

Primary Care Partnerships

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Relations need improving between StHAs and PCTs says major report

Some Strategic Health Authorities and PCTs still lack understanding about each other's roles according to a major review of their relationships carried out by the NHS Alliance, DoH and Prime Minister's Office of Public Services Reform.



Mike Sobanja

StHAs do not have a clear grasp of the breadth of PCTs' new responsibilities, particularly their management of primary care providers such as dentists and optometrists or the role of the PEC with the PCT, according to PCTs.

This was attributed to the lack of primary care experience among StHA staff and the lack of opportunities for clinical engagement between the StHA and PCT.

PCTs also expressed concern that the performance management role of StHAs was dominating the relationship.

This concern and confusion is hindering development of services says the report* published this month by the NHS Alliance, which found that responsibility for NHS-wide targets is interpreted differently by StHAs and PCTs.

The report makes a raft of recommendations for action to improve relations, communications and performance. However, it points out, many of the recommendations require 'adult to adult' relationships that are 'consistent, realistic and driven by a mutual desire to improve health services for patients.'

'Relationships of this type grow with time and trust,' it says. Meanwhile, good performance should be rewarded by autonomy and poor performance tackled.

Devolving power, resources and responsibility to front-line staff (as set out in *Shifting the Balance of Power*) requires a fundamental re-think of relationships between public service organisations, it says.

Yet the review finds that while relationships were developing productively overall, it was often 'without focus on enabling frontline staff' or 'developing services around the needs of the patient.'

Based on the views of health care professionals, senior managers and non-executive directors throughout England, it included semi-structured interviews with Chief Executive Officers of 8 StHAs and 15 PCTs and an Expert Panel with clinical, managerial and non-executive representation from PCTs and StHAs.

It comments that though interactions between StHA and PCT chairs were developing well, engagement with PEC chairs and lay chairs was less well developed.

It says: 'The full breadth and nature of new roles in both PCTs and StHA's functions is not always fully understood.'

To improve relations and performance, it calls for a better understanding of the 'rules of the game' in the local health economy and a 'no shocks' policy to breed greater transparency.

It makes five key recommendations for StHAs and PCTs as possible levers for change and improvement in the development of their relationships.

- Multi-lateral agreement between StHAs, PCTs, Acute Trusts and other service providers within the health system on expectations of performance and associated behaviours

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Editorial

Few PCTs or StHAs in England will be surprised that the NHS Alliance survey reveals relationships between them leave a lot to be desired. If not through personal experience, they will have heard on the grapevine that some PCTs feel they are not getting the support they need from StHAs. Indeed, there have even been rumours of positive obstruction. Both organisations have their grievances.

Now, however, is the chance to stop the slide if all concerned heed the common sense advice of the report. Poor communications appear to have been at the heart of many of the misunderstandings and unless that is tackled urgently, neither relations nor performance will see much improvement.

NatPaCT since its inception has been committed to communication and education. Recently they have been talking to American healthcare organisations to see what can be learned and passed on to help PCTs develop commissioning. See Andrew Donald's article on page three.

As a certain telephone company keeps telling us, 'It's good to talk!' But PCTs and StHAs also need to act.

Jenny Sims, Editor

HPA strategy

Reducing the impact of infectious diseases will be one of the key objectives of the new Health Protection Agency. The agency, set up on 1 April, has published a five-year plan describing its strategic goals. Available at www.hpa.org.uk

Patient choice

The government has launched a national consultation exercise ending November to ask patients, user groups, NHS and social care staff what they want in terms of choice, involvement and flexibility in their care and treatment. Harry Cayton, Chief Executive of the Alzheimer's Society and part-time Director of Patients and the Public is leading the work which will shape government policy.

NHS Alliance conference

The NHS Alliance's 6th Annual Conference, *Engage & Deliver - delivering the vision by engaging the professionals and the public*, will be held 9-10 October, Bournemouth International Conference Centre. Speakers include John Reid, Nigel Crisp and all those relevant to work in PCTs and Primary Care in the largest annual event of the PCT calendar. Details from Health Links on 0121 248 3399, fax 0121 248 3390 or email yhunter@health-links.fsnet.co.uk

Flexible working for doctors

A new DoH campaign has been launched to encourage GPs, consultants and hospitals doctors to continue working with or to return to work in the NHS in England. The three month publicity campaign will feature real case studies of doctors successfully combining careers and lives outside work and highlight different ways of working including the Flexible Careers Scheme (FCS). There is a £6,000 payment for GPs joining the FCS. The response line number is 0845 60 60 345.

Health informatics

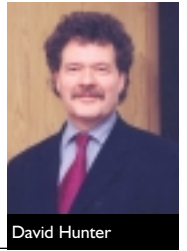
The NHS Information Authority has launched an interactive website for healthcare IT enthusiasts to voice their opinions and access latest news. www.informatics.nhs.uk is also the National Electronic Library for Health's newly revamped specialist library in health informatics. Users can enter polls and surveys on key informatics issues and can also set up their own special interest group.

Yellow card review

The Medicines and Healthcare products Regulatory Agency has said stakeholders will be asked to participate in its review of the 'yellow card' system of reporting adverse drug reactions. The announcement has been welcomed by the Association of the British Pharmaceutical Industry.

Improving the public's health**Putting health before health care**

David Hunter, Professor of Health Policy and Management at the University of Durham, looks at the rhetoric and reality of recent government steps to improve the public's health.



David Hunter

In the face of evidence that health inequalities are widening and the state of people's health deteriorating through rising obesity and lack of exercise, two new initiatives are the latest attempt by the government to demonstrate its commitment to improving the public's health.

In July, the Department of Health published a programme for action to tackle health inequalities and help meet the national target for 2010 which aims to reduce inequalities in health by at least 10 per cent as measured by infant mortality and life expectancy at birth. The programme concedes how stubborn, persistent and difficult to change health inequalities are. It also stresses the importance of integrating health inequalities into the mainstream of service delivery and acknowledges the need for greater diversity in order to meet varying local needs.

The programme is ambitious and spans all government departments, regional and local bodies. Within the NHS, PCTs have the lead role locally in making progress on health inequalities in partnership with others. The programme calls on them to work with hospital trusts across care pathways to improve access to people from disadvantaged communities. Strategic Health Authorities will be required to show that tackling health inequalities is an NHS priority.

How can more fine words actually be made to bite, halt widening inequalities and narrow the health gap? The second announcement may be important here. Hard on the heels of his report last year on the future long-term funding needs of the NHS, former banker Derek Wanless has been invited to review progress in implementing the 'fully engaged' scenario. The scenario is based on several heroic assumptions,

including by 2023 high levels of public engagement with their health, life expectancy increases beyond current forecasts and a dramatically improved health status.

The government signed up to the 'fully engaged' scenario because it estimated a possible saving to the NHS of £30 billion over the worst case 'slow uptake' scenario. Wanless will report by February to the Prime Minister, the Chancellor and Health Secretary.

The review will consider how to implement cost-effective approaches to improving health as well as reducing health inequalities. It will be wide-ranging and embrace both national and local arms of government and related agencies. Wanless is keen to look at delivery mechanisms for public health and the decision-making structures for producing and implementing plans to improve health and tackle health inequalities. He will wish to satisfy himself that these are 'fit for purpose' and that the resources available are sufficient in terms of capacity and capability.

Wanless has become an unexpected advocate of 'upstream' preventive interventions and is critical of the 'downstream' preoccupation with acute health care services. He can be expected to be as robust in his latest analysis. He will need to be. Nearly a year ago, former Health Secretary Alan Milburn in a speech to the Faculty of Public Health Medicine, proclaimed that a better balance between prevention and treatment was needed. He called for a 'sea change in attitudes'. It hasn't happened yet. Maybe the programme for action combined with Wanless's searching look at whether the present arrangements can deliver will finally trigger it.

Diabetes testing service

A Type II Diabetes Early Identification Testing Service by community pharmacists is to be rolled out nationwide following the success of three city pilots in Glasgow, Cardiff and Bradford.

In the UK 1.5 million people have been diagnosed with Diabetes, 90% with Type II but it is estimated that because of its slow onset and poor patient knowledge of risk factors, another 1 million people could have the condition but be unaware of it.

A survey commissioned by Lloydspharmacy found that 41% of people questioned did not know the risk factors for diabetes and that many people got their information from either family and friends (22%) or newspapers and books (24%).

Following the survey the company launched a patient awareness campaign and a free testing service through patient information leaflets and the media.

Pharmacists and trained healthcare assistants gave random blood glucose tests to around 5,000 people in community pharmacies: 15.5% were invited back for a fasting glucose test and 6.9% were afterwards referred to their GP.

Andy Murdock, the company's Pharmacy Director and Superintendent Pharmacist said: 'Some community pharmacists offer screening and monitoring already but the full potential of community pharmacists currently remains under-utilised. Pharmacist-led testing services can be effective in helping PCTs achieve their Diabetes NSF targets.'

What are we learning from others?

Andrew Donald, Director of Operations at the National Primary and Care Trust Development Programme (NatPaCT), describes how PCTs can be helped and supported in developing commissioning skills – including learning from others.



Andrew Donald

NatPaCT is striving to support the development of commissioning in the National Health Service into a robust, balanced and connected process which links Primary Care Trusts (PCTs) commissioning intentions with their contracting requirements whilst being underpinned by service redesign.

With PCTs and others, NatPaCT has embarked on the introduction of a learning and development programme which provides PCTs with the opportunity to develop their commissioning function and enable them to deliver key NHS policies such as Payment by Results, Patient Choice and new initiatives which include the introduction of Diagnosis and Treatment Centres and Foundation Trusts.

To deliver these areas of work PCTs need to be supported in being able to access development opportunities that are relevant and create different thinking whilst increasing their capacity to deliver.

One of these opportunities is to learn from the experience of others who commission. NatPaCT with the Department of Health and a number of PCTs is working with two US healthcare organisations (Kaiser Permanente and United Health Group). Both organisations undertake commissioning for large populations.

Early work has focused on how these organisations commission healthcare. These arrangements are being compared with the present NHS system of commissioning. This learning will be disseminated to all PCTs.

What have we learned so far?

- Kaiser Permanente and United Health Group are very different organisations, ie, one organisation is not for profit whilst the other is for profit. However, they have the same philosophy about patients - they are at the centre of their work and they commission for those patients
- Real commissioning does occur but the levers are with the commissioners not the providers
- Both organisations commission the givers (ie, the clinicians) of care not the facilities. In many respects this is a fundamental difference when compared to the NHS where we tend to commission organisations. Clinicians are at the heart of the process
- Commissioning is undertaken through the use of pathways, protocols and evidence with the commissioners concentrating on areas of disease and illness where their commissioning differently can make an impact on patients and the quality of their lives
- Commissioning for chronic disease is seen as being more important than commissioning for acute interventions. Clearly this is related to the impact on the cost of the acute part of an individual's care

if patients with chronic disease are effectively managed in the community

The above present interesting challenges for the NHS in relation to models of commissioning. It maybe that without changing organisational structures, the way commissioning is undertaken in the NHS could be changed.

There are many options and models. However there are three models that seem to be of interest to PCTs and their partners:

- 1 Commissioning clinicians directly (both primary and secondary care) with separate commissioning of facilities to support the clinicians
- 2 The delivery of commissioning through the introduction of expert provision provided for/on behalf PCTs
- 3 The further development of commissioning through clinical networks

Each of these options poses challenges for current NHS organisations. However, they all start to address the fundamental issue of redressing the balance between the commissioners and providers. If there is a shift in the balance of power in this relationship then real commissioning will occur, services will be redesigned and patients will be at the centre of commissioning decision making.

Managing delayed discharges

Strong partnerships are crucial to success

Blackburn with Darwen Council is rated as the best authority in the North West for achieving timely discharges. Stephen Sloss, the council's Director of Social Services, looks at whether their experience is the result of good luck or good management. He concludes that the strong partnerships built up between the council and the local health trusts enable good management and are crucial to the delivery of an effective service.

When it comes to delayed discharge, we are lucky in Blackburn with Darwen. There is adequate capacity in the care market locally. The incentive to sell up is nowhere near as pressing as in other regions. Relatively low property prices mean keeping care homes open is still an attractive option. Meanwhile, low staff turnover in the relevant teams across all partners means that delivery is by experienced staff. They have, with well-developed working relationships, been able to work around any problems that occur.

We could squander the advantages this gives us but there is good management across the system, backed by a commitment to partnership. Social Services has invested in Social Care to maintain stable capacity in the residential and domiciliary care markets. There is high-level commitment to funding packages of

care, without the self-imposed caps of other authorities. A strategic decision to place dedicated care managers in the hospital has facilitated early response to discharges. Assessments are provided by multi-professional teams where all partners work together to deliver an efficient high quality process. This is reinforced by the co-location of our Emergency Duty Team with NHS Direct and the GP Out of Hours Service. We can effectively manage crisis response, prevent inappropriate admission and effect timely discharge if people are admitted. This is all underpinned by clear management systems with clear eligibility criteria. These are applied by staff competently and with confidence.

There is effective partnership in intermediate care as well. With the two East Lancashire Primary Care Trusts and the Hospitals Trust we have developed a joint Intermediate Care Strategy. Together we provide a range of intermediate care services including step-up and step-down beds, emergency domiciliary care, intermediate residential care and rehabilitation.

Working together has helped us all to develop a shared understanding of the whole system. We are more aware of how the actions of one organisation affect the others and of the problems that can cause delayed discharges.

Continuing our partnership approach, we are

working together to meet the challenge of the new Community Care (Delayed Discharges) Act. A multi-agency group has worked on the policies, procedures and guidance for staff necessary to implement the act. We have developed joint protocols that allocate responsibility in a fair and equitable way. They will also help prevent disputes from arising or escalating. These should be approved before autumn and will then underpin our current performance and allow us to improve.

Good luck is nothing without good management and good management could not exist without good partnership working. The commitment to partnership displayed by Blackburn with Darwen Borough Council and by our partners in the health and care sectors has ensured and will continue to ensure success.



Stephen Sloss

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A Vision for Pharmacy in the New NHS DoH report

This framework for a new community pharmacy contract follows on from the DoH programme for pharmacy services, based on NHS Plan principles, published in 2000. It highlights successes since then and makes proposals for building on the achievements. Rosie Winterton, Health Minister, says in the foreword: 'We are committed to ensuring that pharmacy is an integral part of an NHS that provides high quality services, access and choice for all patients wherever they live and are treated.'

Available at: www.doh.gov.uk/pharmacyvision

Payment by Results Consultation: Preparing for 2005 DoH report

The document identifies the key decisions needed for implementing the next stage of payment by results. It outlines how these will apply to NHS Foundation Trusts from April 2004 and to all NHS Trusts from April 2005. Questions are primarily aimed at NHS Trusts, PCTs and StHAs. The deadline for responses is 31 October and can be emailed to:

financial-flow@doh.gsi.gov.uk

The consultation document is available at: www.doh.gov.uk

Chronic Heart Failure: management of chronic heart failure in adults in primary and secondary care

Royal College of Physicians report

Commissioned by the National Institute of Clinical Excellence (NICE), new evidence-based guidelines to improve the care of patients with heart failure have been published by the RCP. They cover primary and secondary care and the interface between the two, including in what circumstances patients should be referred to or admitted to hospital. They aim to promote co-ordination and sharing of the management plan for individual patients between different professionals and sectors of care and with the patient.

Short version available at www.nice.org.uk or £25 from the RCP Publications Department on 020 7935 1174 ext 254.

Hip replacements: an update

Report by the Comptroller and Auditor General, National Audit Office

Procedures have improved since the NAO's previous report three years ago but more progress needs to be made, including the spreading of good practice said Sir John Bourn. One in ten consultants decide priority of operations on waiting lists rather than clinical urgency. The percentage of consultants who consider that a quarter or more of referrals from GPs are inappropriate has increased from six to ten per cent.

Available at: www.nao.gov.uk or £9.25 from The Stationery Office on 0870 600 5522

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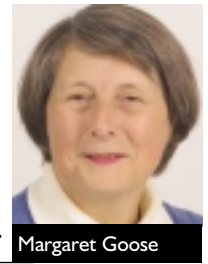
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Stroke prevention, treatment & care

Time is running out for meeting the NSF milestones for Stroke



Margaret Goose

Margaret Goose, Chief Executive of the Stroke Association, urges PCTs to check if they are on target and to take action.

Each year over 100,000 people in England and Wales have a first stroke; about 10,000 of these are under the age of 55. Stroke is the single largest cause of severe adult disability with over 300,000 people affected at any one time. It is estimated that 25% of nursing home residents have had a stroke. Stroke consumed some 6% of the NHS and Social Services expenditure in 1995/1996 and it has been estimated that this could rise by 30% in real terms by 2003.

There are now agreed national standards for stroke prevention, treatment and care in Standard 5 of the National Service Framework for Older People – but applicable to all adults. The April 2004 milestones for general hospitals and Primary Care Trusts have been included as a priority in the DoH Priorities and Planning Framework 2003 – 2006.

Yet the last national sentinel audit for stroke showed that only one in four stroke patients spend the majority of their time in a stroke unit. More hospitals may have stroke units but these are obviously not large enough in spite of the evidence that people who receive care in an organised setting have a 25% better chance of avoiding death or serious disability.

We do not have similar audit material for primary care but our experience is that Primary Care Organisations do not perceive stroke as a priority in terms of primary prevention, secondary prevention and long term support let alone commissioning of specialist services.

Similarly, the general public is not aware of the risks and the need to dial 999 if they suspect they have had a stroke, rather than wait for a member of the primary care team to assess their condition.

The Stroke Association is therefore keen to know what progress is being made and how organisations can work together to help people affected by stroke.

- We would therefore urge you to ensure you know what is expected by April 2004 and take the necessary action to achieve it
- Fill in the survey circulated with this newsletter to help us assess the current situation and what more needs to be done
- Watch out for FREE primary care workshops on stroke being organised in the autumn and book as soon as possible. For further details please visit www.medman.co.uk
- Take advantage of the stroke specific Clinical Governance Development Programme being run by the Modernisation Agency, starting on 7 October 2003 (details available from their website: www.cgsupport.nhs.uk)

Hopefully the progress made by primary care on coronary heart disease will help with the establishment of stroke registers and identification of people at risk of a stroke

Liaison with specialist stroke services is more productive if there is a lead physician for stroke but the last sentinel audit indicated an average of only two consultant physician sessions per week in most hospitals. It is hoped that stroke will soon be recognised as a sub-speciality for medical training.

However, basically 6,000 people are currently dying when they shouldn't and 6,500 people are suffering disability when they shouldn't.

Relations need improving (cont'd from page 1)

- StHAs describe negotiated levels of earned autonomy for local health economies against performance outcomes
- PCTs describe the nature of the support they require from StHAs
- StHAs work with PCTs to develop appropriated knowledge and expertise in the management functions related to the full range of primary care providers
- Performance management measures incorporate the concept of added-value against baseline data and populations health indicators as well as defining absolute goals
- Understanding the complexity of relationships
- Defining and agreeing performance management

Michael Sobanja, NHS Alliance Chief Officer, said: 'It is clear that relationships between PCTs and Strategic Health Authorities have some way to go. It is absolutely critical that both discuss and agree together how they are going to improve health and healthcare for their local populations.'

*Developing relationships between Strategic Health Authorities and Primary Care Trusts, a report from the NHS Alliance, DoH and Prime Minister's Office of Public Services Reform.

Available at www.nhsalliance.org

It suggests key factors in promoting high performance include:

- Agreeing the nature of public and patient involvement
- Incentivising clinical engagement