

Primary Care Partnerships

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New NHS Payment by Results system could cause problems says BMA

Health Minister John Hutton says the new Financial Flows system - Payment by Results - to be phased in from 1 April will promote fairness in payment for work done but the British Medical Association has concerns.



James Johnson

Under the reforms to NHS Financial Flows, instead of being commissioned through block agreements as previously, hospitals (and other providers) will be paid for the activity they undertake. PCTs will commission:

- The volume of activity required to deliver service priorities, adjusted for case-mix
- From a plurality of providers
- On the basis of a standard national price tariff, adjusted for regional variation in wages and other costs of service delivery.

The DoH says the aim of the new financial system is to provide a transparent, rules-based system for paying Trusts. It will reward efficiency, support patient choice and diversity as well as encourage activity for sustainable waiting time reductions. Payment will be linked to activity and adjusted for case-mix.

The system aims to ensure 'a fair and consistent basis for hospital funding rather than being reliant principally on historic budgets and the negotiating skills of individual managers', however the British Medical Association has expressed concerns. Mr James Johnson, BMA Chair, commented: 'There is nothing wrong with the principle of the money Trusts receive being related to the quantity of work they do. In practice, however, the tariff system could cause the NHS problems.'

'At the moment there is no system sophisticated enough to take account of all the factors that can affect hospitals' costs.'

When an elderly patient goes into hospital for a simple operation, doctors often have to diagnose and deal with a range of other related problems that will not be covered by the tariff.

'As a result, some tariffs will be far lower than the real costs of providing care, putting undue pressure on hospitals to make cuts. Given that the NHS cannot afford to lose staff, how will these savings be made?'

'It is also envisaged that Independent Sector Treatment Centres (ISTCs) and NHS hospitals will eventually be paid the same amount for carrying out the same procedures, however, they are working under a completely different set of conditions. Unlike some ISTCs, NHS hospitals cannot do all their work as day cases and the patients with the most complicated problems will still need to be treated in the NHS.'

Health Minister John Hutton published the NHS Reference Costs and the new National Tariff last month (5 Feb) to help the NHS prepare for the new system. He said: 'Payment by Results is a fundamental reform to the way finances flow around the NHS. The system is central to our plans for giving patients greater choices about their treatment.'

John Hutton added: 'Where staff do more work and are more efficient, their organisation will benefit. Financial surpluses will be re-invested in clinical or other services.'

www.dh.gov.uk/home/fs/en

Editorial

Implementation of the National Programme for IT is still a major challenge for PCOs but the announcement of an extra £30 million funding will certainly help.

The NHS Alliance had warned that at least £24 million - a quarter of the amount needed to pay for maintenance and minor upgrades of GP practice computer systems - was missing from PCT budgets. Following the announcement Dr Michael Dixon, NHS Alliance Chair, said: 'The immediate threat of IT becoming an obstacle to the full implementation of the new contract has been removed.'

However, an NHS Confederation survey has found 'one in 10 organisations (Acute Trusts and PCTs) still have no plans to assess their readiness to implement the IT Programme and over 20% have not yet agreed how they will engage clinicians in the roll-out.'

The survey's good news was that nine out of ten respondents had structures in place to co-ordinate implementation across the local health economy (See IT Watch: Implementing IM&T in the community, p.4).

Jenny Sims, Editor

Public Health White Paper

A White Paper on improving the nation's health will be published following a major public consultation to be carried out over the next few months. Areas include cancer, heart disease, obesity, smoking and sexually transmitted diseases. A healthier population could save the NHS £30 billion a year in 20 years' time said Health Secretary John Reid.

National Diabetes register

A survey starts next month (April) to establish how many people in England have Diabetes and what their standard of care is. The survey is part of a new national audit service provided by the NHS Information Authority for the Commission for Health Improvement and will result in the setting up of a national Diabetes register.

www.nhsia.nhs.uk

Emergency care boost

Hospital Trusts, which set out plans to prove they can improve A&E care, will receive £500,000 in stages between April 2004 and March 2005, Health Secretary John Reid has announced. Trusts and PCTs with lead responsibility for mental health services are also eligible for extra funding for improvement plans on emergency care.

www.dh.gov.uk/home/fs/en

Expanding membership

The NHS Confederation is extending its affiliate membership to voluntary and independent sector providers of NHS and social services. It says the move reflects changes in the NHS and will build partnerships between the full range of players involved in delivering services.

www.nhsconfed.org

Scottish safety

A new programme to assess whether interventional procedures – including surgical operations – are safe enough and work well enough for routine use in the NHS in Scotland has been launched by the National Institute for Clinical Excellence, NHS Quality Improvement Scotland and the Scottish Executive.

www.nice.org.uk

Three at the top conference

Health Minister, John Hutton will hold a Q&A session at the NHS Alliance conference *Three at the top: New contracts, new targets*, for PCT chairs, PEC chairs and chief executives on 27 April at Church House Conference Centre, Westminster. More details from Health Links Tel 0121 248 3399, Fax 0121 248 3390 or Email yhunter@health-links.fsnet.co.uk

Stroke services and treatment

Surveys conflict over NSF Stroke targets

Two surveys reveal a wide disparity between PCOs and Stroke Specialists on whether they will hit Government Stroke targets.



Ian Philp

By April 2004 protocols should have been agreed with PCTs for GPs to identify and treat patients at risk of Stroke to meet the National Service Framework for Older People milestone but in a recent survey carried out by the British Association of Stroke Specialists (BASP) 52% of members said they had not yet agreed a protocol.

A survey of PCTs, mailed with Primary Care Partnerships, presented a different picture - with 79% of respondents saying they had agreed a protocol.

BASP members say PCOs and practices are giving Stroke services and targets low priority, even though under the new GP Contract GPs will be able to earn 31 quality and outcome points for monitoring and treating Stroke patients.

Prof Ian Philp, Older People's Services Tsar, said that following talks with SHA Older People's Leads, he was much more confident than he was before Christmas that the vast majority of PCOs and hospitals would make the April targets.

He said: 'Members of BASP are great champions of Stroke services and want to see a gold standard, as do many commissioners and managers. However there is a gap between aspirations for a gold standard and what is required to be delivered by April.'

He added 'A milestone is only a milestone on the journey to improve services. Other strong drivers are the GMS Contract and the RCP's National Stroke Sentinel Audit but it is really important we have basic Stroke services in place.'

By April 2004, protocols should also have been agreed with PCOs for GPs on the rapid referral and management of TIAs. While 69% of PCOs said they had agreed them, only 62% of BASP members said they had.

Other discrepancies arose from questions concerning consultation over: early supported discharge (only 40% of hospitals said they had been consulted compared with 60% of PCOs who said they had); specialist community therapy teams; support for long-term disabilities and support for young people.

Only 29% of BASP members said they had been consulted by their PCT about support for those with long-term disabilities, only 37% about specialist community therapy teams and 27% about support for young patients.

More than 75% said they did not know how prepared their GP practices would be to achieve the 31 points in the Clinical Domain for Stroke/TIA in the new GMS2 GP Contract. One said engaging GPs in the Stroke strategy group 'has proved very difficult' but another said GPs were 'very receptive'.

Since April 2002 hospitals should have had plans to introduce a specialist Stroke service. BASP asked hospitals if they had such plans and whether they were currently being implemented. Over 91% said 'yes', over 5%

said 'no' and nearly 3% said they didn't know. Several said PCT funding was 'limited' or 'a problem'.

Since April 2003 hospitals should have a clinical audit system that ensures delivery of RCP guidelines for Stroke care. The BASP survey showed implementation of the guidelines was patchy and both Trusts and PCOs were blamed. Comments included: 'No support from trust and no interest from PCO,' and 'No adequate resources to implement fully as yet.'

The BASP survey also showed the information and treatment patients received at discharge, including days' supply of anti-platelet treatment, varied considerably. Most patients were given Stroke Association or other leaflets, some personalised pamphlets with contact information, others a discharge pack.

The survey results were discussed at a recent series of outcome-driven workshops involving Prof Ian Philp, Prof David Colin-Thomé, BASP members and PCO clinicians and managers. These have culminated with three 'Putting Stroke Policy into Practice' feedback reports, which highlight local progress, the need for secondary prevention and local action plans for developing integrated care pathways for Stroke. Copies of these reports can be requested from enquiries@medman.co.uk.

Since the workshops, the National Institute for Clinical Excellence has launched its Appraisal Consultation Document on treatment for secondary prevention of Stroke.*

The committee's preliminary recommendations for people who have had an Ischaemic Stroke or a TIA say the following is recommended as part of the secondary prevention of further Ischaemic Strokes and TIAs:

- The combination of modified-release (MR) dipyridamole and aspirin for two years
- For people who are intolerant of aspirin, MR dipyridamole (alone) for two years
- For people who are intolerant of both aspirin and dipyridamole and who have had an Ischaemic Stroke, clopidogrel for two years.

The guidance does not apply to people who have had or are at risk of, a Stroke associated with atrial fibrillation or who require treatment to prevent occlusive events after coronary revascularisation procedures. The closing date for comments is 11 March.

Dr Graham Archard, NHS Alliance Clinical Governance Lead, said: 'The NICE recommendations will give a lot of power to the elbows of doctors who have had difficulties obtaining funding. These are hard statistics and should inform the debate.'

*Appraisal Consultation Document: Clopidogrel and modified-release dipyridamole in the secondary prevention of occlusive vascular events. Available at: www.nice.org.uk

How to reduce falls in primary care

A Bradford primary care project has cut the number of fallers presenting at A&E by 15%. Beverley Slater, Assistant Programme Director, Bradford Community Health reports on the success of its Pursuing Perfection falls project.



Beverley Slater

The Bradford falls project has successfully demonstrated that GP practices with a 'Falls Nurse' role at primary care level generate 15% fewer fallers at A&E than other Bradford practices. The project has also helped improve the integration of existing innovative falls prevention initiatives across Bradford including facilitating the development of a common assessment framework and communication links. The next stage will integrate work with people at high risk of falling alongside those who have already fallen.

These and other successes across other Pursuing Perfection project areas have been achieved through redesign techniques that most people in the NHS are now familiar with.

- **Process Mapping** - In our experience the key tool that generates insight and commitment for change providing that it involves front-line staff across organisations in the same room together
- **Small Change Cycles** - Enabling us to learn rapidly from new ideas with little or no risk. For example, a GP doing tests using a five-question screening tool as part of a regular consultation identified a double negative that needed changing. They also concluded that this was a practical and easy way to build a falls register and refer high risk older people for more detailed assessment

- **Capacity and Demand** - Building on the work of Small Change Cycles, Capacity and Demand relationships can be estimated at a very early stage. For example, out of ten GP consultations with older people, four were identified as at a high risk of falling
- **Involving Older People** - We used a mixture of separate events and existing forums to obtain the views of older people about preventing falls. Older people have challenged some of the thinking of health professionals (including dislike of the term 'faller'). Patient promises have helped us focus on the needs and wishes of older people themselves
- **Whole System Engagement** - Not just managers and planners but changes led by front-line staff and supported by managers within and between organisations
- **Links to Commissioning** - That can demonstrate a tangible local impact on outcomes helps commissioners reshape resource use with confidence.

In addition to the explicit redesign techniques above, there are also some key 'alternative' or 'shadow' techniques emerging that breathe life into the tools listed above.

- **Imagination** - Many of the explicit redesign techniques are ways of getting away from our mind-sets or assumptions

- **Free-flowing Conversation** - Creating relationships that sustain free-flowing conversation, rather than 'stuck' conversations that repeat themselves, is an essential condition for effective redesign
- **Playing Your Part** - Essentially redesigning complex health services is about everyone playing their part - well. It is not about asking people to do more than their own job - but it may involve clarifying how that job contributes to the whole
- **Sacred Space** - This concept has been used by Michael Greco, Head of Patient Experience for the National Primary Care Development Team, to describe our relationships with patients and users. It can shape the work of a team, not only in their dealings with people who use the service but also in how they learn from each other
- **Keeping Faith and Following Through** - The health community can be seen to keep faith with the redesign process by engaging with the findings, keeping the resources released by redesign on the table and sharing risk across organisations.

For more information email:
beverley.slater@bradford.nhs.uk
*see box on page 4

Keep priorities – change the emphasis!

What do you think? Primary Care Partnerships is asking Chairs and Chief Executives what they would like to see in the Government's priorities and planning framework to be published in the autumn. Barbara Kennedy replies.



Barbara Kennedy

Overall priorities should not be changed from the last document as these remain central to delivering the NHS Plan, however, there needs to be an overall change of emphasis. The Government's intention to devolve responsibility to local health services needs to be evident in setting fewer targets and allowing more scope for local target setting based on health needs. Of course if we mean business, local targets should emerge from a process of discussion with, and feedback from; patients, the public and local stakeholders (including clinicians).

Instead of devices like the patients' prospectus which are an annual requirement, I think that we need to increasingly publish information through the web, the media and through open discussions, information sharing with the Patients' Forums and Overview & Scrutiny Committees which inform the public about:

- Health and social care outcomes – local mortality rates/outcome indicators

- Improving service standards – how we are achieving key targets
- Evidence of value for money – publication of annual audit data
- How to access services and where advice/information may be obtained.

Within the overall priorities, we should place greater emphasis on public health and & safety and quality. For example:

- Infection rates
- Compliance with the 28 core clinical standards, (which will soon be released for consultation)
- Reduction in childhood obesity rates
- Improvements in screening for Diabetes and reductions in incidence rates for Type II Diabetes
- Improvements in screening/treatment for sexually transmitted diseases.

Priorities, their targets and performance measurement against these, should be judged on a whole systems basis and be measures which apply to the Acute Trust, PCT, Ambulance Trust, Local Authority and Mental Health Trust jointly, (as appropriate), rather than severally.

By 2009 all Trusts will be meeting the National Standards for Access and the success or failure of services will be judged by:

- External review (eg CHAI inspections)
- The public's view of local services and where they choose to access services.

Barbara Kennedy
Chief Executive, Milton Keynes PCT

Our sponsor



NICE Citizens Council Report on Age - role of age in healthcare decision-making

Age should be considered when the National Institute for Clinical Excellence issues recommendations, according to this report from its Citizens Council. NICE will be issuing a formal response to the recommendations at its meeting on 17 March and publishing it on its website. www.nice.org.uk/cat.asp?c=101366

Managing in Health & Social Care - essential checklists for frontline staff By William Bryans

This is an accessible handbook that aims to help managers and frontline staff cope in work areas where they may not have much experience. It will be of interest to anyone wishing to review current arrangements or design a fresh approach to practical or financial problems.

Radcliffe Medical Press
£19.95 ISBN 1 85775 856 0
www.radcliffe-oxford.com

Storing up problems: the medical case for a slimmer nation

The nation is facing an epidemic of obesity and people who are overweight, according to this report produced jointly by the Royal College of Physicians, the Faculty of Public Health, the Royal College of Paediatrics and Child Health. Its recommendations are aimed at government, local authorities, health professionals and includes examples of some local initiatives.

www.rcplondon.ac.uk/pubs/index.html

Facing the Childcare Challenge - Is the National Childcare Strategy reaching all parents and children? By the Daycare Trust charity

Though the NHS Childcare Strategy is helping to recruit and retain staff, more needs to be done, according to this report commissioned by the DoH. In particular, more provision in the NHS for children aged 11 plus during school holidays as well as 'before and after school clubs' is needed. A more in-depth analysis is planned for 2005. www.daycaretrust.org.uk

Overcoming disadvantage: An agenda for the next 20 years Joseph Rowntree Foundation report

Commissioned by five leading think-tanks, this report finds growing signs of agreement from centre-left to centre-right that long-term action should be taken to prevent widening inequality and associated social problems.

www.jrf.org.uk

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IT watch

Implementing IM&T in the community

IM&T in the NHS has tended to focus on acute and mental healthcare as well as general practice. Shirley Chambers looks at IM&T in the community.



Shirley Chambers

The community nurses have in many cases seen little investment and had to work with old equipment and systems designed for other sectors and, at best, adapted for their use. In most PCTs a large part of their workforce is employed in the community and focus is now turning to this group of staff.

In Durham Dales PCT and its predecessor PCG, IM&T has always had a high priority with strong leadership and direction. In addition, due in part to its rural location, community nurses have strong links with general practices and in some cases are based within the practices.

Durham Dales PCT has 13 practices which all use the EMIS LV system and there is strategic agreement for integrated systems across general practice and community nursing. It was therefore a logical step for the PCT to implement the EMIS community module for the community nursing teams.

The first stage in integrating community nurses onto the general practice system was to provide access to the systems. This includes installing PCs at nursing bases and linking them to the EMIS systems. We have three large health centres that are located in close proximity to general practices. These centres have all been connected to their respective practices with direct links.

Difficulties in physical access arise where nurses cover multiple practices. We have found no easy solution to this, as the current systems are not really designed around multiple access and dialling in and out of multiple systems can be impractical. It is particularly difficult for school nurses where they may have to cover as many as 12 practices. The long-term solution for this is in centralised systems but this will take time to implement. In the meantime, we need to find a way to provide economic and efficient access for all staff.

Once the nurses have access to the system the next stage is training. The PCT has funded a package of training on the EMIS community module. Three training sessions were identified to cover the basics and inputting the caseload, searches and reports, then a follow up session to look at advanced requirements.

We are still part way through the training but already there have been a number of lessons learned. For example, we initially allowed mixed sessions between district nurses and health visitors to give us flexibility with scheduling, however the different needs and ways of working of the two groups meant that the training tended to be more relevant to one group than the other and we have now gone back to training separately.

In order to standardise recording, reporting and managing patient information the EMIS system uses templates. The district

nurses and health visitors in Durham Dales have developed local standards for coding and templates. Again, there have been issues that came out of this work: in particular in the area of Read coding. Although there are Read codes available for community use, there are still items that we would like to record where there are no codes available, in particular for health visiting. In Durham Dales PCT we will continue to apply nationally for additional codes to extend those available for community staff.

The response from the community nurses and general practices has been very positive. The patient record is more complete with information from the community nurses who benefit from being able to see relevant background information for their caseloads. However this does have drawbacks in that there can be a lot of information against a record.

We are able to get round this by setting personal profiles for GPs to see the information pertinent to them, however the electronic record is inevitably going to get larger in the same way many Lloyd George envelopes have. This is an issue that we are going to have to work on to make the appropriate information visible without creating information overload.

Overall we have made great strides in working towards an integrated system that is relevant and beneficial for community nursing staff and for primary care in general. There is still a lot of work to be done, in particular to extend the accessibility of the systems in more remote areas and more training to complete our initial programme.

Whilst we look forward to the new systems that will be delivered under the National Programme for IM&T, we feel that we have laid good foundations on which to build robust integrated systems for the care of our patients.

Shirley Chambers
IM&T Manager
Durham Dales PCT

Falls clinical guideline

*A clinical practice guideline on falls is being developed for use in the NHS in England and Wales. Views from registered stakeholders and others are currently being considered by the National Institute for Clinical Excellence (NICE). A second round of consultation will be carried out by NICE from 15 April to 13 May and a report is planned to be published in August 2004. More information at: www.nice.org.uk