

The Doctors' Tale: Professionalism and public trust

By Donald Irvine

Sir Donald discusses candidly the struggles in the profession and with successive governments over key issues. He provides perspectives that are both startling and enlightening, criticising the BMA for its past resistance to accept the need for change and explaining why its future role must be radically different.

He calls for specific fundamental changes to the NHS and for government to be separated from managing the provision of healthcare. And he outlines the qualities that the bodies regulating doctors in the future must have to succeed.

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Community Engagement

The government has announced continued funding – a total of £3.6 million over three years – for projects in its Community Engagement programme, following new research from the University of Central Lancashire in its report, *Community Engagement*. Commissioned by the DoH, the report looks at the needs for drug education, treatment and prevention among black and ethnic minorities.

Available from: The Centre Administrator, Centre for Ethnicity & Health, University of Lancashire, Preston PR1 2HE

Chief Executive's report to the NHS 2002/2003

"There is now real evidence that the planning and delivery of services takes account of the whole system of health and social care," said Nigel Crisp, NHS Chief Executive in his annual report. It summarises key activities during 2002/03 but a full statistical analysis will be published in the autumn.

Available at: www.doh.gov.uk

NHS Lift

The standard NHS LIFT documents have recently been updated and issued by Partnerships for Health.

Available at: www.doh.gov.uk

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Osteoporosis & the NSF for Older People

Charity helps DoH tackle targets on falls and fractures



Ian Philp

A variety of measures are being looked at by the government to help boost implementation of Standard 6 (preventing falls and reducing fractures) of the NSF for Older People, said Professor Ian Philp, National Director for Older People's Services prior to the launch of National Osteoporosis Awareness Month (June).

Progress on the NSF for Older People was 'as we expected' said, Professor Philp. 'Most Trusts have got their plans in place for the development of services by the 2005 milestone.'

However, he said he was having talks with other NSF national directors, Professor Ara Darzi (day surgery) and Professor George Alberti (emergency services) to see how they might work together on older people's services and he expected to be able to comment on their 'shared vision' before the summer. 'The key point is to use other drivers to get good integration of falls and osteoporosis services,' he said.

In addition, the charity, National Osteoporosis Society (NOS), which relaunched its Primary Care Strategy and Falls document for PCT's last year, is working with the 20 Falls Collaborative Sites, led by the National Primary Care Development Team. The sites are working to reduce falls and the impact of falls in the over 65 population, engaging multi-disciplinary teams - including both service users and front line clinicians. Prevention and management of osteoporosis is clearly a key factor in achieving the objectives of the Falls Collaborative, and the NOS are presenting and handing out literature at collaborative events.

Angela Jordan, the society's Health Service Liaison Manager, said: 'We've got lots of good examples of best practice that would enable PCTs to make a start. We have funded a number of pilot projects in PCTs to tackle osteoporosis across the UK which have given some simple examples that could easily be transferred to other PCTs.'

'We need PCTs to realise that they can make progress with small initiatives that don't necessarily need to cost a lot or entail an increase to their drug budgets.'

During Osteoporosis Awareness Month, the NOS is sending out 2,000 packs of leaflets and information to GP surgeries, hospital clinics and units, high street pharmacists, shops and fitness centres.

Ms Jordan expressed concern that osteoporosis may not feature as much as it should in PCT's integrated falls service. Osteoporosis currently costs the NHS £1.7 billion a year (£5 million a day), mainly to treat hip fractures.

She said: 'We need PCT's to make the connection that they do pay for the consequences of osteoporosis one way or another. If a patient breaks their hip, the cost will be far greater than if medication, which could prevent a fracture is prescribed at an earlier stage.'

For further information visit: www.nos.org.uk

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New initiative to aid PCT awareness and prioritisation of osteoporosis

A new osteoporosis service development group has recently been launched by Merck Sharp & Dohme Limited (MSD) to work directly with Primary Care Trusts in the prioritisation and identification of osteoporotic patients at high risk of fracture – those already with a history of fracture.

The PCT service team aims to complement a similar group working in secondary care identifying the need for a fracture discharge protocol for all patients admitted to hospital with a new fracture. It is estimated that a potential 1.3 million¹ patients with osteoporosis with a previous fracture remain in primary care, the large majority not receiving the benefit of standard guidance on management.

The goal of the osteoporosis service group is to support PCTs in the development of a

long-term osteoporosis strategy. The group however aims to provide more than just a clinical audit service.

Chris Boulton, MSD lead for the primary care initiative, said; 'The goal is to provide the necessary education and awareness of the disease area to PCTs endorsed by key osteoporosis thought leaders.'

'Obviously identifying high risk patients by clinical audit and the assessment of patients by a nurse are key components of the project; but we will be looking to aid the PCT in the long-term by providing training and support to key osteoporosis leads within the PCT to manage the project.'

For further information on the group or programme, contact the osteoporosis service helpline on **0800 106007**

¹. Data on File, Merck Sharp & Dohme Limited

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MSD

Mental health costs over £77 billion a year says new research



Matt Muijen

The cost of mental illness in England adds up twice as high as previously estimated, when quality of life is considered alongside the costs of care and lost work, according to a study published by the Sainsbury Centre for Mental Health (SCMH).

Matt Muijen, SCMH Chief Executive said the figures should help to put the importance of mental health in perspective.

'The cost of mental health is greater than both the NHS budget and the total cost of crime in England. Effective prevention, treatment, care and support represent good value for everyone's money,' he said.

Mental health problems placed a major burden on individuals and society, yet much of the burden was avoidable.

'PCTs should be enabled to commission mental health services more freely than they can today but to do this they will need excellent management and far better information about the needs of the people they serve,' he commented.

Health Minister Jacqui Smith said the inclusion of mental health, as one of the ten new sets of guidelines for GPs with Special Interests (published in April), was an important step in the reconfiguration and improvement of NHS mental health services.

Speaking at the Sainsbury Centre for Mental Health's annual primary care conference, Ms Smith said: 'More of the same isn't enough to deliver real improvements for people with mental health problems. Service redesign and strengthening local partnerships across traditional organisational boundaries is essential.'

She added: 'If more specialised services are to be provided in primary care, it is important

to assure their quality and to support and reward the staff appropriately who are providing them. That is why the development of GPs and Nurses with Special Interests is so important.

'What's different about this approach is that it unites the special interests of individual nurses and doctors with local and national priorities for service development. It's a "win-win" for staff and service users.'

The NHS Plan sets a target for 1,000 GPWSIs working by 2004 and there are already around 650. Dr Clare Gerada, south London GP and National Lead, Hurley Clinic, said the first tranche of GPWSIs would come from experienced GPs. Neither accreditation nor payment had yet been decided, and she thought they should be benchmarked by the BMA.

SCMH Primary Care Director and London GP, Dr Alan Cohen said: 'Many PCTs find it hard to make significant changes to mental health services, especially where mental health trusts are becoming too big for individual PCTs to influence their work.'

But opportunities were emerging. Personal medical services pilots and the proposed new GP contract offered greater flexibility for apportioning resources across the whole health system than the existing general medical services contract allowed.

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Editorial

New practical guidance to help nurses and GPs take on new roles to expand primary care services, improve access and reduce waiting times have been published by the DoH.

There are already GPs and nurses with special skills and interests, the guidance will build on this good practice. 'Did not attend' rates for special interest GPs are typically only between one and two per cent, reflecting the popularity of this approach with patients.

Both the RCGP and the RCN have welcomed the initiatives. But questions remain unanswered for GPs. How will their competencies be assessed and how will they be rewarded?

Prof David Haslam, Chair, RCGP, sounds a note of caution. 'As with GP Vocational Training, standards for GPs with Special Interests must be assessed and maintained, and doctors must be supported.'

However, if 'properly implemented,' the scheme will be of real benefit to the NHS, he says.

Jenny Sims, Editor

Asthma Charter

The National Asthma Campaign has launched a 10-point charter outlining the rights people with asthma should expect to receive from the NHS (www.asthma.org.uk). It says 74% of people with asthma in the UK face real restrictions on their quality of life when, with improved standards of care, they could be living virtually symptom free.

Star ratings unfair

Star ratings as PCT performance indicators are 'unfair and unreasonable' and a new system was needed, the NHS Alliance told Health Minister John Hutton at the recent 'Three at the Top' conference in London.

NHS Alliance Chief Executive Mike Sobanjan said: 'There is an urgent need to make sure that this year's star ratings are published with full details of the local context of each PCT. That is the only way to ensure public information is accurate and meaningful.'

'Talk to Frank' about drugs

A telephone helpline, Frank (0800 77 66 00) and website (www.talktofrank.com) have been launched as part of a new government campaign against drugs. They will offer advice, information and support to young people, parents and carers.

Top Ten advise on CHAI

Paul Streets, Chief Executive of Diabetes UK and Stephen Thornton, Chief Executive of The PPP Foundation are among ten shadow Commissioners who have been appointed to help establish the new Commission for Healthcare and Inspection (CHAI) which will be operational from April 2004.

Safety inquiry into antidepressants

Professor Alasdair Breckenbridge, Chair of the Medicines and Healthcare Products Regulatory Agency (MHRA), has welcomed the start of a new inquiry into the safety of widely prescribed antidepressant drugs, including Seroxat and Prozac and others of their class in response to growing public concerns.

Cancer equipment boost

The government has announced an extra £165 million to modernise cancer equipment over the next three years. The programme will replace all CT and MRI scanners over ten years old and all Linear Accelerators (Linacs) over 11 years old.

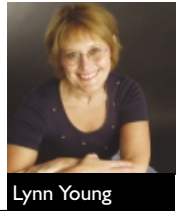
More eye operations

Strategic Health Authorities and local clinicians will be asked to develop flexible and imaginative plans with NHS and private providers to make best use of the extra £52 million for cataract operations announced by Health Secretary Alan Milburn.

Nurses with Special Interest in primary care

Launch of Framework for Nurses with Special Interests welcomed by RCN

Lynn Young, Primary Health Care Adviser, Royal College of Nursing, looks at how and why nurses should be helped to develop special interests.



Lynn Young

This framework has the potential to enhance primary healthcare capacity and improve patient care. Capacity is an issue within health care and we do not have the simple luxury of appointing yet more appropriately skilled and knowledgeable people. The task for all of us is to seek comfortable and patient centred ways of getting more effective services from the same number of staff.

Exhausted nurses do not nurse well, so we are challenged with enabling nurses to enhance their skills and knowledge, while improving their personal job satisfaction and patient care.

A year ago the Royal College of General Practitioners published the guidance¹ which has helped to develop a similar framework for nurses working in primary care. *Liberating the Talents*² celebrates the community generalist nurse while at the same time calls for nurses to build upon their existing skills and knowledge so they can become a local resource for a specialist domain, such as rheumatology, COPD and diabetes.

The development of special interests should, of course emerge as a result of identifying local health needs, capacity, enthusiasm and problems.

The proposed new pay system for all NHS employees (apart from doctors), *Agenda for Change* aims to provide a vehicle to develop their careers through a skills and knowledge framework and then be financially rewarded for doing so. Generalist nurses who have the energy to also have a special interest,³ in line, maybe with GP colleagues – and in the future AHPs too, should be in a strong position to argue their case for an increased band.

Without being aggressively prescriptive there are a number of principles attached to the role of nurses with a special interest. These include, working across a number of general practices, linking with different organisations – the acute and primary sectors and being a local

acknowledged expert for all to have access to. This development, along with the new 1st Contact Care Programme which is due to be launched by the NHS University this month (June) should help to enhance the capacity of a stretched workforce.

Primary Care Trusts have far too much to do but hopefully these nursing developments will prove to be irresistible to both nurses and managers. Adequate training and support is critical to success and nurses will need to feel confident that their organisation values their efforts and will reward accordingly!

In time we will all be happy to learn that the rise in the model of practitioner generalist with a special interest contributed to improved integration, better patient experiences, higher job satisfaction with the accompanying reduced levels of staff turn over and sickness and in short – the successful delivery of the NHS Plan.

Human and professional potential will need to be identified, along with the skills and knowledge required to do the job, plus the education and support essential for success. Workforce Development Confederations have to be involved, strong links made with universities and a scattering of generous mentors throughout healthcare will prove to be helpful.

References:

¹*Implementing a Scheme for General Practitioners with Special Interest*, DOH/RCGP April 2002
www.doh.gov.uk/pricare/gp-specialinterests/index.htm

²*Liberating the Talents*: Department of Health 2003

³*Department of Health Practitioners with Special Interests in Primary Care Implementing a Scheme for Nurses with Special Interests in Primary Care*

Mental health costs (continued)

Dr Cohen said: 'With foundation mental health trusts on the way, it is more important than ever that PCTs are given the clout they need to reshape mental health services to meet the needs of the communities they serve.'

He claimed the US experience should provide valuable lessons of what could be achieved and what could go wrong for patients through the commissioning process.

In a policy paper* launched at the conference, Dr Cohen and Donald Light argue that English PCTs could benefit from understanding the different ways American health maintenance organisations commission mental health services.

For example, the Group Health Cooperative in Washington produced increased efficiency and quality by commissioning all services, from GP consultations to specialist care, from a single budget. That enabled it to bring services closer to home and improve the support it offered to people with long-term problems.

**Commissioning Mental Health Services*, by Alan Cohen & Donald Light and *The Economic and Social Costs of Mental Illness* are available from the Sainsbury Centre for Mental Health on 020 7827 8352 or at www.scmh.org.uk.

Half way there and closing the gap meeting CHD targets

Simon de Lusignan describes how an audit-based educational intervention can help busy primary care professionals close the management gap in heart disease.



Simon de Lusignan

The Primary Care Data Quality (PCDQ) programme is a computer-based educational intervention designed to raise data quality and the standard of clinical care in target disease areas¹.

Its first and largest programme, the heart disease programme, has been running since 1998 and now been rolled out to over 25 localities. Its aim is to provide audit-based education resulting in an improvement in data quality and a rise in the standards of care. Learning opportunities are created around clinicians' own data and they are given the opportunity to see how this compares with the rest of their locality.

The size of the programme means that it has been able to produce the largest published audit of cholesterol management in the UK². This illustrates the enormous progress made in the management of patients with coronary heart disease in the UK and the rise in the quality of computerised medical records. However, although great strides have been made, there is still a considerable gap to be closed in the management of patients with coronary artery disease.

The National Service Framework for Coronary Heart Disease (CHD NSF) was the first NSF produced³. It set goals for treatment and dates by which they should be achieved, on a national scale in a way that had never been done before in the UK. Though the goals are very similar to consensus expert opinion - the Joint British guidelines recommending cholesterol-lowering therapy is initiated for patients with a total cholesterol measurement above 5.0 mmol/l⁴ - the timescales set to achieve these goals was arbitrary. This is not surprising considering this approach was being taken for the first time.

Programme Method

A locality wishing to join is invited to an introductory meeting to find out about the programme and to see how it had operated in other areas. The practices all have to individually sign a data agreement prior to participating in the programme. Most now also sign an additional agreement that the pooled

anonymised data can also be shared with their Primary Care Organisation's (PCO) clinical governance team.

The data is collected via a computer programme which extracts information from patient computer records that are held in GP surgeries, called MIQUEST (Morbidity Information and Export Syntax.) MIQUEST is a piece of Department of Health sponsored software that allows the same search to be made of different GP systems (eg, EMIS, Torex, IPS, etc) and for the extracted data to be aggregated.

The PCDQ heart programme feeds back a broad range of information: about prevalence of CHD, blood pressure recording and control, the use of aspirin as well as life style advice, heart failure, atrial fibrillation and use of b-blockers.

This article however, provides an overview of the results presented in our British Journal of Cardiology paper² about cholesterol and the gap in its management.

The dataset represents nearly 2.5 million registered patients across the practices who are part of the programme. Just under 90,000 of these patients had a computer diagnosis of CHD. Remarkably, the 'rule of halves' then takes over: Around half of these patients (48%) are recorded as having a cholesterol recording, and about half of them are receiving a statin of whom about half still have a cholesterol over 5 mmol.

The PCDQ heart programme shows that although there has been considerable progress in managing patients with heart disease. This is a 'glass is half-full' story, not a 'glass is half empty.' Having been to well-attended meetings in both the north and south of the country, there is considerable enthusiasm among professional colleagues to address the quality agenda.

Previous audit and trial evidence suggests that only one-third of eligible patients (including secondary prevention patients or those who have established cardiovascular disease) receive lipid-lowering therapy and that many treated patients fail to achieve target low-density

lipoprotein cholesterol (LDL-C) levels⁵. Further evidence that progress is being made

The limitations of this study are that it only looks at the data on the practice computer system. Many patients will have risk factor data recorded in written records GP records (especially any that remain without GP-lab-links) and in hospital letters and computer systems. Patients who are having their dose of statins titrated, may have had their initial raised reading and now be on an increased dose and be awaiting retesting. However, the recording of statin prescriptions on the computer is likely to be a more accurate reflection of reality.

Further research into which implementation strategies are most appropriate for UK primary care needs to be conducted, so that an evidence base can emerge about what is the most effective way to translate evidence into practice. What is known suggests a complex intervention offering a range of learning opportunities to match different learning styles is more likely to be effective⁵. This is the approach adopted within the PCDQ programme.

As a 'snapshot' of cholesterol management in patients with coronary heart disease in UK primary care, it shows we are halfway there.

Simon de Lusignan is Senior Lecturer, Primary Care Informatics, Department of Community Health Sciences, St George's Hospital Medical School, London.

More information at:
www.gpinformatics.org or www.pcdq.org

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¹de Lusignan S, Hague NJ. The PCDQ (Primary Care Data Quality) Programme. *Bandolier/Impact*. January 2001. URL: <http://www.jr2.ox.ac.uk/Bandolier/booth/mgmt/PCDQ.html>

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⁴British Cardiac Society, British Hyperlipidaemia Association, British Hypertension Society. Joint British recommendation on prevention of coronary heart disease in clinical practice. *Heart* 1998; 80 (Suppl 2): S1-S29

⁵Davis D. Clinical practice guidelines and the translation of knowledge: the science of continuing medical education. *CMAJ*. 2000; 163(10):1278-9.

PCDQ study confirms heart Tzar's findings

The findings of the study echo those voiced in a Primary Care Partnerships' CHD supplement in February by UK Heart Tzar, Dr Roger Boyle, who said: 'There is still work to be done in identifying all patients suitable for statin therapy particularly older patients following the Heart Protection Study and those at risk of CHD

'There is evidence too that about half of all patients receiving statins are not achieving target levels (total cholesterol less than 5mmol/l).'

Dr John Pittard, GP in Staines and member of the NSF for CHD Implementation Task Force, said: 'The findings of PCDQ study do

not surprise me.'

Commenting on the recent launch of a new class of medicine for the treatment of high cholesterol, a cholesterol absorption inhibitor (CAI) which can be co-administered with any statin at any dose, Dr Pittard said: 'This significant advance in cholesterol management offers an innovative approach to help reduce patient's risk of CHD-related illness in the UK. It is likely that in the near future treatment goals for cholesterol will become even lower than current guidance recommends.'

However, he said greater awareness among the general public of the link between CHD and heart disease was still needed.

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