

Primary Care Partnerships

DEC 2003 • ISSUE 16

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New guidelines for Coronary Heart Disease will take care 'to the next level' says NHS Heart Tzar

The Department of Health has launched the first in a new series of toolkits designed to help staff involved with Coronary Heart Disease (CHD) look at their standard of performance to see how they can improve their skills, knowledge and service.



Roger Boyle

The National Workforce Competence Framework for Coronary Heart Disease sets out the core skills needed to deliver the best possible services for those with or at risk from CHD - which currently affects around 900,000 people in the UK.

It covers the competences required by those working in the three priority areas of prevention, heart failure and rehabilitation. However, it will eventually be extended to cover the whole of CHD including heart attack and other acute coronary syndromes, angina and revascularisation.

In addition to the competence units, the framework includes a guide, case studies showing uses in a variety of settings, a presentation, tools and templates to support implementation as well as a feedback form. It will enable practitioners to check they are working in line with the CHD National Service Framework and national and local guidance.

The framework is not set in stone said Dr Roger Boyle, National Director of Coronary Heart Disease. It will change to reflect developments in practice and incorporate the experience of users.

Dr Boyle commented: 'A great deal of hard

work and commitment has gone into making this toolkit as accessible and useful as possible.'

He said he was looking forward to seeing NHS teams of heart professionals put the theory into practice and taking CHD care in the UK to the next level.

The framework will help organisations to:

- Plan their workforce requirements
- Design job descriptions and person specifications
- Redesign roles and patient pathways
- Recruit people with the necessary knowledge, skills and experience
- Provide targeted induction to bring new appointments quickly up to speed
- Identify individual and team development needs then plan to address these
- Appraise and develop the performance of individual practitioners
- Deliver services to quality standards
- Redesign the way in which services are organised and support service redesign
- Apply common standards of performance across organisations and partnerships

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Editorial

Often seen as the 'Cinderella' condition, heart failure has traditionally lacked resources and suffered a low profile - despite the fact it is the country's biggest killer. More than 110,000 people die from CHD in England each year. The new guidelines are therefore being widely welcomed within the NHS and patients' representatives.

Older People's services are also often described as a 'Cinderella' service, so it's good to hear of innovative approaches by PCPs to improve them. Martin Howard of Evercare reports on how the US organisation is helping nine PCTs in Bristol reduce illness and manage chronic conditions among high risk or chronically ill people (see p4).

Team working and enthusiastic partnerships are proving key to the success of the Bristol project. These same elements have also been the key to success of Central Cheshire PCT's piloting of the NHS's new pay system, says Sally Oliver in an update on Agenda for Change (see p3).

We can also report strong collaboration north of the border where seven institutions have been working together to develop extended and supplementary nurse prescribing in Scotland (page 2).

Also, exclusive to PCP readers, Professor Peter Hutton, Chair of the new National Clinical Advisory Board to the National Programme for Information Technology, enthuses about how effective IT will help everyone deliver a better NHS.

Your comments on all these topics will be welcome for publication in the new year.

Jenny Sims, Editor

£28 million for Out-of-Hours

The Government is to give an extra £28 million to help local areas develop high quality Out-of-Hours (OoH) care. The new money is being made available over the next two years to help local areas deliver services from December 2004 when GPs will be given the choice to opt out of providing OoH services.

CHI self-assessment tool for PCTs

The Commission for Health Improvement (CHI) has launched a new self-assessment tool for PCTs to enable them to hold a mirror up to themselves and see how they can make improvements. It focuses on strategic capacity and the PCT's ability to monitor and improve patient care. Available on CHI's website: www.chi.nhs.uk/eng/assessment/index.shtml. It follows earlier tools aimed at acute, mental health, ambulance and combined trusts.

New NHS website

Health Minister John Hutton has launched www.nhs.uk a one-stop website to access NHS services and a portal to all NHS organisations. He said it would play an essential role in helping patients choose the options that were right for them.

1,400 NHS job cuts

The DoH is implementing a radical change programme that will cut the core Department from 3,600 posts to 2,200 by October 2004, Health Secretary John Reid told the Health Select Committee. He warned there maybe more cuts to come. The DoH is also looking at arms-length bodies in health and social care, which currently employ 19,000 people.

NHS Direct praised

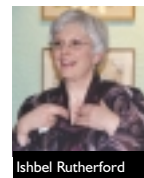
NHS Direct staff received special praise in a report by the Commission for Health Improvement, which found them polite, professional and reassuring. It also found the nurse-led telephone advice was well regarded by the public. However, it did find that some centres were not meeting targets for answering calls. This was largely due to increasing demand for the service leading to capacity problems for some units. More at: www.chi.nhs.uk

Write to patients not doctors

Health Secretary John Reid has said he wants to look at changing the way that doctors' and patients' correspondence is handled, with consultants writing letters direct to patients, rather than writing letters to GPs which are then copied to patients. The idea has been raised in the national consultation by patients, run by the DoH, on the development of patient choice in the NHS. Consultation on extending patient choice ended on 11 November.

Difficulties in implementation are being overcome

Ishbel Rutherford describes how Extended and Supplementary Nurse Prescribing is being developed in Scotland



Ishbel Rutherford

The first course for Extended Independent Nurse Prescribing in Scotland started in April 2002. There are now seven courses being offered by Higher Education Institutions across the length and breadth of the country that all offer both supplementary and extended nurse prescribing outcomes.

The institutions offering courses are:

- Glasgow Caledonian University
- Napier University, Edinburgh
- Paisley University
- Queen Margaret University College, Edinburgh
- Robert Gordon's University, Aberdeen
- University of Dundee
- University of Stirling

Scotland may be small in overall practitioner numbers but there are difficulties in covering all the health board areas, especially those that could be classified as remote and rural. To overcome these problems of distance, two institutions have developed distance learning elements to the programmes using web-based materials. Web-based materials for part of the curriculum will soon be available to all students. The majority of this material will focus on pharmacology but other aspects are also addressed. This is the result of an NHS Education for Scotland project to be launched in early December.

A Scottish Extended Nurse Prescribing Network has been established with membership coming from the teaching teams of all course providers. This has been very supportive and has facilitated the rapid development of courses across Scotland. Having a recognised network where issues can be discussed has also helped provide consistency of approach across courses.

The Scottish Executive has supported nurse prescribing through funding for course development. The funding has been used in different ways to enable institutions to resource course development activities, for example, the employment of designated course co-ordinators with practice expertise or the freeing up of lecturer time for the development of learning materials.

At present no formal evaluation of the implementation of extended and supplementary prescribing has yet been undertaken but plans are being made for a Scotland-wide study to be carried out. Therefore, in the absence of a more formal

evaluation, some of the strengths and limitations identified locally from the course at Queen Margaret University College have been highlighted.

Difficulties experienced by students/practitioners include:

- Release from practice to study either face-to-face or web-based
- Completing the heavy assessment load within the six-month period as well as continuing to meet the demands of the specialist area of practice
- Lack of certainty in developing clinical management plans as specific Scottish guidelines have not yet been published
- Implementing nurse prescribing in practice where there is no previous template or system.

Difficulties experienced by academic staff include:

- Developing curriculum for a new area of practice
- Meeting the needs of the wide variety of practitioners attending courses
- Ensuring assessments are relevant to all course participants
- Keeping up-to-date with changes to prescribing legislation.

Strengths identified include:

- The support participants receive from their Designated Prescribing Practitioners (DPP) (medical colleagues)
- Provision of briefing sessions for the DPPs
- Course handbook for DPPs
- The wealth of knowledge practitioners /students bring to the course
- Opportunities to discuss and debate changes to practice
- Opportunities to share good practice.

In summary, Extended and Supplementary Prescribing has developed rapidly across Scotland within the last eighteen months. Developments have been collaborative between the seven teaching teams involved and supported by the Scottish Executive and NHS Education for Scotland. It is hoped that the proposed evaluation will demonstrate that this has been a quality development that has improved patient care and made the best use of nurses' skills.

Ishbel Rutherford, Course Leader, BSc Community Health Nursing, Queen Margaret University College, Edinburgh

New guidelines for Coronary Heart Disease (cont from page 1)

'It is only by working together – efficiently and positively – that we can promise our patients the very best advice, treatment and care' Dr Boyle added.

Peter Stansbie, Director of Strategy & Skills for Health, said: 'The launch of this new toolkit should be welcomed by everyone involved in the prevention and treatment of CHD.

It includes tools to help people apply the competences in their workplace. It is being designed as a "living" document – we're encouraging feedback so that it will help people both now and in the future.'

*Copies of the National Workforce Competence Framework for CHD are available at: www.skillsforhealth.org.uk

New group for health staff will help shape NHS computer plans

Professor Peter Hutton, Chairman of the Academy of Medical Royal Colleges & Chair of the National Clinical Advisory Board, outlines how clinicians and other healthcare staff will inform its work



Peter Hutton

The £2.3 billion National Programme for Information Technology (NPfIT) aims to connect branches of the health service together allowing access by appropriate health staff to up-to-date information about patients whenever and wherever they need care.

The National Clinical Advisory Board (NCAB) – a committee representing healthcare professionals, has been set up to help shape the Programme and to extend and formalise consultation with healthcare professionals.

Effective information technology will help us to deliver a truly national health service. In the future, patients will have their own electronic health record, from cradle to grave, which they can check and help to keep up-to-date.

Although contracts for the IT systems and services are currently being negotiated, the information they will carry and the way the system will work, are under development and NCAB will feed into this process.

NCAB consists of representatives of some thirty branches of the health service including GPs, consultants, nurses, dentists, health visitors, midwives and pharmacists. The Board will meet every three months but carry out work in between in sub-committees.

The purpose of NCAB is to listen to health staff and shape the way the National Programme develops in partnership with technical experts.

The implications of the National Programme mean a culture change in the relationship between doctors and patients, not simply the delivery of thousands of computers or miles of cabling.

The National Programme for IT is not just about putting a computer screen on hundreds of thousands of NHS desks. It is about building a service around the patient's journey through the health system and linking scores of mini-NHS's into one truly National Health Service.

The function of NCAB is to provide ongoing advice and input into the Programme from the people at the coalface who will make it work. NCAB will be a vital conduit to ensure that the voice of healthcare professionals is heard and acknowledged.

We want to develop robust and vigorous channels through which we get feedback and buy-in from health staff. Their support is vital to this Programme.

We will set up working groups with speciality experts. The groups will feed back through NCAB to the Board of the National Programme for IT and to the Ministerial Taskforce, which is chaired by John Hutton.

Our brief is to bring information from the NHS clinician body – doctors; nurses, midwives, physiotherapists and allied health professions – to make sure the objectives of the National Programme are in line with general NHS

objectives of improving care around a patient-centred model.

I am aware of the criticisms of some doctors and others that there has been insufficient clinician involvement in the planning. There has, however, already been clinical input to the National Programme but not all of this has been in the public domain for commercial reasons.

As we are now coming to the end of the first phase of the Programme, it is an appropriate time for the wider clinical community to become involved in shaping the Programme.

It is true that some objectives have been set and these are given in the output-based specification. However, putting the flesh on the bones of those objectives has not been done – we are in the business of doing that. There's still the majority of the work to play for.

One of the messages I'd really like to get across is that the National Programme is about putting in place the facilities for the use of information for the benefit of patients.

When people learn that NCAB will be setting up working groups, taking in a larger number of people with a variety expertise, my hope is that most people will feel it is a good representative structure in which healthcare professionals are having input and interaction with the National Programme.



Human resources & pay modernisation

Agenda for Change update from a pilot implementation site

Central Cheshire Primary Care Trust (CC PCT) was selected, along with 11 other sites, to begin piloting the new NHS pay system with effect from June 2003 as an Early Implementation Site.

The Trust has found that the key to successful implementation is real partnership working. Commitment from all areas of the organisation, as well as good strategic and forward planning, are also essential to the success of implementing the system.

Agenda for Change is managed internally by three Project Leads; Sally Oliver, Director of Human Resources and Learning; Gill Storey, Staff-side Chair (Paediatric Physiotherapist and CSP Representative) & Alex Mitchell, Deputy Director of Finance. Staff within the Trust have been kept up-to-date with the progress of Agenda for Change through a systematic communication plan. This included regular staff updates, an Intranet site designed specifically for Agenda for Change and regular visits to staff by the three Project Leads.

Out of 1,000 staff, 327 jobs have been identified. Approximately 110 will be locally

evaluated and the remaining 217 will go through the Job Matching Process. This is a system where posts within the Trust can be compared to national profiles. Each matching panel consists of a minimum of three trained 'matchers' (at least one staff-side representative and one management-side representative). The Trust estimates that this process will be completed by the middle of November 2003.

The Local Job Evaluation process, (to individually review those jobs for which there is no national profile or where posts do not match national profiles), began during mid-October. Post holders must complete a questionnaire about their job, which must be agreed by their line manager and analysed by trained analysts, (one staff-side and one management-side representative), prior to the post being examined by an Evaluation Panel. These panels are made up of at least three trained Evaluators, (at least one staff-side and a management-side representative). CC PCT aims to complete this process by the end of December 2003.

Sally Oliver, the Trust's Director of Human Resources and Learning, said: 'The process has

required a great deal of commitment and dedication from the whole organisation and specifically those staff-side representatives who have needed to take time out from their regular roles within the organisation.

'It has been a great help to have our staff-side Chair as one of the joint Project Leads and certainly a choice I would recommend for all organisations as they begin to plan for Agenda for Change National Roll Out in 2004.*

*The DoH has said a full review of progress in Early Implementation of Agenda for Change – Modernising the NHS Pay System and timing of the rollout will be published in March 2004.

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PUBLISHED BY:



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PCTs take an innovative approach to improving care and efficiency

The Bristol area is one of a handful testing out a new model of providing care for vulnerable older people. Martin Howard of Evercare reports on progress so far.

In March 2003 the Department of Health invited the American Evercare organisation to work with nine PCTs. Evercare (affiliated with United Health Group) provides services to public sector and non-profit organisations in the United States. The Evercare organisation is acting in a consultancy role to assist each of the PCTs, giving advice and teaching in clinical, managerial & evaluation fields. The pilot started in April 2003 and will end in November 2004.

The aims of the programme are:

- To reduce illness and manage chronic conditions for high risk or chronically ill older people
- To help keep them healthier longer and minimise avoidable or over-long hospital stays

The story in Bristol

In our area the project is being run jointly by Bristol North, South Gloucestershire and Bristol South & West PCTs. The size of this community means that different approaches can be trialled and the lessons learnt applied elsewhere.

Our pilot started with approximately 600 older people cared for by fourteen new nurses (known as Advanced Primary Nurses), working with a similar number of GP practices. Most of the fourteen Advanced Primary Nurses are working with patients living in their own homes. However, we also have two nursing homes directly working with a nurse. The demographic range and the size of the practices is a deliberate mix and includes inner-city areas.

How it works

The specially trained nurses work as care co-ordinators. As well as offering advanced clinical skills themselves, they can call upon a team including district nurses, the GP and practice nurses. One of the real benefits of the work has been to improve co-ordination with Social Services and mental health teams, so that these too are part of the network.

The older people are all over 65 and have been admitted into hospital for an emergency at least twice in the last year. The nurses have

a relatively small caseload and they work proactively with the person and their family. Instead of waiting for the decline in health that can so easily lead to a hospital admission, they teach the person and carers to spot early signs. Often a call to the nurse means that antibiotics or other care can be given in time to avoid complications.

The nurse gets to know the patient and their home circumstances really well. Often medication reviews have been able to reduce pain and the side effects of multiple drugs giving both a better quality of life and fewer hospital admissions.

Better integration of services

As well as Social Services, the local Acute Trusts are enthusiastic partners in the project. We now have a process for notifying the nurse on the day following emergency admission of one of their patients. Perhaps uniquely, the Advanced Primary Nurse will then visit the patient in hospital and liaise with the Discharge Team. This has also meant developing working relationships between nurses and key ward staff and professional development through linking each nurse with a senior clinician in addition to a GP mentor.

Is it working?

The wheels of true research grind slowly and the local health community is keen to make decisions before the Department of Health commissioned research becomes available in three years time. Important stories from the nurses and the carers are telling us that hospital admissions are being avoided and lengths of stay reduced when there are admissions as well as quality of life being improved. Quantitative data on these will become available in 2004.

Meanwhile, in a difficult local financial climate, it may be that local policy makers will want to take the risk and continue with this innovative approach to improving both care and efficiency.

Martin Howard
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Stroke Association campaigns for higher priority of stroke services

The Stroke Association claims 12,000 people are dying or becoming disabled each year because of a lack of specialist stroke units. It says hospitals are failing to deliver on the NSF for Older People's target of every hospital having a stroke unit by April 2004.

Jerry Doyle, Director of PR at The Stroke Association said: 'Emergency care for stroke is more important than ever now that we have new clot-busting drugs that need to be given to patients within three hours. Most people with stroke currently do not get this chance.'

Health Secretary, John Reid has refuted the claim. He said the NHS would meet the target by April. However, The Stroke Association says that because the NSF failed to give a proper definition of a stroke unit, some hospitals are now calling their stroke wards stroke units without providing specialist equipment or staff in order to meet the target.