the staff wore uniforms and most wore name tags. As can be seen from figure 5.4.7 the practice scores 13 points for section 4 of PAM

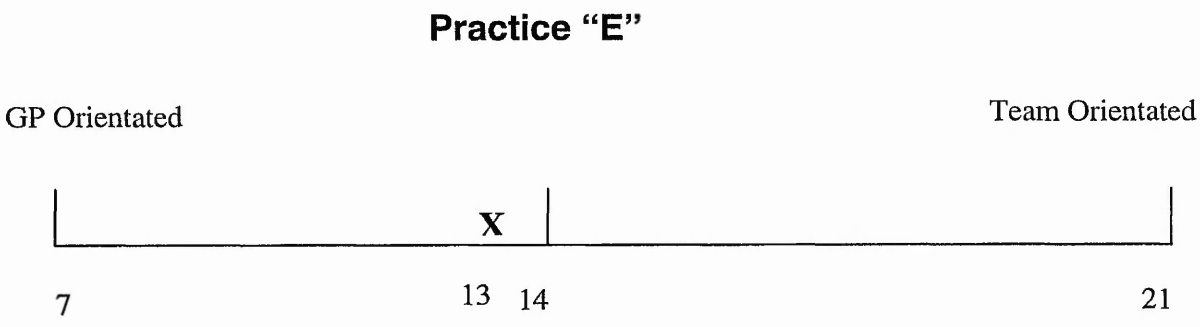


Figure 5.4. 7

This is a very accurate reflection of the practice, with the doctors being dominant. They believe that the employees work for them. From their perspective the notion of a team was a non-starter, which contrasted acutely with their espoused views elicited in the interviews. There is a tension here between the practice manager, who is attempting to generate a team orientation, and the doctors, who know he is right but are unwilling to embrace new ways.

The final analysis for practice "E" considers clinical standardisation and the relationship between clinical principles. As has previously been discussed the doctors have an average of 2,259 patients each which is 19% above the national average. This is over the 5% middle buffer for PAM and scores 3 point in section 5.1.

There are no clearly stated protocols for doctors as it was felt that they are all naturally similar and tend towards identical treatment as individuals without guidance. When selecting new partners this was an area that was examined in great detail. Some examples were the way in which asthma was treated and the management of hypertension and heart disease. However, because of lack of trust, the nurses did have precise written instructions, which were monitored on a regular basis. They have got four or five formularies (mainly for the benefit of locums) but these have not been added to in the last eighteen months. The practice scores 2 points for sections 5.2 & 5.3.

The standard deviation in consulting times has already been discussed and is 1.3 minutes, so scoring 3 PAM points. The GPs meet informally once a week to discuss medical cases and more frequently on an ad hoc basis dependant on case. None of the partners carry out any private non NHS work. Relations between the GPs are warm and friendly.

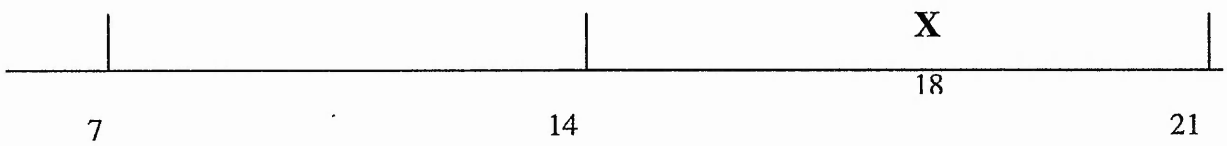
The practice scores highly on standardisation because of the extent of harmonious relations between clinical principles. It might seem incongruous that the practice is very GP orientated and yet heavily biased towards standardisation. The doctors would argue that it is a function of thinking similarly, having high clinical standards, rather than lack of autonomy. They believe that there is a high degree of autonomy, but that they are generally

correct in their clinical judgements and that there is only one best way of treating certain conditions.

The score for the final section of PAM is shown in figure 5.48.

Figure 5.4. 8

Practice "E"



Chapter 6

Conclusions

6.0 Conclusions

The first part of this dissertation (chapters 2 & 3) reviewed ways in which the state has attempted to control GPs, through a managerial structure and culture. The second theme was that whilst the majority of doctors interviewed expressed negative feelings towards the managerial demands of their job, they often embrace aspects of managerialism wholeheartedly. This is borne out by the research. A quote from doctor "C" from St Endors emphasises the resentment towards management at the same time as underlining aspects of control by the state:

> "you can be a good clinician - but spend a lot of your time doing other things... chasing the paper... but you have to, as part of your income depends on it. Sometimes that is not recognised and you are not paid for the extra work and responsibility, if this happens people will become disillusioned... that is why morale is so low at the moment... you work harder, achieve results, do a better job and can actually get paid less".

The research has investigated the impact of this tension on GP's attitude to management. These tensions went through many stages and as a result the relationship between GPs and the state has become similar to that of a franchise. As in the case of classic franchises, such as McDonalds, the franchiser seeks to exert more control over the franchisee.

(6.1) Research Methods

The pilot study carried out in Derby was vital to the design and implementation of primary research. By observing the running of a GMP the relative importance of some aspects of practice management, that had not hitherto been considered became apparent. Two of these were used as dimensions within PAM, notably **Clinical**

standardisation and the relationship between clinical principals and also **The focus of service delivery.**

One major weakness in the method concerns validity, the way in which the practices, that were the subject of research, were selected. This problem is widely recognised and written about.

> "Access may also refer to your ability to select a representative sample of organisational participants (or secondary data) in order to attempt to answer your research question(s) and objectives in an unbiased way and to produce reliable and valid data" (Saunders, Lewis & Thornhill 1997:95)

In this instance all the practices that allowed me access were concerned about the effects of the new legislation of 1990. Paradoxically the fact that GPs were being encouraged to become more managerially aware reminded them of the value they must put upon their own time and that of their staff. In consequence an implicit negotiation took place and the price of my access was the provision of a practice survey that they could use as evidence to the (then) FHSA of having carried out a recent audit. It might be argued that practices that allowed access were more astute and managerially aware than those that declined permission and were, almost a self selecting group.

(6.2) Analysis of Findings

A comparative analysis of the key indicators can be found in Table 6.1, and a diagrammatical representation plotting each practice against the four dimensions of **PAM** can be found in Figure 6.1. This is a model depicting: managerial orientation; and aspects of managerialism within general medical practice, from the four case studies

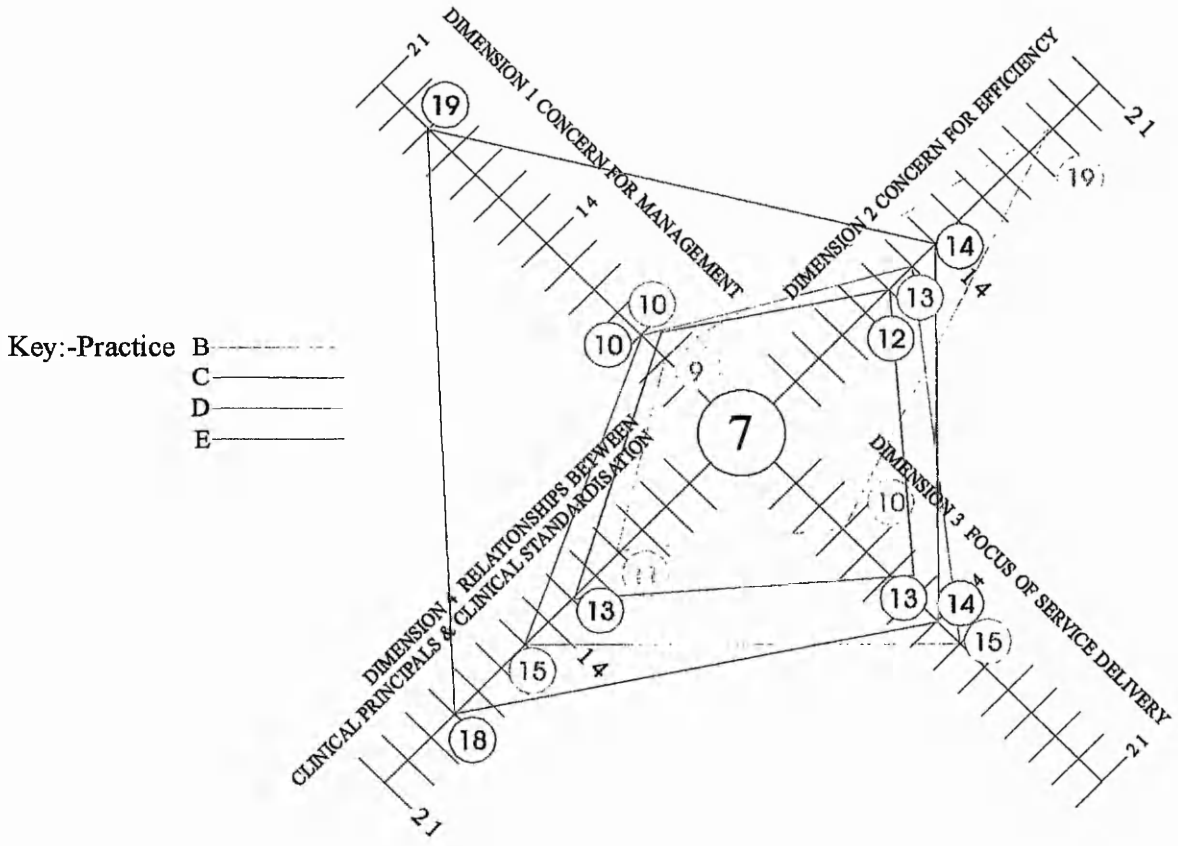


Figure 6. 1 Adapted from Fisher and Best (1995:52)

Practice "B" could well be described as a "traditional" practice, we can see from Figure 6.1 that the practice is very GP orientated with little standardisation of procedures, they place little emphasis on teamwork and put a low value on strategic management values. But when concern for efficiency is considered the practice is far more efficient than any of the other three practices. This helps prove the point that whilst many doctors criticise the management function, some wholeheartedly embrace elements of it.

Practice "C" could be described as a modern practice enthusiastically embracing the new management thinking. If we look at the profile, it is surprising that a practice appearing to embrace strategic management values to a far greater extent than the three other practices should only score half way along the matrices for concern for efficiency and also team orientation. At the same time they score the joint highest score when considering the extent to which services are standardised, although this might be explained firstly by the need for disease protocols on a triple site practice, where doctors switch between surgeries. The second explanation might be that they are a prescribing practice.

With the exception of strategic management values, practice "D" scores in the middle of the other dimensions, displaying the attributes that one might associate with a more traditional practice. Practice "E" could also be described in a similar way, with the exception of their standardised approach to the delivery of services.

Three of the four case study practices have at least one dimension where they score well above average on the PAM matrix.

Comparisons between practices

Practice	"B"	"C"	"D"	"E"
% GP Time spent on management	7.3%	5.5%	3.3%	5.5%
Practice Management Hours per GP	11.5	16.9	10.6	13.8
Number of Patients per GP	2062	1973	1683	2259
Average Consulting Time (Mins)	**6.2**	**8.1**	**6.2**	**7.9**
Average Hours GPs spend on visits	3.01	4.9	2.38	6.2
IOS income as ratio of staff costs	**£ 0.88**	**£ 0.74**	**£ 0.36**	**£ 0.43**
IOS Differential	0.2312	0.2031	0.1375	0.2548
% of Patients visiting to see Doc.	**42%**	**28%**	**28%**	**27%**
% of Patients visiting to see Nurse	4%	10.2%	20.3%	11.0%
Ratio of professionals allied to medicine vrs. GPs	**0.29**	**0.35**	**0.77**	**0.22**
GP's hours face to face with patients as % of total patient care	78%	79%	67%	79%
Clerical Staff hours per GP hours (Mins)	**25.5**	**50.9**	**77.8**	**49.9**
No of patients as % of national average	9%	4%	-11%	19%
Standard Deviation in consulting times	**2.4**	**3.0**	**1.1**	**1.3**

Table 6.1

There is a large variation in the reported time GPs in practice "B" spend on "management" compared with practice "D". Before we put too much store by this we must remember that this information was elicited by interview with the doctors and is their own subjective view of how much time they spend on various aspects of general medical practice. One explanation could be that compared with practice "B", "D" is

not only well managed, but also well resourced. This certainly would seem to be the case, because shortly after the production of a report outlining the findings from the research the FHSA agreed to fund a full time assistant practice manager for practice "B".

There is little variation in the total number of practice management hours per GP, with the exception of "C". When we look at figure 6.1 we can see this illustrated by looking at the strategic management dimension. Here, practice "C" scores much higher (nineteen points) than the others which form a tight cluster with PAM scores of nine or ten. This is an accurate reflection of the case study. The importance that the practice puts on strategic management matters is emphasised by the number of inter and intra departmental meetings that are held. The practice objectives are reviewed every six months and the strategy is set for the short, medium and long term in which direction the practice is set. This degree of commitment and detail was not found in the other three more traditional practices.

There is a very large difference in the average number of patients per GP in each of the practices. This ranges from 1683 to 2259, the latter having very nearly a third as many patients. There were partial explanations for both of these figures, neither of which implied one practice was actively pursuing "customers" whilst the other was not. On the contrary the practice with the most patients had effectively "shut its list" as they believed that they could cope with no more, but wished to retain the advantageous capitation fee.

Whilst the other practice, which had lost patients through moving over a mile away in a densely populated inner city area, was trying very hard to increase their list, whilst retaining its existing patients. It is interesting to note that practice "B", also substantially over the average patient list, was seriously contemplating closing its list. This might imply the average patient:GP ratio is at an optimum, in other words there is a delicate balance between maximising income (and patient numbers) and being able to "cope" and provide an adequate service.

Neither of the over subscribed practices were contemplating accommodating the increase in numbers by employing another doctor. This demonstrates the uniqueness of general practice and emphasises that it is not wise to "graft" the principles of accepted strategic management practice in their entirety to GMP. It could be argued that within most profit making organisations the objective would be planned and sustained growth in an ever ending pursuit of additional profits. Sir John Harvey-Jones is renowned for claiming that a business that doesn't grow will die. Quality of life was clearly an issue for the doctors and also that an increase in "turnover" did not equate to extra income for ever more, because when the increase necessitated the appointment of another doctor, once they reached parity, the collective income would be reduced. This is a function of professional partnerships, that a partner takes a share of the profits, whilst staff do not. Another consideration when taking on a partner is that unlike staff they have a major say in the direction the business goes. They can dictate the power dynamics of the partnership. To some extent, appointing a new partner is taking on the unknown, with far reaching consequences and often doctors are reluctant to take this risk.

There is considerable variation in the average consulting times for the various practices. There seems to be no explanation, except that of individual styles of consulting. When the age and gender of the doctor is taken into account no pattern emerges. When interviewed, no specific group of quick or slow consultants showed different underlying philosophies to treating patients than the others.

None of the doctors interviewed were comfortable with the notion of standard agreed consulting times, although most were concerned with equity of workload. The receptionists, though, in most cases booked patients in for the same period of time, whilst acknowledging that a particular doctor would inevitably be running at least half an hour late by the end of surgery as they were slower that their colleagues. Here the receptionists were attempting to standardise, in this case to make their job of scheduling the patients easier.

Despite variances in the times GPs said they spent on visits and cognisant of the earlier caveat, this seems far more straightforward. The highest figure was 6.2 hours for practice "E". It might be argued that this is a function of size, if there are a third as many patients per doctor then it is logical (all other things being equal) that the doctors will see a third as many sick people on their visits. This arithmetically nearly does account for the variance. When we then consider practice "D", with a time of 2.38 hours per week, and then factor in their innovative manner of managing the emergencies, both explanations seem reasonable.

There are large differences in the IOS income as a ratio of staff costs, with practices "B" and "C" having £0.88 and £0.74 respectively. The national average (Slingsby 1995) stands at £0.75, so "B" has done exceptionally well, which is a reflection of their leaning toward efficiency. The other practices "D" and "E" have ratios of £0.36 and £0.43 respectively. One explanation for "Ds" score could be that some of the staff claimed for were doing work concerned with the minor operations administration, which would skew the findings. The practice manager did have difficulty in estimating the proportion of staff hours spent specifically in this area and, as no member of staff was employed separately' for this task it is the most likely explanation.

However, when we look at the IOS differential, that is the weighted difference from the regional averages, whilst we see a figure that is 13% higher than the average, this is much lower than the other practices researched. This might imply inefficiency in either reaching the targets, or inefficiency in claiming the item of service payments.

Turning now to practice "E" their IOS ratio is also low at £0.43 (nearly half that of practice "B"), however their IOS differential is the highest at 25.5% above the regional average. Some of this success is due to the diligence of the clinic support coordinator, who was responsible for the practice being the only one in the county to boast a 100% immunisation programme throughout all ages of children. She was also responsible for encouraging patient attendance at health promotion clinics, which the practice received just under twice the regional average for. If, therefore, the claims were being met in an efficient manner another plausible explanation for the relatively

poor IOS versus staff costs must be that the staff costs are very high. This would seem natural as the high number of patients would mean the doctors required a higher level of support.

There seems to be a paradox here, and a potential weakness of PAM. On the one hand we imply that having a higher ratio of patients to GP is a sign of being efficient (PAM 3.1), but on the other we are saying that to employ enough staff to enable that to happen is a sign of inefficiency (PAM 3.6). This suggestion was based on the assumption that if there was a higher proportion of patients per GP then it was reasonable to assume that the practice required extra staff to provide an acceptable level of service.

When the practices are compared it is not the case that practice "B" has 9% more patients than the national average but also has a better than average IOS staff ratio than average (88p in the pound). Conversely practice "D", which has 11% less patients than the national average, has an IOS ratio of 36p in the pound. Comparing all the practices in this research programme showed no correlation whatsoever between the number of patients per GP and the ratio of IOS payments to staff costs.

Figure 6.1 shows that practice "C" scores 19 points and appears to be the most efficient, despite showing the lowest orientation to strategic management and values. This does make the point that some practices.

> "have developed an organisational capacity for management, in at least some activities. This does not mean that a practice has to buy into the full

blown ideology as represented by the managerial methods and values." ***(Fisher & Best, 1995)***

Practice "D" scores 14 and is in the middle of the continuum. Practices "E" and "F" score 13 and 12 respectively. This is partly explained by their low IOS ratios. However practice "E" scores slightly lower because of higher consulting times and more time spent on visits.

Practices "C", "D" and "E" have almost identical percentages (28%) of patients coming to see their doctors. However practice "B" has 42% of patients coming to see the doctor and just 4% to see the nurse. When translated to the PAM matrix this is reflected in practice "B" scoring the lowest (11 points) within the dimension for focus of service delivery. This practice also scores the lowest when considering team versus GP orientation. Indeed, despite having eight GPs, individual autonomy was prized over teamwork.

By computing the average number of consultations per doctor during the research period we see that there is comparative similarity. The practices had the following average number of consultations: "B" 98.8; "C" 97.62; "D" 81.6; and "E" 92.1. Given each doctor was observed for a similar period of time, but varied in the length of consultation by up to 25%, this is quite surprising. What is clear is that the much higher proportion of patients seeing the doctor can not be explained by extra numbers of patients seeing the doctor. This becomes even more puzzling when we see the small proportion of patients (4%) seeing the nurse. But if we add the percent of

patients seeing the doctor to that seeing the nurse we arrive at a figure of 46%. When this amalgamated figure is compared to similar figures for the other practices it is almost the same.

To further complicate matters, practice "B" had the second highest ratio of professionals allied to medcine to GPs. How did this come about if only 4% of patients coming to the surgery saw the nurse? One explanation might have been mis-categorisation of reason for patients visit. Another reason might have been a mis-categorisation of staff designation; when filling out the form for the number of staff in each category, possibly, the practice manager put some nurses down as clerical staff. This appears not to be the case as the practice also has the lowest number of staff hours per GP, half as many as any other practice.

Practices "C" and "E" have similar percentage of patients to see the nurse. Practice "D" reports twice as many and could be a function of the minor operations scheme being run in the surgery at the same time as list patients are seen by the doctors.

The GP's hours face to face with the patients as a percent of total patient care, shows a very similar pattern for each of the four practices.

Practice "C" & "E" have similar clerical staff hours supporting the GPs. Practice "E" has over twice as many. Again the minor surgery argument may be relevant here as well. When plotting the scores against the PAM team orientation, as we can see from figure 6.1, practice "B" tends to be slightly less team orientated than the other three

practices. This is the category where there is less difference between the practices than any other.

The numbers of patients per GP as a percentage of the national average shows considerable variance, with a range of 30%. Possible reasons for this have been discussed in detail earlier in this chapter.

There is a vast range in the standard deviation in consulting times between doctors in the same practice. The range is from 3 minutes in practice "C" to just over 1 minute in practice "D". These were the only two areas of striking difference in the section looking at standardisation. Practices "C" and "E" were very standardised, scoring 18 points each, practice "D" was two points behind with a score of 16 and practice "B" were far more given to GP autonomy.

What such analysis does serve to do is to illustrate that there are different dimensions to "management". By looking at figure 6.1 we can immediately see that Practice "C" was head and shoulders above the other practices where managerial values were concerned, but not for efficiency. It was the practice that scored the lowest for management orientation. Practice "B", that scored the highest for efficiency. Both "B" and "C" were more highly standardised than the other practices. These findings do much to refute the claim that

> "involving staff in management development is a problem... they are very tied up in their clinical needs.. There appears to be a very negative attitude to management amongst the medical staff" (NHSTD 1994)

(6.3) Management and GPs

A fundamental concern of GPs is the way in which they see themselves becoming more managerially orientated, often without their consent:

> "Fundholding would take me away from clinical work, as well as my colleagues. We're interested in being General Practitioners, not negotiators for contracts. Basically I can not see any benefits for my patients by our becoming a fundholder." (Practice B, Dr. A)
>
> "a lot of extra work for no extra pay... a real government con trick"
>
> (Practice B, Dr. C)

Whilst large number of GPs have negative feelings to management, my research shows that even the practices where these doctors are in a majority, they are demonstrating aptitude in some managerial aspects of the practice and feel it an integral part of their role. One example of this is Practice B, which scores only 9 on the PAM matrix, expressing a 'low concern for strategic management values' whilst on the other hand, scoring 19 out of 21 on the PAM matrix indicating a high concern for efficiency.

However, it must be realised that there are basic differences between the management of a GP Practice and other types of management. For example, it is often desirable to increase throughput in the manufacturing sector. This is not always so in the arena of a General Medical Practice (GMP). In this case, a short consultation time may not be a sign of **effective** consultation because this could lead to extended sick leave for the patient or lead to repeat consultations.

Moreover, in industry, the degree of autonomy and extent of options available to a manager are severely limited compared to the diagnosis and treatment of a medical condition. Therefore, neither relationships between managers, or the focus of service delivery are as important to outcomes in manufacturing as they are in General Medical Practice. This last statement is to some degree dependant on the clinical principal's philosophy of medicine. It could be argued that the practice that is more orientated towards team work, might well focus more on preventative medicine as opposed to disease management. Nevertheless, there are some similarities between industry and GMP. Operational efficiency and income maximisation are goals shared by both, specifically emphasised in the new contract with Doctors (managing the plant, energy conservation etc.). There are often changing and conflicting goals, largely dictated by the current political climate. An example of this would be the previous government's emphasis upon preventative medical initiatives, upon which, less emphasis is now placed.

Management in General Medical Practice can be seen from different perspectives, only one of which focuses on (what are called in the public services) management values. The others are lower profile but equally important. These are: the focus of service delivery; the degree of GP's autonomy and concerns for efficiency. Whilst this research shows that most GPs reject management values, this doesn't prevent them taking a management approach more often associated with small business entrepreneurs.

Appendices

Appendix I

Home Address:-
19 St Philip's Road
Burton on the wolds
LOUGHBOROUGH
LEICS
LE12 5TS

22 nd August 1998

Address
Address
Address
Address
Address
Address

Dear Doctor ***.

Research into General Practice

I am currently researching into general practice for my M. Phil., I have spoken to a colleague of mine about the possibility of meeting you to discuss the above. I am hoping to conduct for in depth case studies which will involve several visits to the participating practices over a period of some weeks. Much of the research will involve me just sitting and watching how the "normal day" proceeds and will not interfere with anyone's work load. I would also like to conduct a few interviews (of about one hour in duration) with the senior partner and the practice manager.

Some of the information that I am hoping to obtain will be of a confidential nature, firstly this information will only be published preserving complete anonymity (ie practice X had such and such a ratio) and only with the express permission of the practice. The second point is that the practice can determine which figures I will have access to. I have schedules overleaf an example of the type of information I am aiming to obtain and how I hope to achieve this.

One of the benefits from the practices perspective is that I will produce a report for them that will include some degree of audit that may well be useful for inclusion in the practice report.

I am currently conducting a pilot study in Derbyshire, the senior partner there has said that he would be very willing to give me a reference emphasising that my presence at the practice did not disrupt the working day and also to attest to my integrity.

I do hope that you feel able to allow me to use your practice as a case study, if there is anything else that you would like to know I'd be only too happy to come over and talk to you about it.

Yours sincerely.

Warwick. A. A. Best.

Appendix II

Interview plan for doctors

1. Tell them about my research and stress the confidentiality of research
2. Ask them to fill in any gaps that the Practice Manager was unable to answer
3. Ask about break down of Doctors working day (ie. proportion of admin. to visits to consultations etc.), fill out PAM form
4. How often do Gps meet formally, or informally to discuss medical cases?
5. Are the partners drawings random or planned are the monthly drawings the same each month, or do they fluctuate? Do the partners draw money pro rata per parity?
6. Do any of the partners carry out private non NHS work? If so do they keep the earnings from such activities, or does it "go into the pot"?
7. Are relations between the partners harmonious and productive, or strained? Anecdotes?
8. Ask opinion on fundholding... why the practice is or is not a fundholding practice ... what they perceive as advantages/ disadvantages of joining the scheme.
9. What are the objectives of the practice, in short, medium and long term? Does the practice have a mission statement? Where they see the practice going in the next few years.
10. What strategic decisions do they see needing to be addressed to achieve 9.
11. Have the practice GPs ever discussed or considered policy concerning the ethics of "expensive patients" or "cost ineffective" treatment?
12. Does the practice have a policy of growth or consolidation
13. Who is responsible for the financial management of the practice?
14. How do you see your market position in relation to other local practices?
15. What "type of customers" do you have .. is this intentional... do you provide the type of product they need... was this in response to them being there or have you adapted the services you offer to attract your "customer"

16. Do you have an area needs document. If so how is it used and what kind of information does it contain?

17. Ask about the skill mix... special clinics etc.

18. Do you measure the performance of your staff? How?

19. What is the practice's training policy?

20. Do you measure the quality of service that you provide your patients? If so how?

21. Are there formal writen formlaries, or protocols and procedures for disease managment.

22. If yes how frequently are they reviewed? Examples?

Appendix III

Interview with Practice Manager

1. Tell them about my research and stress the confidentiality of research.
2. Ask about staff structure, who does what, try to fill out profile 1
3. When & where the practice formed, a brief history. Any relationship between Drs (ie husband & wife)
4. Size & type of building (purpose built, new... Victorian, former home terraced... etc.). Any recent improvements, or any planned in the near future?
5. Geographic location... rural/ inner city... a mix, depravation rating (Jarmon index)
6. List size...No of Drs
7. No of Staff.. full time ... how long worked there.
8. Do you know your turnover of patients year on year? How does this compare to the regional averages?
9. Are the partners drawings random or planned are the monthly drawings the same each month, or do they fluctuate? Do the partners draw money pro rata per parity?
10. Do any of the partners carry out private non NHS work? If so do they keep the earnings from such activities, or does it "go into the pot"?
11. Are relations between the partners harmonious and productive, or strained? Anecdotes?
12. What are the objectives of the practice, in short, medium and long term? Does the practice have a mission statement? Where they see the practice going in the next few years.
13. What strategic decisions do they see needing to be addressed to achieve the above.
14. Have the practice GPs ever discussed or considered policy concerning the ethics of "expensive patients" or "cost ineffective" treatment?
15. Does the practice have a policy of growth or consolidation
16. Who is responsible for the financial management of the practice?

17. How is the annual business plan viewed, primarily as a means of bargaining with the FHSA, or as a strategic tool...explain.

18. Who complies the BP... the practice manager, the lead GP, or is it compiled in consultation with both staff and GPs?

19. Does the practice use spreadsheets as a management tool?

20. How are decisions made in the practice? Examples of big & small decisions.

21. Does the practice manager reconcile the FHSAs account of what is due with the practice records on a monthly/quarterly basis?

22. Over the last 12 months is the practice over or under spent on their drugs budget? Please express this in % terms

23. Over the last 12 months is the practice over or under spent on their overall budget? Please express this in % terms.

24. How do you see your market position in relation to other local practices?

25. What "type of customers" do you have .. is this intentional... you provided the type of product they need... was this in response to them being there or have you adapted the services you offer to attract your "customer"

26. Do you have an area needs document. If so how is it used and what kind of information does it contain?

27. Ask about the skill mix... special clinics etc.

28. Do you measure the performance of your staff? How?

29. What is the practice's training policy? Give examples of courses staff attended over last year

30. Is an appraisal scheme in place. What is the frequency? How does the PM view the scheme?

31. Is there a practice pension scheme for staff?

32. Describe frequency, attendance and purpose of ALL the meetings within the practice. Are these meetings chaired and minutes kept? Are there action plans, are these regularly reviewed?

33. How frequently is any for of administrative audit carried out?

34. Do you measure the quality of service that you provide your patients? If so how?

35. Clarify staff data collection forms, I.e. just how to fill in, can I speak to staff?

36. Ask PM to fill out hours per week form with absent doctors, explain my one day visit.

37. Ask about PACT information for practice.

38. Ask for IOS sheets for last year.

39. Ask for total staff costs for last year.

Appendix IV

"St. Endors" Critical Incidence and Notes

1) It was only possible to directly observe the doors of three out of the four doctors when observing consultation times. The un-observable doctor agreed to place a card in their window when they had a patient in and remove it when the consultation had finished, at times they forgot to do this, in some small way this might skew the data for consultation times.

2) Most of the staff have been at "St. Endors" for a long time, one of the receptionists has been there 38 years.

3) The senior receptionist has worked at "St. Endors" for 22 years, she, at one time or another, has been relief manager at all three surgeries. She has seen a lot of changes, particularly she remembers how the influence of the influx of 'problem families' affected the "St Clements" surgery. More recently with regard to fundholding she comments ***"I feel that the staff are being exploited, being expected to do more duties, with more patients and for the same money. Another thing I run a surgery that is bigger than most practices, and yet am called 'a senior receptionist', that can't be right"***

4) The staff all wear white coats, only the caretaker wears a name tag.

5) The problems of running a split site were well illustrated by the following: A circular had been sent round by the administrative staff at "St.Ewes" collecting for a member of staff's birthday, one of the receptionists said ***"this is ridiculous***

we don't even know her, we should stick to our own surgeries". This raises the question do you allow surgeries total independence and autonomy, or do you attempt to integrate them, if so how?

6) There was increased nurse activity for the fortnight under observation, due to a number of flu inoculations.

7) 29/11/94 there should have been 7 office staff and 1 dispensing chemist on duty, due to ill health and staff on courses only 3 receptionists and the chemist were on duty. The staff had to work extremely hard, but coped well.

8) 29/11/94 one patient was brought in under a two man police escort, she had robbed the local graveyard. There was a very loud exchange and she had to be taken away out of the back way to be 'sectioned'. This took 30 minutes of the Doctor's time (skewing their consultation times).

9) 29/11/94 All the doctors had a 15 minute conference discussing a patient's trace.

10) 29/11/94 There were 2 emergency call outs, which meant that one doctor was away for 1 hour during normal surgery hours, causing patients being seen 45 minutes behind appointment times by the remaining doctors .

11) 13/12/94 Patients have to wait a full week if they want to see the lady doctor.

12) 13/12/94 PM only 1 doctor on duty, they were also on call for the whole of the practice, they were called out and the remaining patients had to wait between ½ an hour and an hour beyond their appointment times. Some cancelled, some waited. One patient who had waited ¾ an hour got very irate, but the staff dealt very well with this.

13) 14/12/94 There was some confusion over what the surgery should provide the district nurses with for the homes for the elderly. For example what budget do disposable gloves come out of? Who determines what drugs get prescribed and which budget does the expense come from?

14) 14/12/94 One doctor who had run their surgery for over 4 hours said to me ***"This is bloody ridiculous I am on automatic pilot and can't be doing my best for the patients"***

15) Consultation observations were taken over 10 sessions.

RECOMMEND that when one Doctor is responsible for being 'on call' for the whole practice that they are not the only doctor on duty at their surgery.

"St Clements" Critical Incidence & Notes

1) Referring to Patient Activity sheets; it seems that there is a high proportion of "other". This was explained in that some of the community activities & duties were initially dealt with by practice staff *ie ordering of ambulances, issuing of*

incontinent pads & hearing aid batteries, returning blood and urine samples, or checking their appointments with the health visitors. Most of these activities relate to Health Authority staff, who get this service "free of charge".

2) The surgery has three Doctors who are full time and two lady Doctors who job share. "St Clements" is a training unit and so has a fully qualified doctor, working full time, who is training as a GP. At the time of the study one of the part timers was on maternity leave and there was a locum carrying out her duties. I only interviewed the permanent Doctor and asked her what her partners hours and responsibilities were, effectively counting their hours as one full timer when collecting information for "Doctor's Activity" (profile 6). I treated the Locum and the part timer as one Doctor for the purposes of computing consultation times.

3) There were two other surgeries that were covered by locums, these were counted as consulting times of the Doctors that they replaced.

4) There was increased nurse activity for the fortnight under observation, due to a number of flu inoculations.

5) When greeted by the Senior receptionist referring to the Practice Manager she said *"I don't know what she knows about this place ... she never visits"* **Was there an under current of friction?**

6) Normal working practice in this surgery is to break for a 20 minute coffee break with colleagues mid-session.

7) ***Community Nursing Activities***

Blood tests, Dressings, Ear syringe, B12 (vitamin injection) & treatment room.

Practice Nursing Activities

Immunisations & Vaccinations (including flu injections), Over 75 year old and New patient screening, Well person; Asthma; & Smoking clinics, cervical smears and Health promotion clinics.

8) Collection of repeat prescriptions is meant to be 48 Hrs after presentation, but in practice this is usually done within 24 Hrs or even the same day.

9) 11/10/94 One patient was very irate at being seen some 50 minutes after their appointment time.

10) .11/10/94 A very noisy, violent and disturbed patient was dealt with quickly but sympathetically by the front of house staff, without unduly disturbing the other patients.

11) 18/10/94 A blind (or partially sighted) patient came to the counter for a repeat script, instead of sticking doggedly to the 24 Hr rule the receptionist got the duty Doctor to sign the script immediately.

12) 28/10/94 A lady patient was late for her appointment, after waiting (uncalled) outside the Doctor's door for six minutes she stormed out swearing noisily.

13) Consultation observations were taken over 9 sessions.

RECOMMEND on busy surgery that one Doctor is responsible for emergencies and call outs only, with no 'normal' surgery responsibilities.

"St. Ewes" Critical Incidence & Notes

1) "St.Ewes" has 2 full time doctors and a trainee. One of the full time doctors was away on maternity leave and was replaced by a locum for the duration of her absence. I have treated the locum as being the full timer for the purposes of calculating consultation times and doctors hours.

2) During the observation period two doctors from other surgeries from within the practice took surgeries, where this happened I show them separately on the consultation computations.

3) 8 sessions were observed.

4) The senior receptionist said ***"I feel that I am being exploited, I am expected to do far more work, we all are, I actually have to take work home (for no extra pay) to cope, and I'm not even called a manager, just a senior receptionist!"***

5) Several times the senior GP kept saying ***"This is just not a typical 3 weeks, we're usually <u>much</u> busier than this"***

6) The senior receptionist believes that patients should be booked in at times that reflect the true consultation times, she suggested 15 minutes would be more accurate than the present 10. Currently patients being seen at the end of surgery would be seen up to ¾ late.

7) 07/11/94 The evening surgery was scheduled to finish at 18:00 Hrs, it was still running at 19:15.

8) 08/11/94 In conversation the senior partner said ***"There are only two of us on today"*** this implied that he didn't count the qualified doctor who was a trainee GP as a proper doctor, despite their seeing live patients.

9) 15/11/94 The senior partner had a day off which meant that the full time locum had to move over to "St. Endors" for the day and a partner from "St. Endors" had to swap with them as trainees have to be supervised by a partner.

Appendix V

Doctor's Profiles

Doctor 'A'

Senior partner at this location, male, in his mid 40's, qualified in 1974 and started at the practice in 1983. Was very positive towards fundholding, believing that patients would benefit by having specialists come to the surgery and reducing waiting times. This has happened, particularity with ENT, orthopaedic and eye specialist. Even allowing for these patient benefits is sufficiently disillusioned with fundholding would be prepared to pull out.

Doctor 'B'

Male in his late 30's, qualified in 1986 and joined the practice in 1992. Feels very frustrated with fundholding, he was excited at first, hoping for more tangible gains that would benefit the GPs personally. There should have been savings that could have been used to improve the premises and facilities offered. Due to the way in which the budget was set this did not happen. He would have liked to apply true market forces, he believes that there is only a quasi market and so such principles cannot be applied. He concedes that the patients have marginally benefited and for this reason alone would not wish to 'pull out', despite feeling 'conned'.

Doctor 'C'

Male in his early 40's, qualified in 1984 as a GP, he is also a qualified dentist and practices at a local dentists one afternoon per week. Joined the practice in 1988. He was very pro fundholding, feeling that the practice would get preferential treatment as first wavers, that as a result the practice would benefit from new premises and equipment. Because there were no savings this did not happen and so he is very disillusioned. He feels that patients have benefited but are unappreciative of the benefits or the extra work involved in gaining those benefits.

Doctor 'D'

Female in her early 40's, qualified in 1980, joined the practice in 1986. She believes that the extra work undertaken by going fundholding is justified in 'payment' for the benefits the patients are currently enjoying. She went into fundholding partly sceptical, believing that the government wanted the majority of practices to become fundholders and that it would be better ***"to jump before being pushed"***.

Doctor 'E'

Male about 35 years old. Qualified in 1989, was at the practice as a trainee GP appointed in August 1994. Is responsible for seeing all the drugs company representatives. Is also a qualified pharmacist, this is seen as useful as the practice has two dispensing surgeries and they are more likely to retain these profitable outlets with a qualified pharmacy on the team. He is very pro fundholding believing that it directly benefits the patients, but is slowly revising that opinion.

Doctor 'F'

Male, about 50 years old, he is the lead GP, qualified in 1971, also has a BSc (Hons) and a PhD. At the time of going fundholding he was highly sceptical, but felt the practice had to go along that route as their patients would benefit, he regards himself as committed but not convinced towards fundholding. He loves the clinical aspect of General Practice but hates paperwork and resents having a computer on his desk.

Initially the practice was under funded both on their budgets and on the management allowance (especially as they are a split site), due to these problems it was thought that the GPs were personally sponsoring Fundholding. He said that if it hadn't been for all the hard work of the GP responsible for Fundholding and the commitment of the Practice Manager the practice couldn't have become a fundholder. ***"on reflection if we knew then what we know now we would never have gone fundholding...I believe that most of my colleagues feel the same"***

Doctor 'G'

He also gave some anecdotal evidence of how in the early days they faced opposition from some groups of consultants. A consultant dermatologist used to come and hold clinics at the surgery, which were very good, he was put under pressure (by his peers) not to come. He could only confirm his availability one month in advance.

The ENT department at all the local hospitals decided to have nothing to do with Fundholding and not to negotiate contracts. In consequence the practice employed a specialist from Leicester, this worked very well, until he was "warned off" Things are now better.

Doctor 'H'

Female in her early 30's, qualified in 1989, spent one year with a first wave fundholder in Arnold. Takes her final exams in two weeks time. Is very much in favour of fundholding.

Doctor 'I'

Male, in his late 40's, qualified in 1972, trained as a surgeon but found it a bit boring, with no real patient contact and having a low diagnostic challenge. Believes whole heartedly in fundholding, saying it allows far greater flexibility, particularly regarding utilising staff more effectively. Despite being an advocate of fundholding, he feels that to some extent that fundholding GPs have been exploited

"you can be a good clinician - but spend a lot of your time doing other things... chasing the paper... but you have to, as part of your income depends on it. Sometimes that is not recognised and you are not paid for the extra work and responsibility, if this happens people will become disillusioned... that is why morale is so low at the moment... you work harder, achieve results, do a better job and can actually get paid less"

Doctor 'J'

Female in her mid 30's, married with one child expecting her next one next month. Worked at the practice as a trainee GP in 1991, as the practice was going fundholding, she returned as a medical assistant in 1993 and became a full partner in May 1994. She feels that she is very much learning the ropes as she had not been allowed to any of the meetings until she was a full partner. She doesn't understand the additional workload involved in being a fundholder. Feels that fundholding benefits the patient, cites 4 weeks wait to see the gynaecological consultant as an example, the elderly can also be seen more quickly and in a familiar less confusing environment without the 'hassle' of going to Nottingham. She does, however feel 'pushed' into gynaecology as she is a woman.

Doctor 'K'

Male, late 40's, qualified in 1974, had done two six month stints as a trainee, at the practice in 1975 and 1978, joined the practice as a full-time GP in 1979 and was now the senior (and only) partner at Cropwell Bishop. Regarding fundholding he felt the patients benefited greatly, but that the clinical management was harder and more complex. He said ***"The FHSA administration has been bad ... we set up our own company to do minor ops, we're not allowed to do that now and that costs the practice a lot more money"***

Doctor 'L'

Female in her mid 30's, working as a locum at Cropwell for six months. She was concerned that her consultation times would be longer than her colleagues (this was born out her average being 13 minutes against the surgery average of 9 minutes). she said ***"I get lumbered with all the middle aged, middle class patients who talk and talk and come in for a social chat. This means that a consultation that could take 2, or 3 minutes may take 10 to 15 minutes"*** She was very pro fundholding.

Appendix VI

WORKING for PATIENTS (1989)

1.0 Introduction.

Dr Michael Goldsmith, a research fellow for the Centre for Policy Studies who was partially responsible for influencing the reforms, described the Government thinking behind them thus:

> ***"The intention of the government is that quality will be improved, choice will be increased and cost will be reduced ... I welcome the new powers which are being offered to GP's because I think they cement the importance of the GP as the pivotal profession within the NHS." (1991 pp 82 & 83)***

The changes in the White Paper were designed to address the problems of both management and funding of the NHS as well as to make services more responsive to users. The four most important of the reforms (Ham 1993 p.2) are:

1) The introduction of a new system of contractual funding.

2) Measures to manage clinical activity more effectively.

3) Proposals to strengthen management at all levels.

4) New arrangements for allocating resources.

1.1 Contractual Funding

Central to the reforms was the need for greater definition between purchasers and providers. The logic was to put market mechanisms to work that would encourage competition between hospitals (some of whom may elect to become NHS Trusts) and also other provider units which, it was hoped, would result in improved quality of services which patients would benefit from.

The main responsibility of the District Health Authorities is to determine the health needs of the people within its jurisdiction and to purchase services to meet those needs. GP's with a list size greater than (in 1993) 7,000 patients will also be able to purchase some hospital services, outpatient care, diagnostic treatment, and a range of inpatient and day case treatments for their patients.

NHS service agreements, or contracts are drawn up between the purchasers (Health Authorities and fundholding GP's) and the providers of care. These agreements will be concerned with matters such as speed of service (the waiting times), quality and cost of these provisions and ensure that the providers are accountable to the purchasers for their performance in these areas. There are three types of contract block, cost per case, and cost and volume. Block contracts cover a defined level of service in return for a set fee, whilst cost per case contracts have a fee based on the particular item of service provided. A mixture of both these alternatives is the cost and volume contract, in this form a baseline level of activity is specified along with a corresponding fee, if services required go beyond that level they will be treated as for cost per case contracts.

Underlying this section of the Paper is the belief that resources will be targeted towards the providers (both NHS and privately owned) and ensure that those units that provide quality, shorter waiting times and represent good value for money will attract more resources.

Contractual funding brings about	Separation of funding and provision of services
	Initiation of NHS trusts
	GP fundholding practices
	Contracts and service agreements.

1.3 Management of Clinical Activity

This section of the White Paper aimed at increasing the clinical efficiency within the NHS, broadly speaking it brought about change in six areas (Ham 1993 p.4)

1) Extension of the Resource Management Programme

2) Introduction of Prescribing Analysis and Cost Data (PACT) for GPs

3) Involvement of medical audit at all levels within the NHS

4) Consultant's terms and conditions reviewed

5) Managers to be involved in decisions on distinction awards

6) New expeditious disciplinary procedures for hospital doctors.

1.31 Extension of the Resource Management Programme

This was first introduced following the Griffiths Report, the philosophy behind this is to involve both Doctors and Nurses more in the management of resources and the day to day management processes. Concurrent with this move was an improvement in the management tools, investment was made in information technology to enable more efficient delivery of data concerning services delivered to patients. Until March 1990 resource management initiatives were run in just six large acute hospitals by the end of 1992 two hundred and sixty (Butler1992 p.39) acute hospitals have joined the scheme.

1.32 Introduction of Prescribing Analysis and Cost Data (PACT) for GPs

The practice fund (see section 1.5) includes an amount to cover the costs of prescribing drugs, this is set by the FHSA against a nationally applicable scale (introduced due to a recommendation in the White Paper "Promoting Better Health") called PACT (Prescribing Analysis and Costs). The rational behind this move was to:

> ***"provide a further incentive for doctors to adopt rational prescribing policies" (Secretary of State for Health 1989 p.5)***

PACT was introduced to enable GPs to monitor their prescribing patterns more closely than had hitherto been the case. Before the implementation, in 1991, of Indicative Drugs Budgets GPs had little interest or control over their prescribing costs, resulting , the government argued, in waste of resources.

> ***"The objective of the new arrangements is to place downward pressure on expenditure on drugs in order to eliminate this waste and to release resources for other parts of the Health Service" (Secretary of State for Health 1989 p.3)***

Now since the implementation of the two White Papers GPs are able to monitor and adjust their prescribing habits and thus control expenditure in this area.

1.33 Involvement of medical audit at all levels within the NHS

Medical audit was introduced in both hospitals and primary care. Audit involves doctors reviewing their clinical practices systematically with colleagues to identify areas in which improvements can be made.

> ***"The principles of audit, as conceived by the White Paper, were that all doctors should participate in the regular and systematic audit of their work; that the system of audit should be controlled by the medical profession" (Butler 1992 pp.39)***

1.34 Consultant's terms and conditions reviewed

Consultants contracts came under review in this White Paper as well as the doctor's contracts. The consultants now have a more explicit job specification and are managed at local level and are appointed by the DHA General Manager.

> ***"In the case of new consultants, the district genera manager would take a direct part in the appointment procedures to ensure the doctor's willingness and ability to accept responsibility for the management components of the job" (Butler 1992 pp.39)***

The job specification includes details concerning the clinical, teaching and administrative elements of the job, a specific programme identifying what the consultant should be doing, where and at what time of the day, as well as identifying out of hours administrative responsibilities

1.35 Managers to be involved in decisions on distinction awards

As well as being involved in the appointment of new consultants a district general manager will also be involved in decisions about which consultants receive distinction awards. The criteria by which these awards are made have been altered to reflect the new emphasis placed on the clinician's role in management.

1.36 New expeditious disciplinary procedures for hospital Doctors.

The White Paper introduced new disciplinary procedures for hospital doctors, which would enable disciplinary matters to be dealt with more expeditiously.

1.4 Better Management

Both Regional Health Authorities (RHA's) and District Health Authorities (DHA's) were structurally altered. Now these bodies have external non-executive directors on their boards that include people chosen for their business experience and commercial knowledge. The Family Health Service Authorities (FHSA's), formerly FPC's, also have revised membership of their board... reduced from fifteen members down to eleven. The membership now consists of the chairman, four professional members, five lay members and a Chief Executive. A strong emphasis has been placed on the devolution of decision making. This new chain of command, in part, ensures that managers at all levels of the NHS accept the new commercial principles. Senior and middle grades of managers are now subject to performance related pay as well as short term, renewable contracts. These changes brought about a new culture

> ***"With the implementation of these changes the NHS acquired a management culture of command and obedience more usually associated with private businesses than with public services" (Ham & Best pp. 482-3.).***

1.5 Allocation of Resources

Fundholding Practices receive a practice fund from the RHA to purchase services for their patients, the size of this fund depends on a number of factors... the largest apportionment comes from a capitation calculation, as well as allowances for the geographical location, historic costs and age of population. The practice fund also includes an amount to cover the cost of prescribing drugs (see section 1.32).

The way in which **all** GPs (including the non-fundholding practices) were paid has been substantially reviewed. The most significant change is the ammount GPs recieve in capitation fees. The reasons behind this was to ensure that monies followed patients, that "better" practices would attract more patients and like areas of the retail industry the more customers a firm attracts the higher (in general) the profit. The government expressed its motivation for emphasising the capitation fee thus:

> ***"In placing a greater emphasis on capitation the remuneration system is to reward GPs who give a high priority to attracting and keeping patients by providing a high quality, comprehensive service. More money will follow the patient than has been the case in the past" (Department of Health 1989)***

Appendix VII

PROMOTING BETTER HEALTH (1987)

1.0 Introduction.

The main changes that this White Paper were designed to address were the issues of preventative medicine as well as the place and function of primary health care in the NHS. The Government set out its objectives thus.

> " - ***to make services more responsive to the needs of the consumer;***
> - ***to raise standards of care***
> - ***to promote health and prevent illness;***
> - ***to give patients the widest range of choice in obtaining high quality primary care services;***
> - ***to improve value for money***
> - ***to enable clearer priorities to be set for Family Practitioner Services in relation to the rest of the health service." (Secretary of State for Social Services 1987, p.2)***

Many of the reforms suggested in this White Paper were introduced through new contracts for both doctors and dentists. The new contract for GPs came into effect in April of 1990 and the dentist's new contract came into force in October of the same year.

The GP's new contract encouraged provision of health checks for new patients, three yearly check-ups for patients that had not been seen during the natural course of events during that time period, and also annual checks for the elderly (patients over the age of 75) were introduced. Along with these new conditions of service GP's were strongly encouraged to meet various targets for vaccination, immunisation and cervical cancer screening. Along with this encouragement was given to develop health promotion clinics, become more involved with child health surveillance and to provide 'in house' minor surgery.

The procedure by which patients could change their doctor was simplified. Extra payments were made to doctors practising in deprived areas, monies were made available to improve the practice premises as well as to employ extra staff. The practice now had to produce an annual report and also a practice leaflet, for patient information.

1.1 REMUNERATION

The main changes that the White Paper brought to the GP's income were; introducing a fee for offering to give a health check to new patients. This new patient medical involves checking the height and weight of the new patient along with the blood pressure and taking a urine sample.

Financial incentives have been introduced to encourage Doctors to achieve certain target levels for immunisation, vaccination and screening. Encouragement to give the elderly comprehensive and regular care, as well as to provide child health surveillance were also part of the new White Paper. A deprived area allowance was introduced along with incentives for the provision of minor surgery at the practice. Doctors were encouraged to constantly enhance their skills by being paid a fee conditional upon their attendance at a minimum of 30 hours of approved study per year. The training costs of professional staff was now fully re-imbersable..

1.2 INFORMATION / AUDIT

It was proposed that GPs provide the **FHSA**s with an annual report that set out the range of services that practice offered patients and the workload of individual doctors over the period of the report. The report should also demonstrate how the practice has fulfilled their objectives and undertakings that year . The purpose of introducing a report was :

> ***"to encourage doctors to focus more clearly on the provision of high-quality, patient orientated services and the need to plan and set objectives for their development and improvement" (Secretary of State for Social Services 1987, p.23)***

Improved information to GPs on prescribing rates and referral patterns was to be made available, the government invested over £3.5 million (Secretary of State for Social Services 1987, p39) in new computer systems to enable this. The purpose of this was to encourage the safe and economic use of medicines. The cost of medicines prescribed by doctors is the single largest element in the **FHSA**s expenditure (Secretary of State for Social Services 1987, p.23) consequently GPs were to be encouraged to prescribe the cheaper generic drugs on a voluntary basis.

Information Technology and computerisation within general practice was encouraged, it was suggested that within a year of the publication of this White Paper all (the then) **FPC**s would be fully computerised. There was talk of links between computers in doctor's practices and local hospitals that would enable doctors to receive immediate information on the discharge of their patients, as well as making available to the practice information about prescribing, general practice activity and information on hospital waiting lists. The government stated:

> ***"The Government will encourage the continued development of information and communication technology and computerisation in primary health care, especially with regard to health promotion and prevention of ill-health" (Secretary of State for Social Services 1987, p.22)***

This was achieved by offering (through the **FHSA**s) a 50% reimbursement for any expenditure on IT that the practice made.

1.3 CONTRACTUAL CHANGES

Health promotion, for the first time, became part of the terms of service. This further endorsed the Government's assertion that:

> ***"the next big challenge for the NHS, and one especially for primary health care, is to shift the emphasis from an illness service to a health service offering help to prevent disease and disability." (Secretary of State for Social Services 1987, p.13)***

The criteria for Basic Practice Allowance was tightened up, this was done to encourage greater commitment to the general medical services. The old payment of £7,850 was paid if the doctor had a minimum list size of 1,000 patients and worked an average of 20 hours per week. This changed to requiring a minimum of 25 hours to be worked on average every week and the list size minimum increased to 1,200 also the allowance was reduced to £6,624.

Compulsory retirement for doctors at the age of 70 was introduced, at the time the White Paper was published there were over 500 family doctors over the age of 70 (Secretary of State for Social Services 1987, p.19). It was suggested that doctors older than this could not reasonably be expected to carry out the exacting responsibilities of general practice past this age. Also the exercise of 24 hour retirement (under which doctors aged 65 and over can retire, draw their pension and return to practice a day later without abatement of pay or pension) was stopped.

1.4 CONSUMER CHOICE

More women were to be encouraged to become doctors , some initiatives were discussed that included job sharing and part time working.

More information was to be made available to the patients through the compulsory requirement of a practice leaflet. Essential information regarding the practice should be included (opening hours, services provided, arrangements for emergencies out of hours etc.), as well as this details of the

doctors qualifications, sex and year of qualification should also be included.

The White Paper allowed changing doctors to become far easier, this was done by amending the NHS Regulations Act (1974) so that patients no longer has to approach their FPCs or existing practitioner before being allowed to register with a new doctor.

The White Paper also simplified the complaints procedure to make it more service orientated and allow problems to be resolved more quickly and effectively. Specifically the following changes were made; complaints no longer had to be made in writing, the period for registering a complaint was extended from 8 to 13 weeks, complaints will now be investigated by another FPC other than the one where the complaint emanated from and all FPCs will make an informal complaints procedure available.

Minimal standards for doctors premises were reviewed, the cost rent scheme was dramatically rescheduled (this provides doctors with financial assistance for their investment in premises development), to encourage doctors to make improvements to their premises.

1.5 STATUTORY CHANGES

Sight testing was removed from the NHS and no longer provided free, also dental charges for examination and treatment were increased, it was said, to help fund the changes proposed in the White Paper.

2.0 CONCLUSION

The main purpose of the White Paper was to improve the standards of service delivery of primary health care. In doing this the Government attempted to eradicate inequalities within the NHS which it recognised:

> ***"there are wide variations in standards across the country, particularly in inner cities, where too many, often elderly, doctors are operating single-handed practices where group practices would be more effective" (Secretary of State for Social Services 1987, p.12)***

Part of the solution to the problem outlined above was to generate a better understanding by the consumer of what is on offer, for them to become better informed about the services that they can expect from their doctors. This coupled with greater consumer choice, it was thought, would stimulate competition amongst doctors and thus raise standards to those being practice by the better surgeries. A further way in which these improvements could be achieve was by adjusting the balance in the doctors remuneration package between income from capitation fees and that from allowances and target payments. This was firmly stated:

> ***"The Government aims to improve incentives and introduce greater equity, so that the many family doctors who already work hard to provide comprehensive, patient-orientated services- and who incur substantial expenses- will be appropriately rewarded, while those whose standards fall short will have to improve their performance if they are to maintain the level of remuneration they receive at present" (Secretary of State for Social Services 1987, p.13)***

Appendix VIII

The remunerative system for General Practitioners is quite complex, however this does allow analysis of various aspects of their practice in an attempt to rate their efficiency. Below is a brief explanation of the components that make up a GPs income.

NON ITEM of SERVICE PAYMENTS

BASIC ALLOWANCE This is a payment made to each GP with a list size in excess of 1,200 patients, currently the amount is **£6624:00**

CAPITATION FEES This is the amount of money the GP receives per patient in each category on their list. The annual allowances are as follows:- For patients up to the age of 65 **£14:30**, patients between 65 and 74 years of age **£18:85** and patients over 75 years old **£36:45.**

DEPRIVATION ALLOWANCE In addition to capitation fees some GPs receive a depravation allowance for patients on their list that live in certain areas (usually inner cities). The payment is calculated using the "Jarman index", this measures the relative numbers of under 5's, over 75's, unemployed, ethnic minorities, number of people per house and the number of single parent families. Payments range from, at the lowest end of the scale, **£5:70** to **£9:95** at the highest end per patient per year.

SENIORITY This is a payment for experience, that reflects how long a doctor has been a General Practitioner. For example a doctor who has been registered for eleven years who has seven years experience as a GP will receive **£435:00** per year. Whereas a doctor who has been registered for 25 years, 21 have been as a GP will receive a fee of £665

NON ITEM of SERVICE PAYMENTS (Ct'd)

DHSS REPORTS

Small payments are made by the Department of Social Security for the writing of reports or carrying out medical examinations. Some examples of this might be :- the sectioning of a mentally disturbed patients, a request for an orange disabled badge for a patient, ensuring the fitness of some one to care for children as a child minder, attendance at court as an expert witness etc.

PGEA

£2100:00 is payable annually to each GP as a Post Graduate Education Allowance, provided they attend the requisite number of modules totalling 30 hours of approved study.

ITEM of SERVICE PAYMENTS

CHILD HEALTH SURVEILLANCE

An annual payment of **£10:35** per child is made for children under five years of age who attend register periodic surveillance under a doctor with recognised experience.

REGISTRATION

A once only payment is made to the doctor for each new patient of **£6:30** who attends for a new patient medical check.

TEMPORARY RESIDENTS

These are patients that the doctor has seen that are not on their list. For the doctor to qualify for this payment the patient has to be in the area for more that 24 hours and less than 3 months an example of this might be a person suffering from acute sunburn whilst on holiday.

ITEM of SERVICE PAYMENTS (Ct'd)

EMERGENCY TREATMENT As above, except the patient must have been in the area for under 24 hours.

MINOR SURGERY This is a payment to the doctor for specific surgical procedures, for example the removal of a sebaceous cyst (a wart!).

MATERNITY Doctors are paid a specific amount for each pregnant lady in the practice when the patient is 16 weeks pregnant and another payment when the patient is 30 weeks pregnant. Doctors also get payments for; the 6 weekly check up, any home visits, if the doctor is present at confinement or if the patient mis-carries.

NIGHT VISITS Payments are made for each home visit that is requested by them and made to patients between 10 O'clock at night and 8 O'clock in the morning. If the doctor personally visits the amount is **£46:65**, however if they use a deputising service the fee is **£15:55** per visit.

CHILDREN'S IMMUNISATIONS & VACCINATIONS These are targets that fall into two categories the first concerns very young babies. Here the baby has to have a series of four injections, if the practice vaccinates 90% or more of the target population they receive **£84:54** per patient at the end of the course of injections. The second category are children requiring pre-school boosters. Again, to attract payment (**£27:95** per patient) the practice has to vaccinate 90% of the target population. The national average numbers for both these groups is 22 children, so we are talking about **£1860:00** and **£615:00** respectively.

ITEM of SERVICE PAYMENTS (Ct'd)

OTHER VACCINATIONS This refers to income generated by giving other vaccinations and immunisations, for example injections for foreign travel

CYTOLOGY Women between the ages of 25 and 64 have to have a cervical smear every five and a half years. To qualify for the payment of **£5:48** per patient the practice has to smear 80% of all women in the target group (there are, on average, 430 women per GP per period

CONTRACEPTION A payment of **£13:25** per year is made for the fitting of dutch caps, coils etc as well as prescribing the "pill, or simply giving contraceptive advice.

HEALTH PROMOTION Specific payments are made for holding specialist health promotion clinics that include: well woman/man, diabetes, asthma, weight reduction, non smoking etc. These have now been phased out, with special payments only being made for diabetes and asthma clinics.

The tremendous advantage, as far as the research goes, of such a complex and detailed system is that because it is used for **payment** of GPs extremely accurate records are kept by the FHSA. Providing that I can have access to these, useful comparisons can be made between fundholding and non-fundholding practices and also possibly before and after comparisons. For instance Item Of Service Payments (broken down into their component parts) could also be compared with both national and district figures expressed as income per patient.

Appendix IX

Earning Capacity of a GP with 2,000 Patients in England

Income from existing fees and allowances before 1990 (£)		Income from new fees and allowances after 1990 (£)	
Capitation		**Capitation**	
Standard capitation fees	7,625	Standard capitation fees	21,850
Supplementary capitation fees	1,700		
Basic Practice Allowance		**Basic Practice Allowance**	
BPA	18,560	BPA	6,000
Supplementary BPA	1,720		
Other fees and allowances		**Other fees and allowances**	
Seniority	5,510	Seniority	3,810
Group practice	1,480	Registration fees	750
Night visit fees	625	Night visit fees	1,440
Other payments	4,850	Other payments	4,850
Total (1)	**42,070**	**Total (1)**	**38,700**
		PGE allowance	1,700
		Minor surgery sessions	480
		Health promotion sessions	540
		Child health surveillance fees	480
		Total (2)	**3,200**
Cervical cytology	310	Cervical cytology target	1,500
Childhood immunisation	480	Childhood immunisation target	2,030
Total (3)	**790**	**Total (3)**	**3,530**
Total Income	**42,860**	**Total Income**	**45,430**

Appendix X

Contents

1.0 Introduction

This proforma is intended to be used by practice managers, or General Practitioners, as a managerial audit sheet. After completing a degree of audit it should be possible to plot their practice in relation to the tables. From these tables it will become apparent that the practice demonstrates certain tendencies. Once these have been identified it will be possible to highlight areas that should be concentrated on and improved so as to become strengths to the business, which in turn should improve efficiency or profitability.

2.0

Orientation towards strategic management and values

This dimension is concerned with the priority given to managerial concerns and activities within the practice. It also considers the importance given to management as a strategic (and not simply an administrative) activity.

2.1 Record the reported percentage of GP time spent on management. Score to the nearest percentage point. ***Remember to discount time spent on Fundholding activities.*** < 4%: score 1, 4%-5%: score 2, >5%: score 3.

Score [ ]

2.2 Calculate the practice management hours per GP. Calculate this by computing the weekly hours of the Practice Manager, their assistant, and any one else directly employed on the management side, add the total time GPs spend on management matters per week to this sum and divide these hours by the number of GPs. ***Remember to discount time spent on Fundholding activities.*** <13 Hrs: Score 1, 13 - 15 Hrs: Score 2, >15 Hrs: Score 3.

Score [ ]

2.3 Has the practice conducted some form of patient satisfaction survey, or audit in the last 12 months? Yes: Score 3, No Score 1. . **Score [ ]**

2.4 Does the practice have a policy of growth or consolidation? Growth: Score 3, Remain same, or don't know: Score 2, Consolidate: Score 1.

Score [ ]

Orientation towards Management Concerns (C'td)

2.5 Please score 1 point for each "yes" answer in this sub section.

Does the practice have a mission statement? [ ]

If yes is this translated into specific stated objectives? [ ]

Is there an annual review of long term strategies? [ ]

Score [ ]

2.6 Have the practice GPs ever discussed or considered policy concerning the ethics of "expensive patients" or "cost ineffective" treatment? Yes: Score 2, No: Score 1. Has the practice ever refused to accept a patient onto the list on any other grounds than the list was full? Yes: Score 1 No: Score 0.

Score [ ]

2.7 Does the practice have an area needs document? This might include local social statistics, % unemployment, planned new developments, comment on how these might affect the practice. Yes: Score 2, No: Score 1. If yes has it been updated within the last year? Yes: Score 1, No: Score 0.

Score [ ]

Total Score for this Section [ ]

If your practice scores over 14 points then it is highly orientated towards management concerns. If the score is less than 14 points then your practice is less orientated towards management concerns.

Low concern for management **High concern for management**

7 14 21

3.0

Concern for Operational Efficiency & Income Maximisation

This dimension is concerned with the priority the practice puts on matters of economy and efficiency. Providing services of an appropriate standard as cheaply as possible

.3.1 Calculate the number of patients per GP; exclude Trainees, but include Part Timers pro rata. If < 1,900: Score 1, between 1,900 & 2,100: Score 2, if > 2,100: Score 3. **Score [ ]**

3.2 If average consulting time is < 6.5 minutes: Score 3, Between 6.5 and 7.5 minutes: Score 2, if > 7.5 minutes: Score 1. **Score [ ]**

3.3 Overall if annual prescribing costs are above FHSA average by more than 2%: Score 1, average (between 2% under and 2% over): Score 2, below FHSA average by more than 2%: Score 3. *(this information is found on the first page of the standard PACT quarterly report)* **Score [ ]**

3.4 If the frequency of administrative audit is less than Once per year: Score 1, once per year: Score 2, if more than once per year: Score 3. **Score [ ]**

3.5 If the average hours per GP spent on home visits per week is more than 5 hours per week: Score 1, between 4 & 5 hours: Score 2, if less than 4 hours then: Score 3.

Score [ ]

Concern for Operational & Financial Efficiency (C'td)

3.6 Calculate the IOS income as a ratio of the total staff costs. *Take the total **IOS** income for the year, divide it by the annual staff costs (including NI, maternity, sick pay & pensions contributions **also remember to discount fundholding activities**).* If this is less than 70p: Score 1, between 70p - 75p : Score 2, if over 75p: Score 3.

Score [ ]

3.7 Excluding the temporary residence and emergency treatment calculate the **IOS** income per patient . Compare each payment, with the regional average & log the difference (Column 4, table 1). Multiply this by the weighting (to compute the weighting take the specific total [e.g. CHS, 12750] divide it by the whole IOS income for the practice [199541] and multiply it by 100, this gives a % weighting [6.39%]) add up the weighted difference column as per the example in table 1, here we have a plus figure of £0.36

	Practice Total	Practice per Patient	Regional per Patient	Difference per Patient	Weighting	Weighted Difference
Child Health Survey	12750	0.59	0.54	0.05	6.39%	0.0032
Registration Fees	4593	0.21	0.43	-0.22	2.30%	-0.0051
Temporary Residence	**5871**	**0.27**	**0.22**	**0.05**	**2.94%**	**0.0015**
Emergency Treatment	**770**	**0.04**	**0.02**	**0.02**	**0.39%**	**0.0001**
Minor Treatment	11800	0.54	0.49	0.05	5.91%	0.0030
Maternity	30542	1.41	1.5	-0.09	15.31%	-0.0138
Children's Imms & Vaccs	32127	1.48	0.59	0.89	16.10%	0.1433
Contraception	18590	0.86	1	-0.14	9.32%	-0.0130
Health Promotion	48510	2.23	1.21	1.02	24.31%	0.2480
Other	11040					0.0000
Total Annual IOS income	**199541**					**0.3655**

Table 1

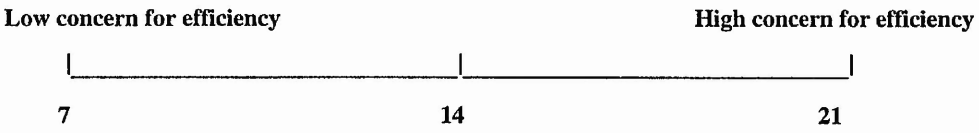
Concern for Operational & Financial Efficiency (C'td)

3.7

If the total figure is lower than -0.05: Score 1, if it is between + and - 0.05: Score 2, if it is more than +0.05: Score 3. **Score [ ]**

Total Score for this Section [ ]

If your practice scores over 14 points then it is more concerned with operational and financial efficiency. If the score is less than 14 points then your practice is not as inclined to such matters.



4.0

The focus of service delivery

focus on the GP or focus on the practice team

This dimension is concerned with the emphasis that the practice puts on the notion of a team providing patient care, rather than a group of Doctors who have staff that work for them.

4.1 If the percentage of patients visiting the surgery wishing to see the Doctors is more than 32%: Score 1, if between 28% & 32%: Score 2, if less than 28%: Score 3. **Score [ ]**

4.2 If the percentage of patients visiting the surgery wishing to see the nurse, other health practitioners or counsellors is less than 8% Score 1, if between 8% and 12%: Score 2, if. more than 12%: Score 3 **Score [ ]**

4.3 Calculate the hours of nurses and other professions allied to medicine as a ratio of GP hours. *Take all the weekly staff hours and add them up. Divide by the number of GP hours. E.g.: if the number of staff hours is 140 and the GP's hours are 401 the following calculation would result:-*

140/401 = 0.35 If the ratio is less than 0.30: Score 1, if between 0.30 and 0.40 Score 2, if more than 0.40: Score 3. **Score [ ]**

4.4 Calculate the Doctor's hours actually face to face with patients (i.e. surgery, visits and on call) as a percentage of total hours of patient care, if it is more than 75%: Score 1, if between 75% and 70%: Score 2, if less than 70%: Score 3.

Score [ ]

GP Vrs Practice Team (Ct'd)

4.5 Calculate the number of clerical staff hours per GP hours. E.g.: *Staff Hours/Doctor's hours* **(divide staff hours by Doctor's hours, multiply by 60**) if the figure is less than 40 mins.: Score 1, if between 40 and 60 mins.: Score 2, if more than 60 mins.: Score 3. **Score [ ]**

4.6 Allocate one point for the following

i) The presence of an annual appraisal scheme. [ ]

ii) The presence of a staff pension scheme. [ ]

iii) Staff meetings held more than every six weeks [ ]

iv) The presence of a staff training and development scheme. [ ]

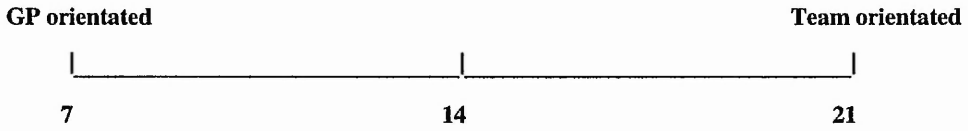
v) Photos, names and job descriptions of <u>all</u> staff and Doctors in a place where patients can see them. [ ]

vi) <u>All</u> staff wear a uniform and name tags. [ ]

Score [ ]

Total Score for this Section [ ]

If your practice scores over 14 points then it is more team orientated. If the score is less than 14 points then your practice is more GP centred.



5.0

Clinical Standardisation and the Relationship between clinical Principals

Focus on co-operation and clinical standardisation; Focus on individuals and autonomy

This dimension is concerned with the extent to which GPs "emphasise their clinical autonomy" as opposed to offering a uniform and standardised service to their patients.

5.1 Compare the number of patients per GP to the average **[1,892 per GP Financial Pulse 22nd Jan. 1995]**, *(take the national average subtract the practice average, then divide that figure by the national average and multiply by 100)* if under by 5% or more: Score 1, if the same within 5% either way: Score 2, if over by more than 5%: Score 3. **Score [ ]**

5.2 Are there clearly stated protocols & procedures for disease management? If none: Score 1, if up to 4: Score 2, if more than 4: Score 3. **Score [ ]**

5.3 Are protocols & formularies reviewed on a regular basis? If so how often? Never: Score 1, :Every 18 months or less Score 2, if more frequently than every 18 months: Score 3. **Score [ ]**

If you are a single GP practice please leave this section adding a further 4 points to your score.

Standardisation Vrs. Clinical Autonomy (Ct'd)

5.4 Measure the consultation times of Doctors and calculate the mean and the standard deviation. If the standard deviation is more than 2 minutes Score 1, if between 1.5 and 2 minutes: Score 2, if less than 1.5 minutes: Score 3. **Score [ ]**

5.5 How often do GPs meet formally, or informally to discus medical cases? Infrequently: Score 1, On a monthly basis: Score 2, More than once a month: Score 3.

Score [ ]

5.6 Do any of the partners carry out any private, non NHS, work? If no: Score 2. If yes is the income paid into the practice account? If yes: Score 3, if No: Score 1. **Score [ ]**

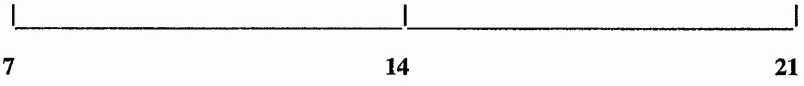
5.7 How are relations between GPs? Harmonious and productive: Score 3, Strained and difficult: Score 1. Somewhere in between: Score 2.

Score [ ]

Total Score for this Section [ ]

If your practice scores over 14 points then it is more autonomous. If the score is less than 14 points then your practice is more clinically standardised.

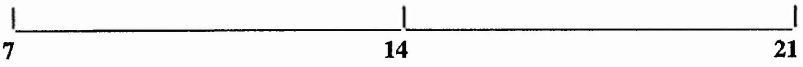
Emphasis given to GP autonomy **Clinical Services are Standardised**



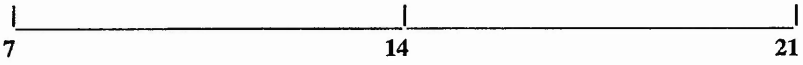
5.0

Overview of the Practice

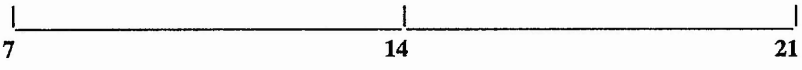
Low concern for management — **High concern for management**



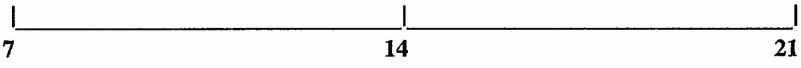
Low concern for efficiency — **High concern for efficiency**



GP orientated — **Team orientated**



Emphasis given to GP Autonomy — **Clinical Services are Standardised**



Appendix XI

We would be very grateful if you would spend a few moments filling out this form, we can only improve the service that we give our patients if they tell us what they <u>really</u> think of us. The contents of this proforma are totally in confidence, unless you wish to do so please do not put your name on the paper, when complete please put it in the post box provided. In anticipation thank you for your time.

Please circle the appropriate box ○

1)Sex/Working status

Male	-Working (paid)	[1]
	- non working	[2]
Female	-Working (paid)	[3]
	- non working	[4]

2)Your age

18-24 [1] 25-34 [2] 35-44 [3] 45-54 [4] 55-64 [5] 65-74 [6]
Over 75 [7]

3)Children

How many children (17 and under) do you have at home?

None [1] one [2] two [3] three [4] four [5] five or more [6]

How old are the children?

0-4 [1] 5-11 [2] 12-17 [3] No children at home [4]

4)Marital Status

Single [1] Married/Cohabiting [2] Widowed/Divorced/Separated [3]

Q1(a) What is the name of the GP/doctor you see most frequently? ----------

(b) How long have you been with this particular doctor?

Less than 5 years [1]5-9 years [2] 10-19 years [3]
20-39 years [4] 40-59 years [5] 60 or more years [6]
All your life [7]

(c) How long have you been with this practice (even if not the same GP)?

Less than 5 years [1] 5-9 years [2] 10-19 years [3]
20-39 years [4] 40-59 years [5] 60 or more years [6]
All your life [7]

(d) How long have you lived in this area?

Less than 5 years [1] 5-9 years [2] 10-19 years [3]
20-39 years [4] 40-59 years [5] 60 or more years [6]
All your life [7]

(e) Apart from today when was the last time that you had any contact at all with the GP practice (including telephone calls or home visits)?

Within the last month [1] Within the last three months [2]
Within the last six months [3] Within the last twelve months [4]
Within the last two years [5] Within the last five years [6]
Longer ago [7] Never [8] Don't Know/ Can't remember [9]

Please give a score (out of 5) where 5/5 is excellent and 0/5 is unacceptable.

Q2 **(a)** Overall how satisfied are you personally with the quality of service provided for you by the GP's practice as a *whole*?

Q2 **(b)** What are you particularly satisfied with and why do you say that?----------

---

(C) What are you particularly dissatisfied with and why do you say that?

(d) Do you have any suggestions or ideas for improvement?

Please give a score (out of 5) where 5/5 is excellent and 0/5 is unacceptable DK denotes Don't Know.

Q3 How would you rate the quality of service provided for you by your GP doctor on the following different aspects?

(a) Their medical knowledge [ ]
(b) They always make the right diagnosis [ ]
(c) Open minded to all kinds of medicine (for example homeopathy) [ ]
(d) They always seek a second opinion if they are not sure [ ]
(e) They are always thorough [ ]
(f) Their attitude towards you [ ]
(g) How much respect they show you as an individual [ ]
(h) How much do you trust your doctor [ ]
(i) Does the doctor always answer your questions [ ]
(j) How well do they explain things [ ]
(k) They don't just rely on pills all the time [ ]
(l) They are **NOT** arrogant/high and mighty [ ]
(m) They always listen to what you have to say [ ]

Q3(Ct'd) How would you rate the quality of service provided for you by your GP doctor on the following different aspects?

(n) They never hurry you [ ]

(o) They are good at getting me to a specialist, or hospital needed [ ]

(p) They keep in touch after a hospital appointment/treatment [ ]

(q) They are good with children [ ]

(r) They know me really well [ ]

(s) They are sympathetic to even trivial aches and pains [ ]

Please give a score (out of 5) where 5/5 is excellent and 0/5 is unacceptable DK denotes Don't Know.

Q4

How would you rate the receptionist at the surgery on the following different aspects?

(a) How easy is it to get through on the phone [ ]

(b) Speed of response to the telephone [ ]

(c) Attitude on the telephone [ ]

(d) Finding the most convenient appointment for you [ ]

(e) Welcome you to the surgery [ ]

(f) Being able to see the doctor of your choice within a reasonable time [ ]

(g) System for repeat prescriptions

About the surgery itself

(h) Clear signs at the surgery [ ]

(i) Relaxing waiting room [ ]

(j) Information provided [ ]

(k) Car parking facilities [ ]

Appointments

Q5 **(a)** How far ahead do you have to book an appointment? .....

(b) Do you feel that this is: Much too long [1]
About right [2] A little too long [3]

(c) How long do you normally have to wait in the waiting room for your pre-booked appointment?.....

(d) Do you feel that this is: Much too long [1]
About right [2] A little too long [3]

(e) How many minutes do you think each appointment with the doctor is?.....

(f) Do you feel that this is: Not long enough [1]
About right [2] Too long [3]

(g) Should the surgery be open longer hours/ more days?
Yes [1] No [2] Don't know [3]
If yes when?.....

New Ideas

Q6 **Please score these out of 5**

(a) A system where patients who attend surgery without an appointment are seen first by a nurse who would consult a doctor if necessary. [ ]
Comments.....

(b) A"phone in surgery", where patients could phone in and speak to a doctor instead of coming in for a personal consultation. [ ]
Comments.....

(c) A nurse instead of a doctor routinely visits those who are chronically sick [ ]
Comments.....

Appendix XII

PRACTICE NAME..... List Size..... .....

Category	Job Title	Hours worked per week	Actual Numbers
Doctors	Total Staff Costs for Last Year Full Time Doctor Part Time Doctor		
Patient Care	Full Time Nurses Part Time Nurses Other		
Clinical Admin.	Full Time Secretary Part Time Secretary Full Time Receptionist Part Time Receptionist Gardener Cleaner Note Summariser Computer operator Other		
Management	Practice Manager Assistant Practice Manager Computer Operator Other		

IOS Payments	Annual Total £'s	IOS Payments	Annual Total £'s
Child Health Survey		Night Visits	
Registration Fees		Children's Vaccs and Imms.	
Temporary Residence		Contraception	
Emergency Treatment		Health Promotion	
Minor Treatment		Cytology	
Maternity		Other	

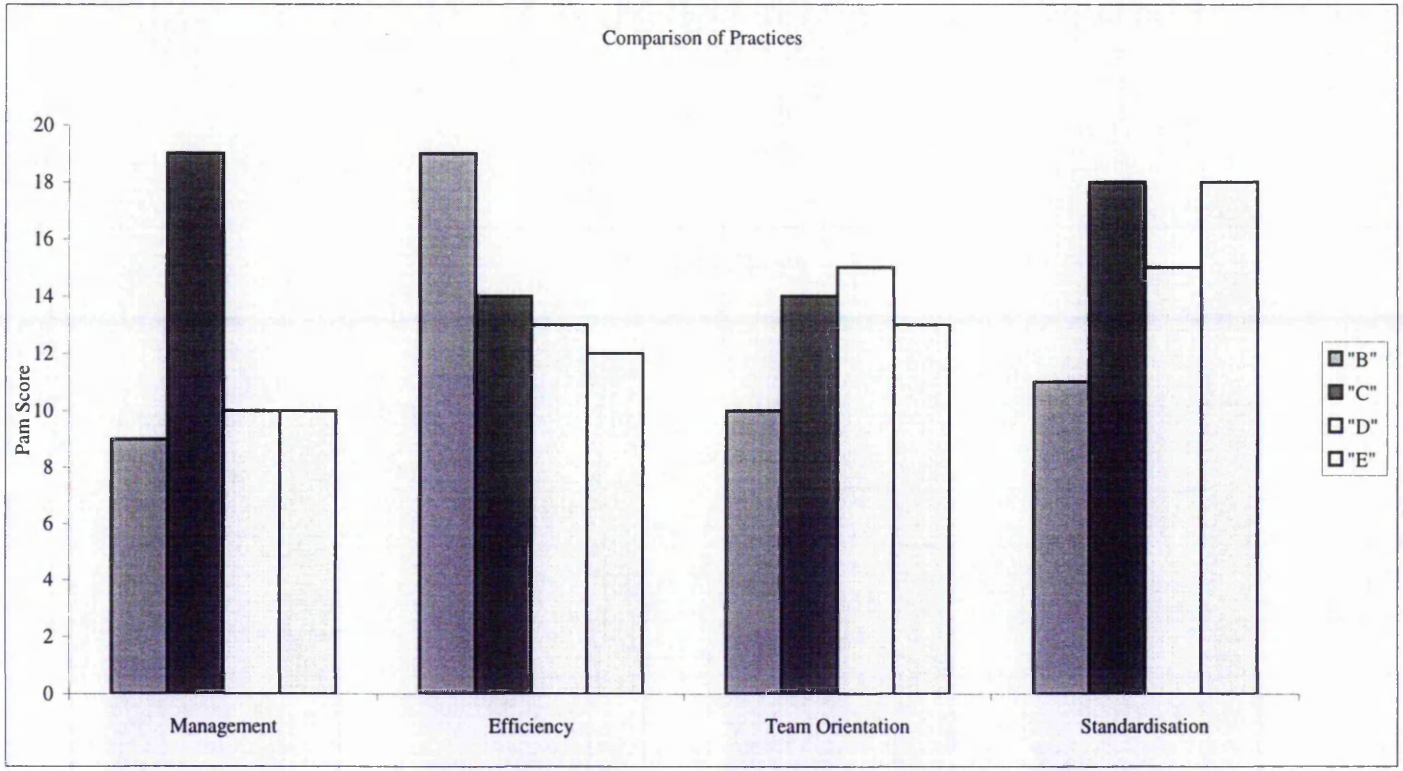
Appendix XIII

Day & Date :- Analysis sheet 27/03095 - 08/04/95

Reason for Visit	*8:00-9:00*	*9:00-10:00*	*10:00-11:00*	*11:00-12:00*	*1:00-2:00*	*2:00-3:00*	*3:00-4:00*	*4:00-5:00*	*5:00-6:00*	*6:00-7:00*	*Totals*
Doctor											
Nurse											
Minor Operations											
Midwife/Health Visitor											
Book Appointment											
Order Script											
Collect Script											
General Enquiry											
Test Results											
Other											

Appendix XIV

Practice	List	Docs (F)	Docs(P)	Docs (S)	PM	Staff (F)	Staff (P)	F/Hold	Area
"A"	3,997	2			1 P		6	3rd W	Pilot survey, inner city high deprivation. area, one site
"B"	13,400	6	1	1	1 F	5	21	No	Centre of busy market town (mining area) one large , purpose built site.
"C"	21,705	9	2	2	1 F 2P	11	16	1st W	Rural mining area, three sites; one in affluent village, one in large mining village and one in market town.
"D"	6,730	4			1	6	11	No	One site, city center, high depravation and immigrant area
"E"	11,293	3	3		1	3	13	No	One site in busy market town, on the outskirts of a city, mix of affluent, and deprived patients


Comparison of Practices
Pam Score
20
18
16
14
12
10
8
6
4
2
0
Management
Efficiency
Team Orientation
Standardisation
"B"
"C"
"D"
"E"

Appendix XV

Management and Medics: How Professionals Adapt to Management

Colin Fisher and Warwick A. A. Best

Doctors often express objections to managerialism in general practice. But, as research in this article suggests, their approach to management, revealed by the ways they manage their own practices and surgeries, can be more complex and less anatagonistic than is often assumed by observers.

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It is commonly assumed that doctors feel uncomfortable acting in the role of manager. Among the responses to a survey about management development and doctors carried out by the National Health Service Training Division (NHSTD, 1994), was the following: 'involving staff in management development is a problem here, they are very tied up in their clinical needs...There appears to be a very negative attitude to management amongst the medical staff'. While views such as this were not said to be universal, they were typical of a large number of responses. That is, perhaps, a reflection of a wider conjecture that there is a recurring tension, in many fields, between the professional role and the managerial role. This article examines these assumptions in the case of medical general practitioners, who are typically regarded as a classical professional group. We focus on the different ways that GPs respond to management imperatives and argues that GPs' reactions to the management role are more complex, and less determinedly antagonistic, than commonly suggested. Much of the analysis here could be applied to other professional groups.

From our experience of working with practice managers and GPs on management development activities, it seems that GPs may take a public anti-management stance but they nevertheless pursue aims which, while not openly described as managerial, would fit well with the definitions of management in the *Occupational Standards for Managers* (MCI, 1991). In other words, GPs may criticise the management function for making accountancy more important than clinical judgement, for ensnaring them in bureaucratic fetters, and for stealing time away from direct dealings with their patients; but they can also, as independent contractors to the National Health Service (NHS) and as people running a small business, be very concerned with cutting costs or maximizing their income. One way of defusing this apparent irony is to suggest that what GPs object to is not the managerial task itself, but the managers who, in the guise of civil servants or administrators, keep interfering (as the GPs see it) with their professional autonomy. Although this may be part of the answer, this article will not concentrate on the relationship between GPs and Family Health Services Authorities (FHSA) and Health Commissions, but on GPs' views about the management of their own practices and surgeries. The ways that practices and GPs have responded to increased pressures to be more managerial are reviewed and a measurement tool for assessing different practices' profiles of managerial interests is suggested.

The Pressure to Become More Managerial

The turning point at which the profession began to come to terms with the managerial role was the implementation of a new contract for GPs in 1990 (Department of Health, 1989; Morrell, 1989). This introduced elements of performance management into general practice by linking certain payments to achievement targets. As a consequence of this the fixed element (the practice allowance) of practice remuneration was decreased by about 25% and seniority allowances were also reduced. One practical result of this change in contractual tone was that many FHSAs required practices to write a business plan to support their claims for funding of service developments and additional staffing. Other external pressures have also caused GPs to take management issues more seriously. In recent years doctors have become more aware of their peers being taken to industrial tribunals for breaches of employment law (Ellis, 1994) and being fined for contraventions of the health and safety legislation. In such ways general practices, which have behaved in the past as if they were too small to be concerned with such things, have had to become more systematic and careful in their managerial behaviour. One study of how GPs spend their working time has reported that the percentage of time devoted to management and administration has increased by 98% between 1985/86 and 1992/93; although the impact of this statistic is lessened when the smallness of the base-line figure, 1.78 hours a week, is taken into account (Warry and Waters, 1994).

Medical partnerships have also become larger. The percentage of principals in partnerships of five or more partners has increased from 32% in

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1981 to 39% in 1992 (Department of Health, 1982, 1993). A larger partnership may have to spend more time on communication and co-ordination between principals. The move towards fundholding has also given an edge to larger practices, and in many areas, such as Derbyshire and Birmingham (Rivelin, 1995), practices have come together in clusters and consortiums in order to become fundholders. In other areas doctors have come together in new associations to avoid having to become fundholders. Nottingham, where the health authority operates a total commissioning scheme is one such place (Nottingham Health, undated). While these arrangements obviously fall short of creating larger partnerships, they still create bigger groups whose co-ordination requires management.

Fundholding of course brings with it a wide range of managerial demands. The most important challenge is the clear delegation of service allocation decisions (to balance needs for service with the budgets for meeting them) to fundholding practices (Glennerster *et al.*, 1994). In practice this has not led, as was originally feared, to patients being denied medical help; but GPs have had to think, for the first time, about such decisions as possibly delaying an out-patient referral for perhaps a few weeks.

Such questions suggest a fundamental difference between clinical values and managerial values, and a conflict about the proper criteria to be applied to the allocation of health care. Culyer (1975) labelled the 'clinical' view as *needology*; the belief that medical services should be triggered by need, and that services should be provided whenever there was some chance of them doing the patient some good. From this point of view it is the possibility of the patient benefiting that matters; the probabilities are not pertinent. As Elliot has reported in his study of clinicians dealing with cancer patients:

> *A good clinician should treat every individual patient as an individual and give him the best treatment that's around. This means it's very difficult to make a scientific appraisal of a new line of treatment. But it's so difficult to generalize...say lung cancer...I can say to you its got a 2% survival rate, but if I say this to a mass audience this implies that the whole lot will die, well they generally do, but for the individual who comes along, he may well not have a 2% chance, but a 50% chance (Elliott, 1973, pp. 214 and 218).*

The increased public awareness of debates about the allocation of health care, and the increased willingness of health managers to enter these debates (for example the argument over whether a health authority should fund bone marrow transplants for a child with leukaemia; see *Independent*, 10 March 1995) has managerially challenged the assumed consensus about 'need' as the trigger for medical intervention, and put greater managerial responsibility on the shoulders of doctors.

Fundholding and the new contract (especially in the beginning when health promotion was funded on an item of service basis) also gave practices greater discretion in the range of services they could supply and the ways in which they were delivered. This recognition of the possibility of adapting services to the needs of people in a particular catchment area has opened up to GPs the possibility of developing a marketing based strategy for their practices. The overall impact of these changes, most of which have taken effect only since 1990, has been to force GPs to recognize the need for some kind of managerial response.

The Maverick and the Adjuvant

The pressure for general practice to become more managerial has caused two types of people to take on a management role: the maverick and the adjuvant. The mavericks are doctors who enjoy the management part of their job; it is tempting to see such doctors as very much the exception, people who have developed, and may vociferously champion, a specialism which is seen as perverse by many of their colleagues. Mavericks, as in other professions, can become managing partners (Lorsch and Mathias, 1987), although it would be rare for them to give up professional practice to concentrate solely on management.

The adjuvant is a helpful ancillary, whose job is to give managerially inclined advice and to perform the necessary administrative and management functions. In hospitals, these people are called business advisors to clinical directors. In general practice, they are known as practice managers, and their numbers have increased greatly in the past five years. (In medicine the word 'adjuvant', when applied to a chemical and not a person, refers to a material which helps the active ingredient to work better. This seems an appropriate image for the work of many practice managers!) This rise of practice managers has been largely forced by the FHSAs, who made it known that they would be willing to reimburse the cost of such posts at the normal level. Once appointed, however, their problem has been to establish their value, credibility and status within the practice. A critical test of whether they have achieved this is the question of access to the practice's accounts. Where they have access they can take on a strategic management role; but in the many cases where the partners refuse to let the practice manager see the books or the accounts, they are restricted to an operational management role. Status is an important factor, and the term adjuvant has been chosen to reflect the generally subservient role of the practice manager. A few practice managers are partners in their practices, but generally their gender and their origins in secretarial or clerical work reinforces their ancillary role. And practice managers who have been appointed to the job from a management position in private industry often find that they do not have the managerial discretion they had in

their previous organizations.

Either by the non-conformity of the maverick GP's managerial role, or by the relatively low status of the managerial adjuvant, the marginality of management within general practice appears to be reinforced.

The Management Development Response to Management in General Practice

Opportunities for management development of people in general practice have expanded as the role has grown. Practice managers have responded to these opportunities more readily than the GPs. A survey of health service organizations, carried out by the NHSTD (1994), reported that while 80% of management development programmes were open to doctors, and were in some cases targeted on them, they showed little tendency to attend. It was rare, in any case, for these programmes to be particularly aimed at GPs. From a survey of all post-graduate medical departments it was discovered that in one year a total of only 37 management programmes were offered and only 208 doctors attended. Some organizations have nevertheless reported great interest from doctors in management education; and a survey by Allan and Brimelow (1994) indicated significant demand for management training from those doctors whose jobs included elements of management responsibility.

Practice managers and fundholding managers, on the other hand, have responded in a big way to management development opportunities. Despite the problems of obtaining funding for training practice managers are now regularly found on management certificate and diploma programmes, as well as on MBA and other master's level management programmes. Specialist programmes have developed to meet the market. At Nottingham Business School there have been five advanced diploma and post-graduate certificate courses in management in general practice. Courses for practice managers, leading to certificates and diplomas in management in general practice, are also run by the Association of Medical Secretaries, Practice Administrators and Receptionists (AMSPAR) and the Association of Health Centre and Practice Administrators (AHCPA). Private sector training organizations have also recognized that management training in general practice is a growing market and are offering a range of short and long management courses.

This brief overview of management development in general practice appears to reinforce the impression that doctors' opinions of management are negative. In fact, the situation is more complex than so far presented.

A Multi-Dimensional View of Management in General Practice

The core of our argument is that management, in the context of general medical practice, has several dimensions, only some of which fuel the common clinical objections to management. From the management development and research work we have carried out, we believe that there are four dimensions of management. The rest of the article describes them and illustrates how different patterns of managerialism can be found in general practices.

Dimension 1: Management Values and Methods

This dimension focuses on values about how resource allocation decisions should be made and about how medical practices should be managed. People with a 'managerial' ideology, for example, do not believe that individual needs alone can be the trigger for clinical activity. They think that the needs of the whole population and the amount of good that can be done with a given amount of resources should be taken into account. They ask questions about whether it would be better to stop doing certain procedures which are expensive and/or clinically ineffective, and spend the money saved on other procedures which will result in more overall benefit. Managerial values are concerned with cost effectiveness. This is most clearly expressed theoretically, if not practically, in the idea of the QALY (Gudex, 1986), which is measure of the improvement in the quality and longevity of life that can be expected as a result of a particular medical intervention; and when this is associated with a cost analysis, distinctions can be made between medical treatments in terms of the maximization of the physical well-being of the population. The clinical view looks at the allocation of health care as a matter of principle whereas the managerial view looks at the issue from a policy perspective. It is this distinction, we think, that doctors mostly have in mind when they criticise managerial approaches. The argument about how resource allocation decisions to health care should be made is not, of course, just an issue for doctors; it is also a matter of debate at a national policy level.

A range of management techniques, such as business plans, SWOT analyses, value chains and mission statements, have become associated with managerialist values. These tools tend to assume that the optimal use of resources is a good thing. The use of these tools within a practice, rather than their presence for cosmetic effect, may well be an indication of an acceptance of managerial values. A concern for growth and entrepreneurial developments is also characteristic of practices with a management value orientation. One practice for example has used its savings on its fundholding budget to set up a 'Real Health Shop', which sells videos on healthy living, physiotherapy aids and woks (*Independent*, 28 February 1995). The entrepreneurial practice will look for growth and for profitable opportunities for new activities.

Dimension 2: Concern for Operational Efficiency and Income Maximization

There are other aspects of management which

doctors may subscribe to even though they may reject the managerial values and methods outlined above. For example, a GP or a practice may give great attention to the operational and financial management of the practice. This is likely to involve a concern for maximizing income and ensuring that all the due fees are claimed for and received. In some fundholding practices, for example, invoices from hospitals are paid without much checking (the individual sums of each invoice are often trifling), while other practices have created their own software to monitor and check every referral and invoice. Another indication of a concern for efficiency is a high level of attention to cost cutting and the elimination of waste. As, in many cases, GPs can see a direct link between this activity and their monthly personal drawings from the practice, a concern for economy and efficiency may be common. This may show itself in a hunt for new ways of maximizing income. Among the 600 first- and second-wave fundholding practices for example, 50 set up private companies which enabled them to act as providers of minor surgery to their own practices. The fundholding regulations were changed in 1993, however, to prohibit the use of this device (Glennerster *et al.*, 1994, p. 17).

Dimension 3: The Focus of Service Delivery

Another area in which the managerial orientation of a practice might reveal itself is in the focus of service delivery to patients. A GP with a non-managerial approach might see service delivery as being focused on him or herself. Managerially inclined GPs would be more likely to see the needs of the patients being met by the practice team as a whole. This team would certainly include specialist nurses, and even possibly nurse practitioners, as well as counsellors and other professionals allied to medicine. In many ways this particular managerial focus is a reiteration of the goals (if not the actual practices) of health centres. It was a clear intention of governmental health policy in the 1970s to encourage GPs to practise from health centres which could provide a seamless service to patients from the combined activities of the GPs (even when they were from different practices) and other health professionals located in the health centres. Between 1968 and 1973, for example, the number of nurses employed in practices increased by 26% (Reedy, 1977). Within this sort of practice the services provided are defined by the health needs of the community and not by the interests and specialisms of the GPs. If the classification of organizational cultures developed by Harrison (1972) and Handy (1985) is used to illustrate the distinction, the 'people culture', with its emphasis on the organization's ancillary role in supporting key and dominating professionals represents the traditional position; while the 'task and team' type of culture, with its emphasis on collaboration between many individuals with different types of expertise, represents the managerial approach to general practice. The organizational values of a task and team culture emphasise the importance of each profession within the practice being willing to trim and compromise to accommodate the anxieties and aspirations of the other professions. At different times the wishes of different professions will be critical; and an acceptance of this resource-dependence (Watson, 1994) approach to professional relations is typical of practices with this managerial orientation.

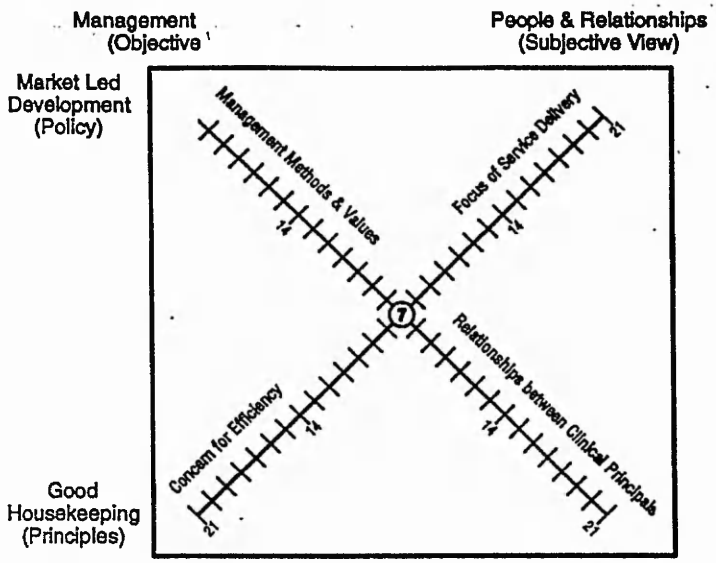
Dimension 4: Clinical Standardization and the Relationships between Clinical Principals

A further area in which GPs may take a managerial stance without necessarily embracing a wholly managerial ideology, is the management of clinical practice and the management of the relationship between principals within a practice. A managerially inclined GP would be interested in the systemization and standardization of clinical practice. These interests might result in the creation of protocols for the clinical management of certain conditions to be adopted by all the doctors in the practice. Medical audit (Marinker, 1990) is a sensible precondition of the writing of clinical protocols and pharmaceutical formularies. This implies a certain, but voluntary, restriction on the clinical autonomy of doctors; and for many this would be unacceptable. It is often assumed that GPs who prefer to work in a single-handed practice (11% in 1993) do so because they are unencumbered by the clinical views of colleagues. A focus on clinical uniformity therefore involves the broader question of the management of inter-principal relationships in general practice.

There are practices we have observed in which the partners seldom discuss managerial or even clinical issues; they meet only by chance when they emerge from their consulting rooms. In others, there is communication between partners, but it is strained and has to be mediated through the good offices of a practice manager or some other relatively neutral party. In yet other cases, the partners work hard at maintaining effective working relationships with each other. In these cases there is an implicit, managerial, focus, on developing communication.

The management of inter—principal relationships has to overcome some inherent difficulties. Economists refer to these as the 'freeloader problem' (Legros and Matthews, 1993). A partner in a jointly-owned partnership arguably should have little motivation to put energy and enthusiasm into the running of the practice because the financial benefits of that effort will be shared by all partners. The temptation is to step back and benefit from the efforts of the other partners; and the consequences of this can be seen in the arguments about the 'fairness' of workload allocation between partners experienced in many practices. In order to avoid such problems, partners have to manage their perceptions of each other. While they consider each other as deserving, sound, competent and

Figure 1. Managerial orientation: aspects of managerialism in general practice.



hard working, the relationships can prosper; but if they view each other as undeserving, clinically doubtful, or freeloading, then collaboration will be undermined. Activities such as medical audit and the development of formularies and protocols will obviously be a victim of a failure of collaboration between principals. This aspect of management therefore is built upon the moral assessments principals make of each other.

A Model of Managerial Orientations in General Practices

The four dimensions of possible managerial concern in general practice can be brought together as a model (figure 1), which can be used to map the managerial profiles of different practices. The model places the four managerial dimensions against two continua. The first continuum ranges from an objective view of management (which concentrates on the hard aspects such as plans, procedures systems and accounts) to a subjective view which concentrates on the relationships between people (either between all the staff of the practice or between the clinical principals). The second continuum ranges from management, which is principle-led, to management which is policy-led. Policy is a way of justifying actions by their impact on the achievement of goals and objectives. A justification by principle, on the other hand, emphasises doing the right thing properly, because it is the right thing and not because of any effects it may have. We are suggesting, therefore, that practices with a concern for efficiency may be reacting to a temperamental need of the partners, and not analytically deciding to concentrate on efficiency because it will improve health care. Similarly, a practice's standardization of its clinical procedures may reflect values of fairness and equity rather than a belief that this will maximize the health of a community.

In the model presented in figure 1, the small circle at the origin represents a traditional, and possibly stereotyped, general practice attitude towards management. Any practice at this point would be one which was single-handed, or where the partners would prefer to be single-handed. The focus of service delivery in such a practice would be very much on the GP as an individual actor, with a big status gap between the GP and everybody else in the practice; there would be a very strong commitment to clinical values and the meeting of clinical needs; and efficiency (and the filling in of forms to claim income) would be given very low priority. As a practice's position moves away from the origin, on any of the four managerial dimensions, its approach becomes more managerial.

Warwick Best has developed a set of qualitative and quantitative measures which can be used to make assessments of practices' co-ordinates on this model. The measures used relate to the activities of a practice and the way it works; they are not attitude measurements. An audit of aspects of practice operations must be carried out in order to apply the model. This involves:

- Interviewing the principals and the practice manager(s).
- Analysing the practice's accounts and operational information.
- Conducting observational studies to measure such things as the flow of patients through the practice and consultation times.

The data from these sources is then analysed to produce scores which show how managerially orientated a practice is on the four dimensions of management. The instrument containing these measures can be obtained from the authors, although it is still being tested and refined; the dimensions and the norms which are used in the

Table 1. The managerial profiles of two practices.

Managerial dimension	*Cardale*	*Tannochbrae*
Management values and methods	16	8
Efficiency and income maximization	19	17
Focus of service delivery	19	11
Clinical standardization	12	13

Note: the range of possible scores is from 7 to 21.

scoring require more calibration. However, the model is at a stage of development where profiles of selected practices can be attempted.

Illustrative profiles of two practices, 'Tannochbrae' and 'Cardale', are given in table 1. The practices are not of greatly different sizes, one has eleven doctors and the other eight. Three of the doctors in the Tannochbrae practice have been there for more than 20 years. Both practices have new, purpose-designed, premises in semi-rural locations with socially mixed catchment areas. Each practice has redundant coal mines in its area. They differ, however, in their approaches to management methods and values. Cardale scores relatively highly on the managerial values dimension, while Tannochbrae is almost at the bottom of the scale. It is perhaps also worth noting that Cardale is a fundholding practice and the partners at Tannochbrae are fiercely opposed to fundholding. According to one of the principals at Tannochbrae: 'Fundholding would take me away from clinical work and my colleagues. We want to be GPs not negotiators of contracts'.

The focus of service delivery in the Tannochbrae practice is very traditional, being based on the role of the GP, whereas the Cardale practice has a much more team-based approach to service delivery—it employs a counsellor and its industrialized approach to giving influenza vaccinations is famous in the area. In the period of our survey 42% of patients' visits to the Tannochbrae surgery were to see the doctors, but, in the Cardale surgery, the corresponding figure was only 28.4% . Interestingly the doctors at Cardale spent an average of nine minutes in consultation with each of their patients, while those at Tannochbrae spent the national average figure of six minutes with each patient (Pritchard *et al.*, 1984). It clearly would be dangerous to assume that the quality of service was simply contingent upon the dominance of the doctor in the delivery of services

The two practices are quite similar on the remaining two managerial dimensions. They are both very concerned with operational and financial efficiency. For example both practices earned more *per capita* on item-of-service activity (such as vaccinations, immunizations and contraceptive work, but excluding temporary residents and emergency treatment which are beyond a surgery's control) than the national average. The ratio of administrative and clerical staff to GPs was similar in both practices and low compared with regional and national norms. Clinical standardization and relationships between partners were considered important in both practices. The partners met more frequently than once a month to discuss clinical matters, although in Tannochbrae the doctors spent half as much more time than those at Cardale in reviewing and systematizing patients' medical records.

This brief examination of Cardale and Tannochbrae shows that a practice's responses to management are not unidimensional. The partners at Tannochbrae, when asked, will say that they are against the increasing application of managerialism in primary care; and this is reflected in the low significance of managerial values and the high importance of the GPs in the way the practice is run. But this does not prevent it being quite managerial in the way it is organized.

Conclusion

Dawson (1990) has argued that management development requires people in organizations to have knowledge about management; motivation—so that people are willing to put in the work necessary to achieve managerial goals; and organizational capacity—the formal and informal arrangements which facilitate effective management.

Our view is that, within general practice, the issue is not knowledge and motivation, but organizational capacity. Practice and fund managers increasingly have knowledge of management and the motivation to implement it. There are also enough maverick GPs to create an interest in management in primary health care. But practices need to have developed an organizational capacity for management, in at least some of their activities, if management development is to succeed. This does not mean that a practice has to buy into the full-blown managerial ideology as represented by the managerial methods and values dimension in the model in figure 1. Developments in any of the other three dimensions would create an organizational capacity on which managerial (and organizational) development could be based. Our initial findings, using the measurement instrument, is that most practices have developed organizational capacities in some areas. A practice which is located at the centre of our model however is not an easy target for management development. ■

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