PRACTICE OBSERVED

Practice Research

Creating a general practice data set: new role for Northumberland Local Medical Committee

ALLEN HUTCHINSON, PETER MITFORD, MALCOLM AYLETT

Abstract

As a first step in planning primary care services for a whole district, the Northumberland Local Medical Committee undertook a postal survey of all 51 practices in the county. Questionnaires were returned by 154 doctors (95%). Information was collected from every practice on doctors' qualifications and postgraduate training, aspects of professional commitments in addition to patient care, professional appointments outside the practice, and clinical services being offered by the practice.

A wide range of clinical services was reported. In general, preventive services in singlehanded practices were provided within normal consulting sessions while the larger practices offered many special sessions and a multidisciplinary approach.

In addition to establishing baseline information for planning primary care initiatives, this first exercise provided valuable experience in data collection and management. Having shown that such a role is feasible, the experience will be used to expand the information and planning activities of the committee.

Introduction

General practice has traditionally been a reactive service and only in the past decade have there been attempts to move towards a more proactive role. Initial proposals for greater emphasis on anticipatory care were based on the principle that a general practice was responsible for the whole of its registered population and not just those who presented with problems.¹ Realisation of these principles has meant that many doctors are now looking outside their own practices to see what others are doing. Various forums have developed—young practitioner groups, for instance—in which quality of care and development of general practice services are often discussed.

By far the largest forum where general practitioners regularly meet in Northumberland is the local medical committee, whose members have increasingly taken the view that general practitioners should participate in planning and developing services for the whole family practitioner committee area as well as within their own practices. As a result several initiatives, often supported by district health authority development money, have already facilitated better blood pressure and cervical smear screening services, promulgated an agreed rubella policy, and helped with the introduction of practice computing technology.

Lack of information on what happens within the 51 practices in Northumberland, however, has remained a consistent obstacle to further development, and local medical committee members responsible for advising bodies such as the family practitioner committee felt particularly handicapped by their inability to describe the services being offered by primary care. In short, it became a priority of the local medical committee to seek better information about Northumbrian general practice.

In 1984 the local medical committee formed a review group which would collect and analyse information on county practices. This initiative was a radical departure from previous practice; though local medical committees are an important force for change through their national representatives, they have rarely influenced the

Ashington, Northumberland

ALLEN HUTCHINSON, FRCP, general practitioner and senior lecturer in health care research

Morpeth, Northumberland

PETER MITFORD, MRCP, general practitioner

Wooler, Northumberland

MALCOLM AYLETT, FRCP, general practitioner

Correspondence to: Dr A Hutchinson, Lintonville Medical Group, Old Lane, Ashington, Northumberland NE63 9UT.

doctors in their own area except in their occasional quasijudicial functions.

Rather than use district health authority or family practitioner committee data, local medical committee members wished the first exercise in data collection to be under their sole ownership and to be a joint effort by all county practitioners.

Method

In March 1986 a postal questionnaire was sent to each principal whose main contract was with the Northumberland Family Practitioner Committee seeking information on qualifications and postgraduate training, aspects of professional commitments in addition to patient care, professional appointments outside the practice, and clinical services being offered by the practice. These data were identified by a confidential study number only, the key to which was held by the deputy chairman of the local medical committee. Questionnaires were returned by post, and failure to return a questionnaire within two weeks prompted a reminder followed in nine cases by a personal reminder from a local medical committee member. So that the data would be non-attributable, the results were aggregated into six areas corresponding to the six local authority districts within Northumberland, survey data being recorded and analysed by computer.

TABLE I—Characteristics of areas and practices

Area	Area characteristics	No of doctors	No of practices represented	Average No of doctors per practice
Berwick/Alnwick	Rural	32	12	2.7
Castle Morpeth	Semirural	27	7	3.9
Wansbeck	Urban	36	10	3.6
Blyth Valley	Urban	34	10	3.4
Tynedale	Rural	33	12	2.8
Northumberland	Predominantly rural	162	51	3.2

TABLE II—Year of qualification of all 154 respondents

	Year of qualification								
	1940-4	45-9	50-4	55-9	60-4	65-9	70-4	75-9	80-4
No (%) of respondents	2 (1·3)	5 (3·2)	11 (7·1)	13 (8·4)	17 (11·0)	25 (16·2)	32 (20·8)	41 (26·6)	8 (5·2)

TABLE III—Years as principal in current practice (n=153 respondents*)

	Years as principal							
	39-35	34-30	29-25	24-20	19-15	14-10	9-5	4-0
No (%) of respondents	4 (2.6)	9 (5.8)	9 (5.8)	7 (4.5)	16 (10.4)	29 (18.8)	36 (23.4)	43 (27.9)

*Data missing for one respondent.

TABLE IV—Availability of antenatal care offered by the 51 practices surveyed

Area	Antenatal care offered within consultation					Antenatal care offered as separate sessions				
	No (%) of practices offering service	No (%) of practices with service provided predominantly by:				No (%) of practices offering service	No (%) of practices with service provided predominantly by:			
		General practitioner	Midwife	Health visitor	Nurse		General practitioner	Midwife	Health visitor	Nurse
Berwick/Alnwick	11 (92)	11 (92)	5 (42)	4 (33)	1 (8)	9 (75)	9 (75)	9 (75)	5 (42)	1 (8)
Castle Morpeth	6 (86)	5 (71)	4 (57)	4 (57)	0	6 (86)	6 (86)	6 (86)	5 (71)	0
Wansbeck	8 (80)	7 (70)	5 (50)	2 (20)	0	9 (90)	9 (90)	9 (90)	6 (60)	3 (30)
Blyth Valley	8 (80)	8 (80)	5 (50)	4 (40)	2 (20)	10 (100)	9 (90)	9 (90)	9 (90)	2 (20)
Tynedale	7 (58)	7 (58)	4 (33)	4 (33)	1 (8)	11 (92)	11 (92)	11 (92)	11 (92)	2 (17)
Northumberland	40 (78)	38 (75)	23 (45)	18 (35)	4 (8)	45 (88)	44 (86)	44 (86)	36 (71)	8 (16)

Results

Early analysis showed that because of the comparatively few doctors and very individual practice profiles serving rural parts of the county the level of aggregation chosen could not preserve confidentiality for practices in the Berwick-upon-Tweed and Alnwick areas. Data from these two areas were thus further aggregated, so that we describe aspects of general practice for Northumberland as a whole and differentiate among five local districts—Berwick and Alnwick, Castle Morpeth, Wansbeck, Blyth Valley, and Tynedale (table I).

At the time of this survey 162 general practitioner principals had main contracts with the Northumberland Family Practitioner Committee. Of these, 154 (95%) returned completed questionnaires. At least one questionnaire was returned from each of the 51 practices, and from three areas—Berwick-upon-Tweed, Alnwick, and Castle Morpeth—replies were received from every doctor. Three further replies were received after completion of data collection and are not included in the analysis.

Of the 154 respondents, 81 (53%) qualified during or after 1970 (table II). A remarkable degree of stability was found, in that only 19 (12%) respondents had been a principal in other than their current practice and 22 (14%) had been a principal in their practice for more than 25 years (table III).

Vocational training for general practice began in the Northern region in 1969. More than half of the respondents (80; 52%) had undertaken a recognised training course or an accredited self organised programme—that is, almost every entrant since 1970. In addition, many of the more established principals had had "appropriate experience," such as postgraduate hospital appointments in paediatrics or assistantships in general practice. Some district variation was evident in the type of postgraduate training that doctors had undertaken. For instance, in Tynedale, where 16 (55%) doctors had graduated since 1970, 23 (77%) doctors had undertaken some form of vocational training. In Wansbeck only 13 (39%) had done so.

Over half of the respondents were members of a royal college, principally the Royal College of General Practitioners (89; 58%), 19 (12%) being members of other colleges. Some doctors were members of two royal colleges, and three also held a degree of Doctor of Medicine. Only 27 (17.5%) respondents had no postgraduate qualification.

Rather more than a quarter of the respondents were engaged in teaching and many had an interest in research, much of this being related to a current Northern regional study on the way in which general practitioners care for

TABLE V—Availability of immunisation programmes for children offered by the 51 practices surveyed

Area	Immunisation offered within consultation					Immunisation offered as separate sessions				
	No (%) of practices offering service	No (%) of practices with service provided predominantly by:				No (%) of practices offering service	No (%) of practices with service provided predominantly by:			
		General practitioner	Health visitor	Nurse	Midwife		General practitioner	Health visitor	Nurse	Midwife
Berwick/Alnwick	10 (83)	10 (83)	2 (17)	4 (33)	0	9 (75)	7 (58)	6 (50)	3 (25)	1 (8)
Castle Morpeth	6 (86)	6 (86)	2 (29)	2 (29)	0	6 (86)	6 (86)	5 (71)	2 (29)	0
Wansbeck	8 (80)	7 (70)	4 (40)	3 (30)	0	9 (90)	9 (90)	9 (90)	3 (30)	1 (10)
Blyth Valley	9 (90)	8 (80)	6 (60)	1 (10)	1 (10)	10 (100)	9 (90)	9 (90)	4 (40)	2 (20)
Tynedale	10 (83)	10 (83)	3 (25)	2 (17)	0	9 (75)	8 (67)	8 (67)	2 (17)	2 (17)
Northumberland	43 (84)	41 (80)	17 (33)	12 (24)	1 (2)	43 (84)	39 (76)	37 (73)	14 (27)	6 (12)

TABLE VI—Analysis of well baby care offered by the 51 practices surveyed

Area	Child health surveillance offered within consultation						Child health surveillance offered as separate sessions					
	No (%) of practices offering service	No (%) of practices with service provided predominantly by:					No (%) of practices offering service	No (%) of practices with service provided predominantly by:				
		General practitioner	Health visitor	Nurse	Midwife	Other doctors		General practitioner	Health visitor	Nurse	Midwife	Other doctors
Berwick/Alnwick	6 (50)	6 (50)	3 (25)	1 (8)	0	2 (17)	10 (83)	6 (50)	7 (58)	2 (17)	1 (8)	1 (8)
Castle Morpeth	4 (57)	4 (57)	3 (43)	0	0	0	5 (71)	5 (71)	5 (71)	0	0	0
Wansbeck	8 (80)	7 (70)	5 (50)	1 (10)	1 (10)	0	7 (70)	6 (60)	7 (70)	1 (10)	0	1 (10)
Blyth Valley	5 (50)	5 (50)	3 (30)	1 (10)	1 (10)	0	6 (60)	6 (60)	6 (60)	3 (30)	2 (20)	1 (10)
Tynedale	4 (33)	3 (25)	2 (17)	0	0	0	8 (67)	8 (67)	8 (67)	2 (17)	0	1 (8)
Northumberland	27 (53)	25 (49)	16 (31)	3 (6)	2 (4)	2 (4)	36 (71)	31 (61)	33 (65)	8 (16)	3 (6)	4 (8)

TABLE VII—Availability of family planning services offered by the 51 practices surveyed

Area	Family planning offered within consultation					Family planning offered as separate sessions				
	No (%) of practices offering service	No (%) of practices with service provided predominantly by:				No (%) of practices offering service	No (%) of practices with service provided predominantly by:			
		General practitioner	Health visitor	Nurse	Midwife		General practitioner	Health visitor	Nurse	Midwife
Berwick/Alnwick	12 (100)	12 (100)	0	5 (42)	0	2 (17)	2 (17)	0	1 (8)	1 (8)
Castle Morpeth	7 (100)	7 (100)	0	4 (57)	0	3 (43)	3 (43)	0	2 (29)	0
Wansbeck	10 (100)	10 (100)	4 (40)	3 (30)	0	5 (50)	2 (20)	0	4 (40)	0
Blyth Valley	10 (100)	10 (100)	2 (20)	3 (30)	1 (10)	4 (40)	2 (20)	1 (10)	4 (40)	1 (10)
Tynedale	12 (100)	12 (100)	0	7 (58)	0	4 (33)	3 (25)	1 (8)	3 (25)	0
Northumberland	51 (100)	51 (100)	6 (12)	22 (43)	1 (2)	18 (35)	12 (24)	2 (4)	14 (27)	2 (4)

children.² Hospital appointments were held by 65 (42%) of the respondents, mainly in the rural community hospitals in Berwick and Alnwick, Tynedale, and Castle Morpeth.

Additionally a wide variety of professional appointments were held outside the general practices. Well baby clinics formed a substantial proportion of these (60 (39%) respondents) together with a range of other activities ranging from teaching (both graduate and undergraduate) through police authority and Department of Health and Social Security appointments to industrial medicine. A total of 123 (80%) of the doctors reported at least one professional commitment outside the practice. A further 38 (25%) served on professional committees, which, owing to the distances in Northumberland, required at least a half day commitment.

All the 51 practices offered antenatal care, children's primary immunisation programmes, and family planning services, 39 (76%) having a functional age-sex register. When offering antenatal care (table IV) the health professionals most concerned were the general practitioner, the midwife, and the health visitor, the last two being more likely to be concerned in practices offering special sessions. Practices that did not offer special sessions were more likely to be single handed or rural, or both, a feature of all the clinical services studied. Fairly commonly, antenatal care was provided both in special sessions and during the consultation; practices offering both would expect to deal with most patients during the special sessions.

Immunisation programmes for children were available in every practice, and most offered the service both during the consultation and as a special session (table V). In most cases the general practitioner and health visitor provided the service, though in larger practices nurses played a substantial part.

Well baby care was offered in 42 (82%) of the practices, clinical medical officers providing the service in the others. More routine well child care was provided in the special sessions than during the consultations. A proportion of the clinics were conducted by the health visitor only (table VI).

Family planning services were offered by all practices (37 (73%) also offering fitting of intrauterine contraceptive devices) and a clear preference indicated for providing care during the consultation as opposed to special sessions (table VII). Health visitors seemed to have an important role in family planning in Blyth and Wansbeck, possibly reflecting the needs of a greater number of disadvantaged families in these two urban areas.³

At the time of the survey cervical cytology screening was offered by all but one practice in Northumberland with a high proportion providing the service both during the consultation and as a separate session. A broad range of other planned care was reported in addition to the more widely accepted preventive services, so that more than a fifth of practices were offering special clinics for blood pressure screening, diabetic care, weight control, and marriage guidance.

Discussion

This survey of 51 practices in Northumberland found extensive provision of anticipatory care, much of it being undertaken as a team approach and offered either during a consultation or in a special session. In some practices, particularly the larger ones, the two delivery systems existed together. We do not suggest that care

during a special session necessarily represents better care; rather it is a different way of offering a service. Special sessions may have advantages—"minispecialisations," participation by other health care professionals, administrative convenience, maintenance of skills, and the possibility that the discipline of a "clinic session" leads to better adherence to clinical protocols. On the other hand, the disadvantages of such sessions are lack of flexibility of timing, inefficient use of time if only a few patients are catered for, the difficulty some rural patients have in getting to sessions during the day, lack of confidentiality, and loss of skills in doctors not included in providing the special sessions, perhaps with some loss of continuity.

It may be reasonable to assume that when special sessions are offered most practices would expect to deal with most patients at that time, though we cannot confirm this. The data clearly indicate that practices least likely to offer special sessions are rural or single handed, or both. Possibly in those practices special sessions may be of less value to both patient and doctor, as it may be more efficient to offer the service during the consultation.

In national terms Northumberland may be unique in having such a large number of general practitioners providing well baby care. Many practitioners undertake sessions on behalf of the district health authority, serving as clinical medical officers. In consequence the care of the preschool child is entirely by the practice, thus ensuring good continuity of care, a unified records system, improved access (particularly in rural areas), and a considerable reduction in the possibility of contradictory advice by maintaining close links with health authority staff. The more rural practices also often serve as a point of coordination for many other services which are not specifically medical and which include voluntary organisations. Traditional boundaries have thus disappeared in providing a comprehensive service. Indeed, by virtue of the distance from hospital accident departments and their commitment to attend road accidents in many parts of the county rural practitioners also provide valuable emergency services.

This survey has laid the groundwork for further studies of care by

the local medical committee. Townsend and colleagues have recently identified several areas of considerable deprivation in Northumberland, concluding that poor health in those areas is associated with poor socioeconomic conditions.³ Our findings suggest that these areas are supported by good primary health care offering a wide variety of services.

Now that results have been disseminated to county doctors plans are already in train to collect data on both the process and outcome of primary care. Strategic planning by local medical committees is a new role,⁴ which will fit uncomfortably in the initial period. Data collection consumes considerable money and effort, but we believe that costs are greatly outweighed by our new found ability to describe general practice.

We thank our research assistant Jane Smyth, without whose excellent work this report could never have been completed. Officers of the family practitioner committee and district health authority provided valuable advice, and we thank them for their generous offers of help. In addition to local medical committee funds, resource was provided in the form of computing and analysis time by the University of Newcastle's health care research unit using funds from the DHSS, to whom we are very grateful. Finally, we thank all our general practitioner colleagues in Northumberland, in particular Scott Urquhart and Alan Dove, comembers of the review group.

References

- 1 Royal College of General Practitioners. *Health and prevention in primary care*. London: RCGP, 1981. (Reports from General Practice, No 18.)
- 2 Irvine D, Russell I, Hutchinson A, et al. Performance review in general practice: educational developments and evaluative research in the Northern region. In: Pendelton DA, Schofield TPC, Marinker ML, eds. *In pursuit of quality*. London: RCGP, 1986:146-67.
- 3 Townsend P, Phillimore P, Beattie A. *Inequalities in health in the Northern region*. Newcastle upon Tyne: Northern Regional Health Authority, 1986.
- 4 Brown AM, Jachuck SJ, Walters F, van Zwanenberg TD. The future of general practice in Newcastle upon Tyne. *Lancet* 1986;ii:370-1.

(Accepted 3 September 1987)

ONE HUNDRED YEARS AGO

The annual meeting of the "subscribers, donors, governors, and friends" of this hospital recently held, was naturally the scene of lively discussion. As not infrequently happens in heterogeneous assemblies, animated by various sentiments, and imperfectly informed as to the subject-matters, the decisions arrived at were the outcome of passion rather than of reason. Nothing could be in better or more judicial spirit than the opening speech of the chairman, Mr. T. A. Bushby. Having traced briefly the history of the late proceedings in connection with the operations performed by Dr. Imlach, he emphasised the difficulty that must embarrass a tribunal chosen by accident more than for any special competency, in its endeavour to adjudicate upon a controversial question of science and practice. He quoted the following passage from the remarks made in the JOURNAL of January 18th: "The governors cannot be expected to pass a definite and conclusive judgment upon an operation new to surgical science, not yet adequately known even to the medical profession, and one which has not emerged from the storm of opposition let loose by ignorance and prejudice, as well as by less blameable motives." And this question of science and practice seems at the present moment to be so intricately mixed up with personal considerations, that a decision free from objection can hardly be expected. A calm perusal of the report of the meeting leads to the conclusion that the question of science and practice has been overwhelmed, or kept out of sight by the personal considerations involved. The whole question may be stated briefly thus: Is the operation for removal of the uterine appendages justifiable? Has the action of Dr. Imlach in advocating and practising this operation been justifiable? The general answer from all sources, endorsed by the governors, to the first question, is in the affirmative. The answer of a majority of the governors to the second question is in the negative. That is to say, in their view it has been wrong for him to do that which is in itself right.

The Chairman showed to what extent personal feelings were mixed up in the affair in these words: "I might have unfolded . . . the curious private history (and guidance afforded to your committee) during the recent troubled times; I might have explained the incongruous personal relations of

the different members of the staff, and the consequent difficulties about consultations, and have shown that the committee were at no period prepared to have given either countenance or effect to the idea that the practice of the hospital was contrary to, or in advance of, the scientific opinion of the day."

It would have been well had the meeting acted in the wise spirit evinced in these words. On the question of re-electing the staff arising, first, Dr. Briggs, a new member, was elected unanimously; secondly, Dr. Burton, who had been on the staff since the formation of the hospital, and who was pointedly accused by Mr. S. B. Bacon of being "the originator" of the quarrels, was elected by 13 votes to 9; thirdly, when the case of Dr. Imlach's re-election came up, it was negatived by 17 to 16 votes. A poll was demanded; and (it seems hard to believe, but so it was) the matter was decided by proxy votes, as at a shareholders' meeting of a public company, and the numbers were—for Dr. Imlach, 137; against, 312. No comment is necessary upon such a mode of deciding a scientific or even a personal question. It settles nothing. It only proves the animus and activity of the canvass for proxies. As Mr. Malcolm Guthrie, the new Secretary and Treasurer, said, "The character of the meeting was ridiculous, because proxies had been sent out by some persons asking for the power to vote without having the speeches. It was like hanging Dr. Imlach first and trying him afterwards."

It will be a consolation to Dr. Imlach to know that condemnation inflicted in this way can have no possible weight with his professional brethren, or with the disinterested public. He is passing through a storm of obloquy, raised artificially by persons not in a position to judge either him or the surgical operation with which his name is honourably associated. He will, we doubt not, before long find this proxy-judgment reversed by a more competent tribunal, and be reinstated in a position in which he will find opportunity for ample vindication of his personal character, and for the advancement of science, in the cause of which he has suffered so much and so unjustly. (*British Medical Journal* 1887;ii:339)