

continued from page 1

contentious one. GPs are allowed to claim locum payments for the time when they are away from the practice, but these have been lower than the actual fees which most of them have had to pay. Locum fees have increased considerably over the last year.

In addition, some health authorities say that if a GP reduces their parity, they are not entitled to claim locum payments because they would not be expected to be in the practice for the days of their PCG work. But the NHS Alliance believes that GPs should still be entitled to the payments.

Compensatory payments for PCG board members have now been increased by 17 per cent and for PCG chairs by 33 per cent. These are payable to the practice/employer of the PCG/PCT member on an invoice basis where locum cover has been required when he or she has been engaged on PCG/PCT work.

With regard to nurse members of PCG boards, they are employed full-time by Trusts and, as such, are members of the NHS pension scheme. Lynn Young, RCN community health adviser, says that their pension status should not be affected by their PCG or PCT work, but if they want to, they could use some of their allowance for board work to top up their pensions with additional voluntary contributions (AVCs).

'We welcome the parity of allowances for all PCG board members, because this gives equality to nurses working on boards,' says Ms Young.

'Health Authorities have improved considerably in their attitude to payments for nurse members and we have managed to resolve most of the problems.'

By Paul Dinsdale



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## CHCs: COST EFFECTIVE COMMISSIONING OF PUBLIC INVOLVEMENT IN PRIMARY CARE

**Primary Care Groups offer a real opportunity for increased public involvement in Primary Care. Since the inception of PCGs, Community Health Councils have been working hard to develop effective links with the new groups. This is a welcome development as some GPs main contact with CHCs was primarily through the CHCs role supporting complainants through the NHS complaint procedure.**

But CHCs, as the statutory body representing the public interest, can and increasingly are offering much more in primary care. The key roles for CHCs are in assisting with the appointment of and supporting the lay member of the group and in developing public involvement initiatives.

Cornwall CHC received funding from the South West Regional Executive to undertake a project investigating ways of involving the public with the West Cornwall PCG. Their report identified a number of roles for the CHC including taking the lead on conducting independent surveys, strengthening information and communication with the public and developing a strategic and co-ordinated approach to public involvement. The CHC with the South West Association of CHCs is organising a series of public involvement road shows to facilitate and share best practice in the South West.

In the North West region all but two PCGs have granted speaking rights to CHCs: Cheshire Central CHC (with the help of other CHCs) provided training on public consultation; Lancaster and Morecombe CHC have a representative on the PCGs clinical governance committee; and Rochdale CHC is being used in a consultative capacity by the PCG to look at public involvement.



Gary Fereday

Genuine public involvement initiatives requires time and resources. There are plenty of expensive consultants and opinion polsters willing to do the work, but CHCs already have considerable experience in this field. The examples above provide only a flavour of what's happening around the country. As well as representing the public interest in the NHS, CHCs can offer PCGs a cost effective means of commissioning public involvement and providing training and advice. The Association of CHCs for England and Wales welcomes enquiries from PCGs about how it can help.

Gary Fereday Policy Officer

Association of Community Health Councils for  
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## PCG TIPS: Books and reports

**The PCG agenda: early progress of primary care groups in 'The New NHS'**

Audit Commission February 2000. Free copies of the briefing on freephone 0800 502030, the full report is on [www.audit-commission.gov.uk](http://www.audit-commission.gov.uk)

Most PCGs have made progress in tackling a challenging development agenda, but poor date and limited resources are slowing progress on some outstanding issues according to this briefing paper. Based on interviews and a survey of chief executives conducted between July and September 1999 it is a follow-up to the Audit Commission paper PCGs: An Early View published in June 1999.

**The NHS: Facing the Future**

By Anthony Harrison and Jennifer Dixon  
Available from the King's Fund bookshop on  
0207 307 2585 £17.99

This King's Fund report says the NHS must address some fundamental issues if it is to cope with the public's demand for health care. It shows that radical changes are needed to bridge the gap between what the NHS can provide and what the public

demand from it. But those changes would work within the current system of tax funding.

**United They Stand – Co-ordinating Care for Elderly Patients with Hip Fracture**

Audit Commission Update February 2000  
(ISBN 1862401896) available on freephone  
0800 502030 £5

Over 66,000 people a year fracture their hips, most of whom are over 75. A short stay in accident and emergency, coupled with an operation within one or two days can help ensure a quick recovery. This study shows some improvement in the last few years, but too many people are still being made to wait too long for treatment.

**A Systematic Review of Brief Psychological Therapies in Primary Health Care**

By Dr Adrian Hemmings

Available from the Counselling in Primary Care Trust on 01784 441782 £10 inc. p&p (£5 for members of the Association of Counsellors and Psychotherapists in Primary Care).

Glenys Parry, director of research and development, Community Health Sheffield NHS Trust, writes in the foreword: 'This comprehensive and sophisticated review is timely. Dr Hemmings shows how pervasive are psychological and psychosocial difficulties in primary health care, in both mental and physical ill health.'

# PRIMARY CARE NETWORK



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MARCH 2000  
ISSUE 18

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In association with

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Supported by an educational grant from



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## Better pay & pensions deal for boards

**Health minister John Denham's announcement that from April 1, allowances for GPs serving on PCG and Primary Care Trust boards will be pensionable has been welcomed almost universally.**

Mr Denham said that he had been 'aware that any potential reduction in their pension entitlement arising from loss of earnings as a consequence of their PCG or PCT role was, quite rightly, an area of concern for GPs in particular serving on PCG boards or PCT executive committees.'

He said that the NHS Executive would be issuing firm guidance to NHS employers to make it clear that nurses and other NHS employed members of PCG boards or PCT executive committees should not suffer 'any pension detriment' as a result of their PCG or PCT role.

There will also be a 2.8 per cent increase in allowances for PCG board members and the allowances payable to PCT board and executive committee members.

The issue of pensionable allowances has been a bone of contention among GP members of PCG boards since their inception.

'This issue has needed sorting out for some time, as many GPs were becoming quite irritated by it,' says Dr Alex Trompetas, chair of Central Croxson PCG.'

'It wasn't clear whether payments to PCT executive committees were going to be on the same basis as PCG boards, so this guidance has cleared that up. It is obviously fair that doctors who are putting in time as PCG leads do not lose out in their pensionable contributions.

'The other issue is that some practice partners are putting pressure on their colleagues who are PCG leads to reduce their parity,

arguing that their practice commitment is less. This is a matter for individual decision, but it can be difficult to sort out because in many cases the PCG lead may still be bringing in as much income to the practice but in fewer days.'

Another chair, Dr George Young of Hall Green PCG in Birmingham, agrees that the announcement on pensionable allowances is good news, but with some caveats.

'It's a very welcome development, but the only disappointing thing is that it took a year to happen,' says Dr Young.

'Since the start of PCGs it has been an anomaly and some people may wonder why the Government did not address it right at the beginning. It could be argued that the NHSE intended the absence of pensionable allowances for PCG board members to be a lever for future use, so that they would only be given to PCT executive committee members and that this would encourage GPs to take on more responsibility later.'

'Perhaps they thought it could act as a differential between PCGs and PCTs. But, thanks to some work behind the scenes by organisations including the NHS Alliance, officials have changed their minds.

'Nurse members of PCG boards should also not be penalised for their PCG work, as this would be highly divisive. Another point is whether lay board members should be able to enter the NHS pension scheme for the time which they commit to their PCG work, and perhaps that issue needs addressing.'

The issue of locum payments has also been a



Dr Alex Trompetas

continued on back page

## EDITORIAL COMMENT

With the beginning of the next financial year looming we decided to give this issue a strong financial flavour. Pay and pensions for PCG and PCT board members takes the lead with the welcome news of increases of allowances, but we also bring you tips from a variety of contributors on several other important funding issues.

Peter Chrisp, an HA financial controller, offers some sound advice regarding the Primary Care Modernisation Fund. Peter Fitton, GP, suggests how PCGs grouping together might influence

HA budgets to their advantage. Norman McGregor Edwards gives us a glimpse of how primary care funding is working in Scotland and Gary Fereday explains how using CHCs can be cost effective in commissioning public involvement in primary care.

On another money matter, don't forget there are £6000 worth of prizes to be won by entering our HImP and HIP Awards (see page two)!

Your comments and ideas for articles, particularly on any aspect of prescribing, would be welcomed for the next issue.

Jenny Sims, Editor

NEWS IN BRIEF

**Donna Covey**

The Editorial Board of PCN are delighted to announce Donna Covey, Chief Executive of the Association of Community Health Councils in England and Wales is joining the Board. Donna's appointment will strengthen PCN's commitment in providing a multi-disciplinary view, a unique advantage that was recognised in a recent readership survey.

**HIMP and HIP Awards of Excellence**

Unrestricted educational grants of £6,000 will be awarded at the NHS Confederation's Annual Conference in Glasgow. The deadline for entries for England, Scotland and Wales is 28 April. Application forms are available from Medical Management Services on 01225 333711 or fax 01225 422533.

**Don't Forget**

'PCG or PCT? - Facing the Challenge Together,' a series of eight regional workshops are being run by the NHS Alliance during March, April and May:

- Eastern**, 16 March, Lynford Hall, Nr Thetford; **West Midlands**, 21 March, Park Hall Hotel, Wolverhampton;
- Trent**, 30 March, Nottingham Racecourse;
- Northern & Yorkshire**, 6 April, York Racecourse;
- South East**, 12 April, Beaumont Training & Conference Centre, Windsor;
- South West**, 13 April, Dillington House, Ilminster;
- London**, 18 April, Royal Horticultural Halls Conference Centre, Westminster;
- North West**, 11 May, Swallow Four Seasons, Manchester.

**EVENT 14 March**

'Open All Hours - improving access to primary care - taking the initiative,' conference organised jointly by the NHS Alliance and the Royal College of General Practitioners, at the Royal Pharmaceutical Society. Details from Jean Trainor at Health Links on 0121 444 3399.

**Primary Care Development Team**

Applications are invited from PCGs/Ts to become members of the National Primary Care Development Team announced by health minister John Denham last month.

Each of the 30-40 PCG/Ts will have a centrally funded manager and access to expert advice and support. For further details call the team on 0161 237 2934.

**Extra £23 million for home care cancer patients**

An extra £23 million to improve care for cancer patients treated at home was announced by public health minister Yvette Cooper. Funding for the *Living with Cancer Programme* comes from the New Opportunities Fund which uses lottery money to support good causes. For details of the programme access [www.nof.org.uk](http://www.nof.org.uk)

# Power or Responsibility

## (or, how to influence your HA's budget)

**Lay members of PCGs and PCTs are being recruited throughout England to participate in the national network of lay board members launched at the NHS Alliance's conference on Public Involvement in November.**

In theory PCGs and their parent HA share both power and responsibility, but there are a number of practical obstacles to this. Here are the main ones I have encountered, and some suggested responses.

- MYTH 1** The purchaser defines the service and the price.
- MYTH 2** The HA has an accurate and up to date list of its balance and liabilities.
- MYTH 3** PCGs and their HA have an equal share of power and responsibility.

So, to what extent does your HA describe, and set criteria for, the services it funds? Get hold of any 'contracts', service specifications, LTSAs, and any quality criteria, (preferably in electronic format) and parcel them out to staff and members to read critically. Where your HA commits new investments (and expects you to contribute), what documents have you seen, and which ones have you not seen? Do they exist? If they committed any large sums in 99/00 (for Mental Health for example) how did they define what they were paying for, and how could they tell if they got it?

Where escalation occurred (eg prescribing) how much information did the HA share, and how quickly, on its plans to fund the deficits? If the answer is 'none' and 'don't know', extract some accurate figures (eg a copy of the HA PPA Budget Statement) before you discuss the 2000/01 prescribing allocation.

Get hold of the 98/99 accounts now – they are public documents and in standard format. Look out for the previous year-end balances, and

find out what happened to them. Ditto GPFH savings, and provisions for negligence. Order the 99/00 accounts – but accept it may be a Christmas present.

On the one side is a large group of full time professionals with careers on the line and on the other a small bunch of amateurs with other jobs. Symmetry is not realistic. The objective is that the shares of power correspond to the share of responsibility, not that they are equal. So, before the HA discuss the coming budgets, give them formal written permission to share with the other PCGs your aggregate figures, and the total (otherwise you will never know the amount they have NOT distributed between the PCGs).

Meet the other PCGs before you meet the HA. This is ABSOLUTELY CRUCIAL – the PCGs will never agree with each other without prior co-ordination. Be prepared – to trade information, to support things you do not want in exchange for those you do, and know the cards you have to play with.

Given the amount of national policy that depends on changing primary care (GP referrals and clinical governance for instance), your main card is the ability to influence GP behaviour. So I am sure you have developed your communication and information flows with this part of your constituency – haven't you?

When the HA tables something they have been working on for weeks, defer any comment and arrange to meet again in 24 hours. That should discourage the practice, and give you time to get your act together. Unless all the PCGs agree, the HA has to do what it wants – a situation it may quite like. But power is for changing things, not about nodding them through.

**Dr Peter Fitton**, GP, Huddersfield



Dr Peter Fitton

## New 'bridge of care' for elderly people promised



Alan Milburn, Health Secretary

Health Secretary Alan Milburn will consult on the future of intermediary and hospital beds following publication of the government's National Beds Inquiry. But he signalled that more beds were likely and promised a new 'bridge of care' between hospital and home for elderly people.

The inquiry's report says beds and services must expand if future patient needs are to be met, and that the trend of the last 30 years of reductions can no longer keep pace with changing needs. It says a 'whole-system' view of services is needed – as well as more beds. Key findings include:

- two thirds of general and acute NHS beds are occupied by people over 65, who also account for more than half the recent growth in emergency admissions
- at least two out of every 10 days spent by people over 65 in acute hospital beds could be better provided in alternative facilities such as intermediate care beds.

Commenting on the report, Mr Milburn said: 'It is the first time so much vital information about hospital beds and related health and social services has been brought together in this way. Consultation on it will form the basis of a national strategy for the long term future for NHS beds.'

Earlier in a speech to the King's Fund Mr Milburn said for too many elderly people the choice was between hospital or home. And he promised in future there would be a variety of forms to intermediate care.

'Some services will be in specially designated hospital wards run by nurse consultants. Some will be step down facilities in the community, perhaps giving new purpose and new life to cottage hospitals. Some will be improved care service in the home and in many cases we'll have to build new facilities.'

# Beyond the wall – *funding Primary Care in Scotland*



*Norman McGregor Edwards*

The NHS in Scotland has always been a bit different (slightly different 'Red Book', all legislation 'Tartanised', and dedicated Mental Health and Community Trusts), but even more so since our White Paper 'Designed to Care' (or 'Designed to Scare' as some GPs called it!).

Instead of PCGs, we have Local Health Care Co-operatives (LHCCs) which are voluntary (only the tiniest number of practices have not joined), formed around natural communities, multi-disciplinary and part of Primary Care Trusts with their LHCC (but not practice) staff on Trust contracts. They do not purchase secondary care and vary in size from about 20,000 to over 100,000 patients. They have been encouraged to develop to reflect their particular local needs and thus there is no 'typical' LHCC. They and their parent Primary Care Trusts (PCTs) have existed for less than one year, which makes it dangerous to generalise – but we NHS managers are known for living dangerously, so here goes!

Most LHCCs have a general management structure. They control and are accountable for funding from four main sources. Firstly, a management allowance of approximately £2.50 per patient. Secondly, any prescribing savings which LHCCs and

practices keep in their entirety. Thirdly, their community nursing and PAMs budgets and, lastly, Primary Care development funds. These are all still public funds and LHCCs have therefore been, to use management-speak, 'strongly encouraged' to produce individual Development Plans outlining their priorities and financial plans. Some LHCCs found this quite daunting but most have produced really relevant, 'bottom up' plans addressing local needs. These are increasingly being used to feed into Health Improvement Programmes to determine investment priorities for the future.

So what has happened thus far? Predictably, the dramatic changes in costs of generic drugs this year effectively scuppered LHCCs plans to really invest in Primary Care. This has undoubtedly affected LHCC morale, although there are signs something may yet be salvaged. Development funds this year have been generally limited to those allocated annually by the Scottish Office, which have been largely used to pump-prime the new structures. In contrast, however, DEVOLUTION (I had to get that in somewhere!) of community and PAMs budgets, and community staff representation on most LHCC governing bodies, has given LHCCs real control of community services for their localities and many are

developing real flexibility in use of resources – especially as they get more closely involved in joint working with Local Authorities.

Most LHCCs initially saw their management allowances funding little more than GP time, locum fees and a bit of management, but a significant number are investing in needs assessment, audit and morbidity coding. We are also beginning to see a wide range service developments – GP pain clinics (no, not for GPs who are a pain – yet!), better secondary prevention of MIs, employment of nurses to develop new services and improving services for older people are a few examples, with many more on the way.

And the future...? LHCCs are, to quote Addison: 'The pale, unripened, beauties of the north'. As they mature, they are becoming more confident (even suggesting rewriting the Red Book), are integrating other Primary Care contractors, and beginning to think along new lines. As always, it might pay to keep an eye on the Scots!

*Norman McGregor Edwards,  
General Manager, Primary Care Division,  
Greater Glasgow Primary Care NHS Trust*

## DON'T 'SPEND, SPEND, SPEND'

**Peter Chrisp, Financial Controller (Head of PCG Financial Support Unit), County Durham Health Authority urges caution over the Primary Care Modernisation Fund.**

Primary Care Groups will be aware that as part of the 2000/2001 national settlement for Health Authorities £60 million was earmarked for the Primary Care Modernisation Fund. The purpose of this modernisation fund is to mainly develop services in a primary care setting and to give PCGs some flexibility in determining the additional services it wishes to provide for their residents.

Whilst on the face of it this appears to be a reasonable increase of funds for PCGs, there are a certain number of factors that need to be taken into account. Despite this funding being labelled as growth there are already pre-commitments to be made against this amount.

Firstly, any inflation uplift for the General Medical Services cash limited budgets need to be found within these resources. The general uplift for budgets is currently being set at 2.5%. Secondly, part of the allocation is earmarked for Primary Care Group management costs. Depending on the amount received,

typically these factors could account for half or two thirds of the modernisation fund.

On top of these pre-commitments, there are a number of other pressures on General Medical Services budgets which will be needed to be funded from within Primary Care Group's general reserves on the modernisation fund. For example, the result of the 1% increase on employer's superannuation will have an effect on staffing budgets as will the pay-review body awards which gave nurses a rise greater than the 2.5% general uplift. Currently the non-pay review body for the year is proposing an interim payment of 3%.

Depending on how the above points are addressed, it is clear that a substantial part of the modernisation fund will be committed. Therefore, PCGs will need to be cautious in their planning for additional primary care services for 2000/2001 until their Director of Finance has done all their sums to see what cash is left for them to use from the modernisation fund.

