Altogether now? Professional differences in the priorities of primary care groups

Kevin Lucas and Graham Bickler

Abstract

Background Little is known about the similarities or differences with which Primary Care Group (PCG) Board members view the relative importance of the three functions with which they are charged, or how representative these views are of local primary care teams in general. This project explores the priorities of medical and nursing PCG Board members in relation to those of General Practitioners (GPs) and practice nurses.

Methods Postal questionnaires were sent to GPs (n=236) and practice nurses (n=137); structured telephone interviews were carried out with PCG Board members (n=61) in East Sussex, Brighton and Hove.

Results There are large differences between the views of GPs and those of their nursing colleagues on how PCG Board members should determine priorities in their work. There are also marked differences in the priorities of PCG Boards (of whom the majority are GPs) and non-Board member GPs. Whereas around two-thirds of PCG Board members believe that improving health generally and reducing inequalities in particular are the most important tasks before them, this view is not shared by most GPs in the same localities, who are generally more concerned about commissioning services. There is some doubt among GPs generally about the suitability of PCG Board members as a vehicle for the tasks they have been set, and this doubt is also found among PCG Board members themselves.

Conclusions The priorities of PCG Board members need to be aligned in order that they have a clear focus on the tasks before them. PCG Boards must also have priorities that are consistent with the local practitioners who elected them. Effective systems of communication will need to be developed between PCG Board members, Health Authorities and individual Primary Care Groups. Local flexibility is essential to the success of Primary Care Groups, but tackling inequalities in health must always be at the forefront of their role.

Keywords: PCGs, priorities, professional differences

Introduction

Primary care groups (PCGs) have been established nationally as part of the implementation of the White Paper The new NHS: modern, dependable.1 They will bring together the expertise of general practitioners (GPs) and practice teams, community nurses, social services, the Health Authority and representatives of local people.

The White Paper defines three responsibilities for PCGs as being to improve the health of, and reduce health inequalities in, their local community; to develop primary care and community services; and to commission a range of hospital services that meets their patients’ needs.

Each group is run by a Board of between four and seven GPs (one of whom is the Chair), two nurses, a social services representative, a non-executive director of the Health Authority, a lay member appointed by the Health Authority and the group’s Chief Executive. The structure of PCGs is intended to bring together different kinds of experience and expertise. This structure necessarily brings together people from different disciplines and perspectives.

Recently, a number of researchers have highlighted important issues arising from the formation of PCGs; some have proposed possible models for clinical governance in PCGs,2 whereas others have expressed concern over possible threats to freedom of prescribing and referral,3 and yet others have noted dissatisfaction over levels of pay for GPs who are Board members.4 In addition, correspondence has debated the validity of current performance indicators for use with PCGs.5–9

To operate effectively, PCG Board members need to have a common vision of their priorities and functions, yet many commentators have noted cultural differences between doctors and nurses, particularly in primary care.10 Moreover, this vision should reflect the view of the primary care teams they represent; as GPs and community nurses are elected to PCG Boards by their peers, it would be difficult if their priorities were very inconsistent with those of their ‘constituencies’.

However, little is known about the similarities or differences with which PCG Board members view the relative importance of the three functions with which they are charged, or how representative these views are of local primary care teams in general. There has been much speculation about what PCGs will be interested in, but as yet little, if any, empirical data are available.

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available. Such data are essential to the organizational development of PCGs, and important to other organizations that have to work collaboratively with them.

A project was undertaken to investigate:

(1) the relative importance ascribed to the major functions of Primary Care Groups by PCG Board members as a whole;
(2) the degree to which the views of PCG Board members reflect those of the professional groups in the primary care teams of which they are representatives;
(3) the degree to which PCG Board members, local GPs and practice nurses were concerned specifically with reducing inequalities in health.

It was intended that such information would assist the organizational development of PCGs locally.

Methods

Two components were employed.

First, a questionnaire was sent to all GPs and practice nurses within East Sussex, Brighton and Hove Health Authority. The Health Authority has five NHS (National Health Service) Trusts and six PCGs. The purpose of the questionnaire was to explore how these different groups view and determine the priorities of the work of the PCG serving their own area. Analysis was carried out using SPSS 9.0. Questionnaires were destroyed after analysis was complete. All interview data were seen only by the interviewer and by the researchers, and results were not made available in a form by which individual interviewees could be identified. Feedback was given to PCGs only on overall findings and on data for their own group if they requested it.

Second, following agreement from the six PCG Chairs, a semi-structured interview schedule was developed for PCG Board members. They were informed by letter that they would be contacted by a researcher, and telephone interviews were conducted by the South East Institute of Public Health with all members of the six PCGs who were willing and able to participate. The questionnaire was embedded in the interview schedule, which was designed to explore the dimensions covered by it in greater depth.

Results

Response rates are shown in Table 1. These response rates were inevitably affected by sickness, annual leave, maternity leave and other factors common to all postal surveys. Nevertheless, the rates obtained compare favourably with those for many such studies.

Differences in priorities

Respondents were presented with the functions of PCGs, set out as follows.

Functions of PCGs:

- improving the health of your local community generally;
- specific action to reduce health inequalities in your community;
- developing primary care and community services;
- commissioning a range of hospital services.

For the purposes of this study, improving health generally and taking action to reduce inequalities were treated as separate activities. The purpose of this distinction was to gauge the level of priority given locally to the reduction of inequalities in health. Respondents were asked to rank, in their personal view, the tasks in order of importance. Results are shown in Table 2.

There were large differences between both PCG Board members and their electorate, and between professional groups.

Table 1 Sample and response rates

<table>
<thead>
<tr>
<th></th>
<th>GPs</th>
<th>Practice nurses</th>
<th>Board members (all)</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>236</td>
<td>137</td>
<td>61</td>
</tr>
<tr>
<td>Return rate (%)</td>
<td>64</td>
<td>50</td>
<td>82</td>
</tr>
</tbody>
</table>

*Non board members.

Table 2 Percentage of respondents ranking tasks first and second in order of importance

<table>
<thead>
<tr>
<th>Task</th>
<th>GPs</th>
<th>Practice nurses</th>
<th>Board members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving the health of your local community generally</td>
<td>49 (33%, 17%)</td>
<td>80 (52%, 28%)</td>
<td>70 (47%, 23%)</td>
</tr>
<tr>
<td>Specific action to reduce health inequalities in your community</td>
<td>34 (14%, 20%)</td>
<td>44 (20%, 22%)</td>
<td>70 (27%, 43%)</td>
</tr>
<tr>
<td>Developing primary care and community services</td>
<td>74 (42%, 32%)</td>
<td>64 (25%, 40%)</td>
<td>47 (25%, 22%)</td>
</tr>
<tr>
<td>Commissioning a range of hospital services</td>
<td>46 (13%, 33%)</td>
<td>12 (4%, 8%)</td>
<td>18 (3%, 15%)</td>
</tr>
</tbody>
</table>

Figures in parentheses indicate percentage ranking task first and percentage ranking task second, respectively. Percentages do not always sum exactly because of rounding.
In general, PCG Board members favoured improving health generally and tackling local inequalities, whereas GPs who were not Board members saw developing primary care as the most important function of PCGs. In contrast to their medical colleagues, practice nurses were far more concerned with improving health generally than with the commissioning of services.

The interviews with PCG Board members amplified these differences, and also demonstrated differences of opinion within PCG Boards. Some members saw improving community health generally, and tackling local inequalities as paramount; other Board members were less sanguine about the ability of PCGs to carry out these tasks.

Ease of achieving the goals

All respondents were asked to rate on a five-point Likert scale how easy they believed the tasks given to PCGs would be to achieve in practice. Results are shown in Tables 3 and 4.

Tables 3 and 4 demonstrate fewer differences between GPs, practice nurses and Board members in the perceived difficulty of achieving PCG goals than there were between these groups about relative priorities. GPs and Board members saw commissioning as a slightly easier task than that of developing primary care. However, nurses were generally somewhat less pessimistic than were doctors. Overall, the tasks with which PCGs are charged were seen as far from easy by PCG Board members.

Suitability of PCGs as a means of achieving their goals

Using a five-point Likert scale, respondents were asked how suitable they felt PCGs were as a means of achieving the tasks they had been set by government. This question revealed important differences in opinion both between professional groups and between Board members and non-members. Results are shown in Tables 5 and 6.

As might be expected, PCG Board members were generally more convinced of the suitability of PCGs as a means of achieving their aims than were the GPs and nurses who elected them. On the whole, doctors were more sceptical than were nurses. More importantly, many PCG Board members themselves have doubts as to how suitable the PCGs are to achieve their goals: one-fifth of Board members felt their PCG to be an unsuitable vehicle for improving health generally, and nearly a quarter felt them unsuitable to reduce inequalities in health in their area.

Discussion

This study was exploratory in nature. Little exists in the way of literature concerning the development of PCGs. Our sample was relatively small and was limited to one Health Authority (although a high response rate was achieved). There may be bias in our responses brought about by differences in methods employed between GPs and practice nurses who were not Board members (postal questionnaires) and those who were on PCGs (telephone interviews). Further, the timing of our survey may be problematic: not only are PCGs still in their infancy, but individual PCGs within our sample were at different stages of development at the time of data collection. It will be necessary to address these issues and repeat our study in, for example, a year’s time to confirm or refute our initial findings.

Despite these limitations, a number of issues arise from our findings. First, there appears to be an important point about

### Table 3 Percentage of respondents rating task ‘easy’

<table>
<thead>
<tr>
<th>Task</th>
<th>GPs</th>
<th>Practice nurses</th>
<th>Board members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving the health of your local community generally</td>
<td>26</td>
<td>20</td>
<td>12</td>
</tr>
<tr>
<td>Specific action to reduce health inequalities in your community</td>
<td>14</td>
<td>28</td>
<td>39</td>
</tr>
<tr>
<td>Developing primary care and community services</td>
<td>33</td>
<td>20</td>
<td>31</td>
</tr>
<tr>
<td>Commissioning a range of hospital services</td>
<td>46</td>
<td>17</td>
<td>37</td>
</tr>
</tbody>
</table>

‘Easy’ was defined as scoring one or two on a five-point (1–5) Likert scale.

### Table 4 Percentage of respondents rating task ‘difficult’

<table>
<thead>
<tr>
<th>Task</th>
<th>GPs</th>
<th>Practice nurses</th>
<th>Board members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving the health of your local community generally</td>
<td>73</td>
<td>39</td>
<td>73</td>
</tr>
<tr>
<td>Specific action to reduce health inequalities in your community</td>
<td>57</td>
<td>52</td>
<td>37</td>
</tr>
<tr>
<td>Developing primary care and community services</td>
<td>23</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>Commissioning a range of hospital services</td>
<td>23</td>
<td>44</td>
<td>22</td>
</tr>
</tbody>
</table>

‘Difficult’ was defined as scoring four or five on a five-point (1–5) Likert scale.
communication between PCGs and primary care and the accountability of PCG Boards. In our sample at least, there were marked differences in priorities between PCG Board members and the people who elected them. These differences need to be handled carefully; it will be necessary to examine the mechanisms currently in place, and to identify which need to be developed, so that PCGs meet the expressed needs of local primary care teams.

Second, the data highlight a continuing issue concerning multi-disciplinary working. Historically, the relationship between doctors and nurses has not always been a smooth one. An early survey of UK nurses showed that almost half were dissatisfied with their relationship with doctors. More recently, changes in nurse education, and the adoption by nurses of many clinical tasks formerly the province of doctors has served to highlight these differences. Difficult relationships within primary care teams was the issue most frequently raised spontaneously in interviews with PCG Board members. In relation to PCGs, differences between nurses’ and doctors’ priorities were shown clearly and consistently in our survey. From our data, it may be argued that practice nurses seem generally more public health/health promotion oriented than are doctors, who seem more focused on primary care service development. Although it is probably true that these reflect differences in training, relationships with patients and so on, they may also reflect views about how primary care should be delivered.

There were also marked differences in the priorities of PCG Boards (of whom the majority are doctors) and non-member GPs. Whereas around two-thirds of PCG Boards believe that improving health generally and reducing inequalities in particular are the most important tasks before them, this view is not shared by most GPs (only about one in ten hold this opinion). The latter overwhelmingly see the development of primary care as paramount and also see PCGs as a suitable means of achieving it. Is it possible that this can be reconciled, as has been suggested elsewhere, by the adoption of community development approaches to service provision and inequity audits in primary care, or explicitly using primary care development as a means of reducing inequalities in health?

The recent guidance on Primary Care Trusts seems to emphasize the provision of high-quality primary care over the commissioning and public health functions. This appears to be consistent with the priorities of GPs as expressed in this survey – and further confirms the notion that within the NHS, improving population health and decreasing inequalities will depend on the kinds of approaches identified above.

A further question concerns the apparent lack of confidence in PCGs among some non-member GPs. There were many GPs in our survey who considered PCGs poorly placed to carry out the tasks they are charged with doing. Moreover, in the case of reducing inequalities, a quarter of PCG Board members themselves feel that PCGs are relatively unsuitable for this task. This should provide a starting point for discussion within PCGs of inequalities and the extent to which they can be tackled by what are still primarily NHS organizations. For example, what can PCGs do about housing or unemployment, even in conjunction with local authorities?

An interesting finding emerged from interviews with Board members. There were differences in priorities between PCGs, and differences in how easy they viewed the tasks with which they are commonly charged. Some of these differences were predictable (for example, PCGs in areas of higher deprivation believed tackling inequalities would be more difficult) but other

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### Table 5 Percentages of respondents rating PCGs ‘most suitable’

<table>
<thead>
<tr>
<th>Task</th>
<th>GPs</th>
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<th>Board members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving the health of your local community generally</td>
<td>34</td>
<td>47</td>
<td>63</td>
</tr>
<tr>
<td>Specific action to reduce health inequalities in your community</td>
<td>36</td>
<td>47</td>
<td>51</td>
</tr>
<tr>
<td>Developing primary care and community services</td>
<td>49</td>
<td>53</td>
<td>78</td>
</tr>
<tr>
<td>Commissioning a range of hospital services</td>
<td>48</td>
<td>45</td>
<td>65</td>
</tr>
</tbody>
</table>

‘Most suitable’ was defined as scoring four or five on a five-point (1–5) Likert scale.

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### Table 6 Percentage of respondents rating PCGs ‘least suitable’

<table>
<thead>
<tr>
<th>Task</th>
<th>GPs</th>
<th>Practice nurses</th>
<th>Board members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving the health of your local community generally</td>
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<td>17</td>
<td>20</td>
</tr>
<tr>
<td>Specific action to reduce health inequalities in your community</td>
<td>32</td>
<td>20</td>
<td>24</td>
</tr>
<tr>
<td>Developing primary care and community services</td>
<td>27</td>
<td>20</td>
<td>6</td>
</tr>
<tr>
<td>Commissioning a range of hospital services</td>
<td>27</td>
<td>15</td>
<td>12</td>
</tr>
</tbody>
</table>

‘Least suitable’ was defined as scoring one or two on a five-point (1–5) Likert scale.
differences were not so easily comprehended (PCGs in areas of higher deprivation were also much more confident in the suitability of PCGs to achieve this task). There is clearly a need for local flexibility consistent with local needs, but health authorities will also need to be aware of these differences in relation to Health Improvement Programme (HImp) development.

Despite its limitations, this study throws light on some PCGs’ development needs, and adds to the small quantity of data currently available about the process of their formation. The priorities of PCG members of different disciplines need to be aligned so that they have a clear focus on the tasks before them. PCG Boards must also have priorities that are consistent with those of the local practitioners who elected them. It follows that effective systems of communication and accountability will need to be developed between PCGs, health authorities and individual primary care teams.

References


5 Myers P. Current indicators have been chosen for ease of collection rather than scientific validity. Br Med J 1999; 318: 803.


Accepted on 7 October 1999