We thank the participants and the general practitioners and their staff.

Funding: AC and DG were supported by a grant from the Wellcome Trust.

Contributors: MK and GM had the original idea for the study, designed the study protocol, and obtained the grant funding. MK acted as principal investigator; he will act as guarantor for the paper. MK, AC, and GM designed the interview for programming. AC and MK recruited the general practices. AC and DG interviewed the participants. AC analysed the data under MK's supervision. All authors contributed to writing the paper.

Competing interests: None declared.

1 Anon. *Criminal statistics (England and Wales).* London: The Stationery Office, 1996.
2 Lees S. *Carnal knowledge. Rape on trial.* London: Hamish Hamilton, 1996.
3 Sorenson SB, Stein JA, Siegel JM, Golding JM, Burnham MA. The prevalence of adult sexual assault: the Los Angeles epidemiologic catchment area project. *Am J Epidemiol* 1987;126:1154-64.
4 Hickson FCI, Davies PM, Hunt AJ, Waetherburn P, McManus TJ, Coxon APM. Gay men as victims of nonconsensual sex. *Arch Sex Behav* 1994;23:281-94.
5 Millsten GM, Irwin CE. Acceptability of computer-acquired sexual histories in adolescent girls. *J Paediatr* 1983;103:815-9.
6 Turner CF, Ku L, Rogers SM, Lindberg LD, Pleck JH, Sonenstein FL. Adolescent sexual behaviour, drug use and violence: increased reporting with computer survey technology. *Science* 1998;280:867-73.
7 Kinsey AC, Pomeroy WB, Martin CE. *Sexual behaviour in the human male.* Philadelphia, PA: Saunders, 1948.
8 Mezey GC, King MB. *Male victims of sexual assault.* Oxford: Oxford University Press, 1992.
9 Hobson WF, Boland C, Jamieson D. Dangerous sexual offenders. *Med Aspects Hum Sex* 1985;19:104-19.
10 Cantwell HB. Child sexual abuse: very young perpetrators. *Child Abuse Neglect* 1988;12:579-82.
11 Finklehor D (1986) *A source book on child sexual abuse.* London: Sage; 1986.
12 Ewing JA. Detecting alcoholism: the CAGE questionnaire. *JAMA* 1984;252:1905-7.
13 Gardner MJ, Altman DG. *Statistics with confidence: confidence intervals and statistical guidelines.* London: BMJ Publishing, 1989.
14 Follette VM, Polusny MA, Bechtle AE, Naugle AE. Cumulative trauma: the impact of child sexual abuse, adult sexual assault and spouse abuse. *J Traum Stress* 1996;9:25-35.
15 Kendall-Tackett K, Williams LM, Finkelhor D. Impact of sexual abuse in children. *Psychol Bull* 1993;113:164-80.
16 Struckman-Johnson CJ, Struckman-Johnson D. Men pressured and forced into sexual experience. *Arch Sex Behav* 1994;23:93-114.
17 Mendel MP. *The male survivor.* London: Sage, 1995.
18 Messman TL, Long PJ. Child sexual abuse and its relationship to revictimisation in adult women: a review. *Clin Psychol Rev* 1996;16:397-420.
19 Wellings K, Field J, Johnson AM, Wadsworth J. *Sexual behaviour in Britain.* London: Penguin, 1994.
20 Bartholomew BN, Doll LS, Joy D, Douglas JM, Bolan G, Harrison JS, et al. Emotional, behavioural and HIV risks associated with sexual abuse among adult homosexual and bisexual men. *Child Abuse Negl* 1994;18:747-61.
21 Bolton FG, Morris LA, MacEachron AE. *Males at risk.* London: Sage, 1989.

(Accepted 10 December 1998)

Towards primary care groups

Joining up care in London—establishing the North Southwark Primary Care Group

J L Campbell, S Proctor

This is the second of four articles showing how primary care groups have been set up in various areas in Britain

Department of General Practice and Primary Care, Guy's, King's, and St Thomas's School of Medicine, London SE11 6SP

J L Campbell, *senior lecturer*

S R Proctor, *lecturer in health services research*

Correspondence to: Dr Campbell john.campbell@kcl.ac.uk

Series editor: Trish Groves

BMJ 1999;318:850–2

The shadow board of the North Southwark Primary Care Group brings together representatives from primary healthcare professionals, local social services, and the public from some of the most deprived inner city communities in the United Kingdom.[1]

The inner London borough of Southwark extends from the River Thames in the north to affluent Dulwich in the south (box). Regeneration of rundown public housing estates has brought with it dramatic changes in the socioeconomic profile in the wards of Bermondsey and Rotherhithe, and the regeneration of Peckham will result in the movement of more than 1000 council tenants over a five year period. The borough is the second most deprived in Britain and is more deprived than its neighbours, Lambeth and Greenwich. The borough is recognised by the government as both a health and education action zone. In addition to the five key areas in the government's Health of the Nation targets, the Southwark Health Charter identified sickle cell disease and diabetes as key health issues for Southwark's population.[1]

Summary points

North Southwark Primary Care Group was established against a backdrop of substantial local deprivation

A supportive health authority facilitated the process

Collaborative working arrangements underpin the ethos of the governing board

Clinical governance is seen as an important opportunity, to be implemented by encouragement rather than coercion

Integrated care crossing boundaries is the goal

History

Since 1990 the south London umbrella group of general practitioners and the local health authority have encouraged and supported the development of locality groups representing the views of local general practitioners across south London. By 1997 four such groups existed in Southwark. In North Southwark, general practitioners were reluctant to embrace fundholding (of 25 local practices, only one is involved in a multifund and none are practice fundholders) but came together to undertake joint working and to present a unified voice on local healthcare issues. The local health authority was astute in bringing together local nursing representatives and health managers as well as general practitioners at an early stage of locality development, when informal contacts suggested the broad approach to be outlined in the government

white paper.[2] The ensuing changes in government health policy (as opposed to any local recognition of problems in healthcare provision) are recognised as the principal driving force in the establishment of the local primary care group. The aims are to ensure a primary care service which is responsive to local health issues and to provide "joined up care," bringing together key players in local delivery of health services and social care.

Establishing the board

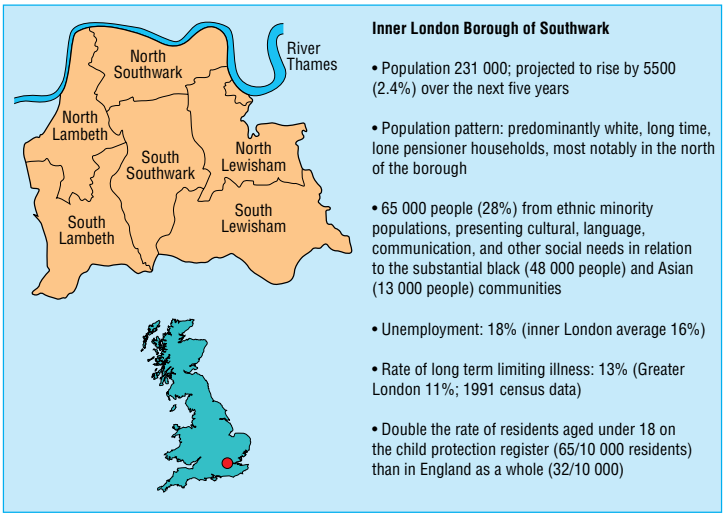
Initial responses to the white paper among local health professionals were mixed but generally optimistic. Though the seemingly endless series of health policy documents emanating from the government seemed to define clear aims but failed to provide clear associated mechanisms for achieving those aims, healthcare and social service professionals have generally welcomed the policy changes and accepted that they might benefit the local population.

Lambeth, Southwark, and Lewisham Health Authority was quick to establish a wide ranging local consultation exercise. This included canvassing views from locality groups of health professionals including general practitioners, from representatives of two local multifunds, and from the South London total purchasing project (six first wave fundholding practices, one of which was located in North Southwark). In all, responses were sought from more than 50 major local institutions covering health personnel, administration, academic organisations, trusts, and the ambulance service. Public opinion was obtained from a wide range of representatives of the local population, including the voluntary sector and ethnic minorities. Interest in the process was reflected in the considerable attendances at over 100 public and professional meetings which were held; responses were invited in four phases. Twenty two consultation points covered the main challenges presented in the establishment of primary care groups, including the level of operation to be managed by the group, the configuration of the group and its managing board, issues relating to geographical boundaries, local arrangements for clinical governance within groups, and involvement of local people in service planning.

Despite the efforts of the health authority, some people inevitably sensed a lack of involvement in the process—perhaps reflecting the complexity and size of the task undertaken. Consultation with lay people happened relatively late in the exercise. As Peta Caine, lay member of the board, explained: "As a lay member, I've come in towards the end of the consultation process. Because this is quite radical, I suspect they [the health authority] needed to get the people involved on a day to day basis on board before they involved other parties, which to me seems sensible. They probably had to go through that process before getting to a stage where they involved yet more variables into the pot." Responses obtained through the consultation process have informed local policy—for example, in defining the geographical boundaries of the six primary care groups in the area, and in the initial guidance sent to boards regarding the process for electing a chairperson.

The inaugural meeting of the shadow board took place at the social services headquarters and adopted the standing orders governing public meetings of the health authority. Around 50 people attended the meeting, which was chaired by a senior executive of the health authority who invited public comments at the discretion of the chairperson (an arrangement considered not completely satisfactory by at least one board member, who noted that such arrangements permit the public to attend but without rights of hearing).

The structure of the board (box 1) reflects the response of local general practitioners to guidance from the Department of Health permitting them a majority on the board. The general practitioners were elected using a "first past the post" system, in which each voting member had a single ballot paper with seven votes. A space on the board was reserved for representation by a general practitioner from a small practice (one or two doctors). Recommendations from



Characteristics of inner London borough of Southwark

Box 1: Board of North Southwark Primary Care Group

- 7 general practitioners (elected; 2 men, 5 women; no fundholders)
- 2 nurses (appointed; both local community nurse managers)
- 1 social services representative (Southwark Council's social services assistant director (children); appointed by director)
- 1 non-executive member of health authority (appointed by health authority)
- 1 lay member (appointed; local resident; executive of a London housing association)
- 1 chief executive (to be appointed)

Box 2: Election of general practitioners to boards

The local medical committee recommended that:

- There should be seven general practitioners on the board of each primary care group
- Every general practitioner principal and their equivalents in personal medical services (PMS) pilots should be entitled to stand for election and to vote
- Different types of practice should be represented
- There should be a geographical subdivision reflecting different " localities"
- The full board, when elected, should choose the chairperson

Box 3: Priorities for action

- Consolidation of collaborative working arrangements in a supportive culture
- Appointment of chief executive
- Allocation of roles, most notably the lead individual on clinical governance
- Agreement and implementation of primary care investment plan including issues relating to technology, practice staffing, and premises
- Implementation local health improvement programme

the local medical committee formed the basis of electing practitioners to the board (box 2).

Other board members arrived by different routes. The nursing members applied to the health authority in response to advertisements. Nurse members were not representative of a constituency—indeed, the nurse constituency needs to be defined, taking account of various working arrangements, locations, and organisational allegiances. Applications for lay membership of the board, stemming from advertisements placed in the national and local press, including the local ethnic minority press, were also managed by the health authority. The possibility of co-opting members has not yet been discussed, although several board members warned about the lack of pharmacy input.

The agenda, and potential barriers to progress

So that the board can work as a functional balanced unit rather than a potential battle ground for developing personal or professional interests, establishing its culture and ethos has been a priority. To this end, arrangements are in hand for facilitating communication between board members, establishing priorities, and allocating initial responsibilities. The process of agreeing management costs and targets was initiated soon after election of the board. The management budget for the first year of operation is £351 310 (based on an allocation of £3 per head of the North Southwark population), and accounting systems are being put in place. Other areas identified as priorities for action are defined in box 3.

Anne Chan (social services representative) and Peta Caine (lay representative) both expressed the hope that the board might take a broad definition of health, recognising the impact of housing, social support systems, and deprivation on health status. Specifically, the idea of reallocating prescribing savings in favour of specific health promotion activities found favour among some members of the board. Recent government publications that promote collaborative working between health and social services through pooling of health and social services budgets, establishment of lead commissioning authorities to transfer funds and delegate commissioning functioning, and integration of social care services[3 4] were welcomed and seen as contributing to the process of collaborative working between health and social services. Lambeth, Southwark, and Lewisham Health Authority has obtained lay input to health policy discussions through health panels of 12 people representing sections of the local population. Margaret Clayton, non-executive member of the health authority, feels that such an approach within the primary care group (possibly coordinated by the lay member of the board) might strengthen user input to board discussions.

Guy's and St Thomas's NHS Trust is a major provider of care to patients from North Southwark. Dianne Gunapala, clinical development manager, noted the importance of developing effective electronic communication links between trust and practices in North Southwark, perhaps through funding from the newly created NHS modernisation fund. Such a move would help achieve the government's aim of "seamless care"—for example, ensuring that hospital appointments can be made for patients while they are attending the surgery. Ms Gunapala suggests that acute trusts might help primary care groups to develop policies on clinical governance. "Some emerging boards have been interested to talk to us about our governance arrangements. Obviously there needs to be roughly the same type of arrangements [between local boards and trusts]. We're not offering advice, which might be seen as patronising, but offering support, not standing on high."

Clinical governance was consistently seen as an important issue; some saw this as a means by which the independent contractor status of general practitioners might be challenged. Stephen Langford, director of the New NHS programme at the health authority, identified the issue as "an opportunity—possibly the last opportunity—to have professionally led regulation of performance in the face of the danger of a more draconian centralist option." Hilary Lavender, GP board member, envisages that clinical governance will be implemented by encouraging local health professionals rather than by policing and coercion. Complaints against health professionals might be seen as "treasured opportunities," for example.

Some board members thought that their lack of fundholding experience could be an obstacle to their work, while others thought that the lack of previous commitment to a particular model of commissioning would be strength. The initial intention of individual members was that entry to the process would probably be at the lower end of the four potential levels of entry—probably in advising the health authority regarding commissioning of care, and taking some devolved responsibility for managing the local healthcare budget.

The future

As the group develops, board members will have to look at ways to integrate services and build effective links with the local authority's social services, housing, and education departments. The members of North Southwark primary care group board say that refashioning the local healthcare services to match the health needs of the local population represents opportunities, not threats, and coherence, not division.

We gratefully acknowledge the cooperation of Stephen Langford, Dianne Gunapala, Steven Curson, Tina Hickson, Peta Caine, Anne Chan, Jin Lim, Hilary Lavender, and Margaret Clayton.

1 Lambeth, Southwark, and Lewisham Health Authority. *Southwark health charter*. London: Lambeth Southwark and Lewisham Health Authority, 1993.
2 Department of Health. *The new NHS*. London: Stationery Office, 1997.
3 Department of Health. *Partnership in action (New opportunities for working between health and social services). A discussion document*. London: Stationery Office, 1998.
4 Department of Health. *Modernising health and social services. National priorities guidance 1999/00-2001/02*. London: Stationery Office, 1998.