

Primary Care Partnerships

APR 2004 • ISSUE 20

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PCT specialist services can cut waiting times dramatically but are not being widely adopted

Two Audit Commission reports show improvements in primary care because of redesigned services. Commission Chair, James Strachan, has expressed concern about equity but has praised PCT successes



James Strachan

Redesigned services where patients are referred to Practitioners with a Special Interest (PwSIs) have reduced maximum waiting times for patients to between one and four weeks, compared with between 17 and 26 weeks for traditional outpatient appointments, according to the report *Quicker Treatment Closer to Home*.

The study says that the redesigned services, which rank highly on the government's NHS modernisation agenda, have yet to be widely adopted. Too often, a redesigned service is dependent on one PwSI and is vulnerable to closure if he or she leaves.

The study found that while four out of five PCTs have redesigned at least one specialty, only 17 per cent have redesigned five or more. In some areas even when a PwSI service is available, it receives fewer than ten per cent of local referrals in that specialty.

A separate Audit Commission study, *Transforming Primary Care*, revealed that GP consultations typically last significantly longer than the ten minutes formally allocated in most appointment systems. Consultation times within the nine PCTs included in the study averaged between 11.3 and 14.4 minutes.

It also revealed wide variations in the resourcing of GP practices. Funding per patient in the best resourced practices was more than double that of the worst resourced and it identified weaknesses in the information available to PCTs and the use they made of data available to them.

It recommends that the impact of the new GP Contract on value for money should be properly evaluated.

Commenting on the reports, Audit Commission Chair, James Strachan, said: 'These in-depth studies which focus on value for money indicate that many patients are receiving better primary care.'

He said the success of the new primary care specialist services was 'particularly heartening'. He went on: 'New services that enable patients to be referred to GPs with enhanced knowledge, rather than consultants, are dramatically reducing waiting times - when they are being used.'

'However, there must be concern about the variation in the range and quality of services available to communities with similar health needs. This has a direct bearing on equity and the choices available to patients. With an extra £1.9 billion flowing into primary care to fund the new GP Contract, it is essential that issues of equity and efficiency are addressed.'

Mr Strachan said the Audit Commission would be working with the new Commission for Healthcare Audit and Inspection to ensure that additional spending on health translated directly into better patient care.

The NHS Alliance said PCTs and NHS professionals would warmly welcome the report *Quicker Treatment Closer to Home*, which proved that practical advice the Alliance had given two years ago on redesigning services to improve patient care had been sound.

NHS Alliance Chair, Dr Michael Dixon, said: 'This excellent, thorough and thoughtful report should be priority reading for every

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Editorial

Recommendations for improving NHS services seem never-ending. In this issue alone we have articles on reports from the Audit Commission on primary care, Derek Wanless on public health, the DoH on community pharmacies and the government on people with learning disabilities. All have considerable workload implications for PCTs.

What is cheering is that even if there isn't always additional funding to put the recommendations into practice, increasingly practical advice and back-up tools to support implementation are being provided from organisations such as the Commission for Health Improvement and the NHS Information Authority.

In fact, the NHSIA recently launched a set of toolkits to help NHS organisations monitor and manage their performance more effectively. For details, see the IT Watch column, page 2.

Jenny Sims, Editor

Hypertension targets and the new GMS

The new GMS Contract and recent guidelines provide tough and demanding targets for GPs, however the real challenge is for PCTs to optimise budgets. Medical Management Services is organising a series of **FREE** regional workshops for CHD and GMS Leads on how to gain maximum quality points in line with AB/CD and NICE guidelines.

Email: enquiries@medman.co.uk for further details

Record NHS staff increase

Despite a record increase in the number of nurses, GPs and consultants, there is still a lot more to be done to deal with NHS staff shortages, Health Secretary John Reid admitted at a conference to launch The NHS Workforce Statistics 2003. He added: 'The figures explode the myth that everyone working in the NHS is a bureaucrat or manager. 84 per cent of NHS staff are directly involved in patient care while managers and senior managers make up only three per cent of the total NHS workforce.'

www.publications.doh.gov.uk/public/work_workforce.htm

Assessing child protection

CHI has launched a self-assessment tool for clinicians to improve protection of children at risk from abuse or neglect. It can be used across all healthcare sectors from ambulance services to primary care, hospital services and mental health.

www.chi.nhs.uk

Managing chronic diseases

John Reid has announced improvement plans for better services for people with long-term chronic diseases such as Asthma and Diabetes. Case-management sites with specialist teams providing advice, care and treatment are to be set up in every Strategic Health Authority during a 2004/05 programme. They will 'introduce active management of high risk patients' said Mr Reid.

Improving children's services

The DoH has published a summary report, *Building a better future for children: Key messages from inspection and performance assessment*. The six-page policy and guidance article is based on the Victoria Climbié self audits and the recent SSI inspections and performance assessment. **www.dh.gov.uk/PublicationsAndStatistics/Publications**

Risk management tool

CHI has launched a self-assessment tool to help NHS organisations identify where their strengths and weaknesses lie in relation to risk management. It has been developed in response to evidence that risk management is one of the less well-developed components of clinical governance.

www.chi.nhs.uk

Health Check toolkit is 'golden key' to better use of clinical information

Jenny Sims reports on the NHS Information Authority's 3rd Clinical Information Conference



Gwyn Thomas

The NHSIA has launched a 'pick & mix' set of toolkits to help healthcare professionals use information more effectively.

Gwyn Thomas, the Authority's Chief Executive Officer said: 'The Health Check suite of products and services is not untried and untested but a mix of new and exciting activities that have been going on for some time, pulled into a cohesive national service.'

It will help roll out the 'pockets of excellence' in clinical governance, commissioning and other areas throughout the NHS.

Health Check's aim is to help NHS organisations monitor and manage their own performance, see where they can save money, help them compare local and national results and identify their priorities. It will provide solutions for five areas:

- Service Performance and Development
- Clinical Governance
- Commissioning and Financial Flows
- General Practice Support
- Data Quality.

Mr Thomas added: 'All of us want the opportunity to share in decisions about our health and healthcare. Health needs are personal and services should be shaped around them. We want the right information at the right time and as well suited to our needs as possible. Health Check is the "golden key" to better communications between managers, clinicians and patients'.

The Authority also announced that it is setting up Communities of Interest - targeted groups of users for the five areas - to support the development of products and services and provide feedback on performance (see box below).

Leonie Mountney, the NHSIA's Assistant Director, warned that the future introduction of the electronic NHS Care Records Service would

lead to an increased volume of information and NHS organisations would need the tools to manage the increase. However she promised that the Authority would provide analytical tools and back-up support. 'Information without interpretation is only data,' she said.

Ms Mountney added: 'The support available with NHS Information Health Check ensures that the information provided can be interpreted appropriately to answer local questions and feed local decision making. This is a national service with local impact but there is a huge improvement agenda and we can't manage it all at once.'

Examples of the way Health Check products and services are already being used by Trusts were given during the day, including the Clinical Governance Assessment Toolkit (CGAT)*.

Several speakers stressed the need for good quality data but Jem Rashbass, Non-Executive Director, NHSIA and a practicing Senior Pathologist at Addenbrooke's NHS Trust said the need for local ownership was also 'essential to encourage data quality at the local level'.

Dr Rashbass said information had a central role to play in improving the consistency and standards of local services but there was also a need for immediate feedback.

'If you are a clinical cardiologist you want to know the success of your interventions within a short time frame. You don't want to wait for months or years, you want immediate feedback from data. That is what will make it of use to you' he added.

Dr Rashbass concluded by stressing the NHSIA had the tools to enable clinicians to match with other local organisations and to make comparison on a 'like for like' basis and encouraging delegates to sign up as members of the new Communities of Interest.

***Further information at: www.nhsia.nhs.uk/ihc or call 01962 814413**

Communities of Interest (CIA)*

The NHSIA is seeking recruits for CIA to act as ambassadors for their own NHS organisations and promote the work and benefits of the Authority. Work will take up to four days a year and may include test piloting new products at the prototype stage of development, providing market research from their own organisations and working with the Authority on case studies.

Benefits include:

- Advance copies of new products
- Priority booking for new training
- Networking opportunities
- Free attendance at all NHS Information Health Check conferences/meetings.

*** For more information, call 08453 660066 or visit www.nhsia.nhs.uk**

PCT Specialist Services

Continued from page 1

PCT and Strategic Health Authority senior manager, every PCT professional executive committee member and all the decision makers at the centre who deal with NHS modernisation.'

He added: 'We would particularly recommend all PCTs, including those now preparing three-year contracts with foundation hospitals, take note of its advice on service level agreements and contracts.'

***Audit Commission reports, *Quicker Treatment Closer to Home: Primary Care Trusts' Success in redesigning care pathways and Transforming Primary Care: The Role of PCTs in shaping and supporting general practice*, available at: www.audit-commission.gov.uk**



Rob Greig

New partnerships and new ways of working needed

Rob Greig, National Director Valuing People, focuses on ways primary care can improve the health of people with learning disabilities.

There are about one and a quarter million people with learning disabilities in England – around a fifth of whom might be labelled as having a ‘severe’ learning disability. A GP practice covering 5,000 people will have over 100 such people on their list - the general health of whom is significantly worse than that of the general population. For example:

- A significantly increased risk of early death
- Death from respiratory diseases is three times that of the general population
- There is a failure to screen for, identify and treat a range of illnesses despite the known fact that they are particularly prevalent amongst people with learning disabilities (eg, thyroid dysfunction, congenital heart problems)
- Over 40 per cent of people have a hearing loss, unidentified in three quarters of cases
- The prevalence of schizophrenia is around three times higher than the general population. There is also an excessive and inappropriate use of anti-psychotic medication.

Despite this, the evidence is that people with learning disabilities are not being fully included in major initiatives to address the nation’s health.

For example, women with learning disabilities are much less likely to undergo either cervical smear tests than the general population (19 per cent vs. 77 per cent) or breast cancer examinations (10 per cent vs. 57 per cent).

To help address these issues, the government produced a White Paper for England in 2001 called *Valuing People*, which sought a radical change in the way the NHS operates. Whilst being primarily about a whole-life, social inclusion agenda, it has the promotion of positive health as an essential building block. Unless people are well, they cannot take their place as full members of their communities.

The White Paper aims to help general practice and acute hospitals improve their knowledge and skills so they are better able to include people with learning disabilities in all aspects of mainstream healthcare.

We know that GPs believe they should be including people with learning disabilities in their work but also that this is generally not happening.

The main reasons identified for this are firstly poor co-ordination between primary healthcare teams and specialist services and, secondly, concerns amongst mainstream services about their knowledge and skill base in learning disabilities.

To help with this, *Valuing People* has a national programme of support concerned with:

- Re-focusing the work of specialist learning disability health professionals to provide greater support to mainstream professionals
- The introduction of ‘health facilitation’ whereby specialist staff take responsibility for supporting and ‘brokering’ people with learning disabilities in having their health needs met through mainstream services
- The development of pro-active personal strategies to improve an individual’s health through the introduction of ‘health action planning’.

It is important to stress that this is not about the unsupported shifting of responsibility for the healthcare of people with learning disabilities onto GPs, primary care staff and acute hospitals. The aspiration is a new partnership where specialist learning disability health professionals change their priorities to work alongside and support mainstream staff. The specialist staff can and will be a willing resource to help make new ways of working a reality.

The aim is to redress the collective failure of the NHS towards people with learning disabilities. Such levels of poor health and often undiagnosed illness cannot be justified in a modern NHS.

At its most simple, this is an issue of clinical governance. This new partnership between primary care, acute services and specialist learning disability staff offers the potential for people to have their health needs comprehensively addressed - often for the very first time.

Practical Ideas for Joint Action

- Identify all people with learning disabilities in a GP catchment area
- Use information systems such as PRIMIS to cross reference people with learning disabilities against health conditions known to be particularly prevalent amongst that population
- Use this information to ensure that NSF targets (eg, in CHD) are equally attained amongst learning disabled people
- Develop disability awareness training for all staff – including receptionists
- Establish protocols and staff training in the acute sector to improve the quality of people’s experiences on hospital admission.

Comment: Worth the extra work for PCTs

The DoH has recently published the conclusion and advice of an Advisory Group set up to look at the regulations which control where and how NHS community pharmacies can be granted in England*. The Advisory Group recommends that all PCTs adopt an accreditation scheme for community pharmacies, so that a new hurdle of minimum expected level of services can be introduced.

It is also recommended that every PCT establishes local market characteristics and adequacy of existing pharmaceutical services in order to determine if a new application would increase the range, choice or quality of current services. Both of these new requirements on PCTs have considerable implications in terms of workload, capacity and resources, with PCTs needing to invest

in local pharmaceutical needs assessment, mapped against geographical, societal and demographical variation.

The recommendations also accept that introducing concepts of adequacy of services, quality and patient choice will leave PCTs vulnerable to appeals and judicial reviews under the current legal framework and changes to primary legislation will be needed. This would greatly increase the timeframe for implementing any new regulations.

The panel did recommend that the proposed exemptions to the regulations – for large shopping developments, one-stop primary care centres, pharmacies opening more than 100 hours per week and internet or mail-order pharmacies – need much better definitions and guidance.

It is evident that PCTs will be faced with a huge new workload, remaining uncertainty and a strain on resources, all at the time that PCTs are implementing the new GMS Contract and the forthcoming new Pharmaceutical Services Contract.

Nonetheless the outcome should be a more flexible provision of pharmaceutical services with more choice and better quality for patients – definitely worth the extra work.

Sue Carter, Head of Prescribing and Pharmacy, Adur, Arun and Worthing Teaching PCT

***Executive Summary of Advisory Group on Reform of NHS Pharmaceutical Services Regulations**

Quality in the New GP Contract

By Andrew Spooner

Essential reading for GPs, practice managers and practice nurses. It will help them understand the background to the contract's structure and what to do to achieve its quality requirements. It also identifies the resource implications for PCOs and the personal requirements of the suitably qualified staff they need to employ or train.

Radcliffe Medical Press £24.95

ISBN 1 85775 853 6

www.radcliffe-oxford.com

Global sum allocation formula

By the Department of Health

This booklet describes the global sum allocation formula used to determine global sum and MPIG allocations to PCTs. It supplements the description published in Investing in General Practice in February 2003.

Available at: www.dh.gov.uk. Search this site "Global sum allocation formula".

What CHI has found in acute services CHI sector report

Hospital care across England and Wales has significantly improved over the last four years and is now focused on the needs of patients. However progress on areas which really matter to patients, such as being treated in safe and clean environments, having privacy and dignity as well as a good experience of care prior to diagnosis and continuing through discharge from hospital, is still variable across England and Wales.

Available at: www.chi.nhs.uk

Tackling cancer in England: saving more lives NAO report

Cancer patients are increasingly surviving the disease as a result of the new initiatives launched by the DoH over the last decade but the NHS needs to continue to do more to ensure all patients are treated swiftly and appropriately, according to this report from Sir John Bourne, Head of the National Audit Office.

Available at: www.nao.org.uk

Clinical Governance in Primary Care, Second Edition

Edited by Tim van Zwanenberg and Jamie Harrison

NICE Chair, Sir Michael Rawlins, says in the foreword: 'This second edition extends and amplifies the principles outlined in the first edition. It explains and explores clinical governance in all its multi-faceted dimensions. It will instruct and enthuse all those involved in delivering care to patients and bring clinical governance alive.'

Radcliffe Medical Press

£27.95 ISBN 1 85775 861 7

www.radcliffe-oxford.com

PUBLISHED BY:



Medical Management Services

Creating Successful Partnerships

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Analysis

Wanless II: Public Health's Renaissance?

David J Hunter, Professor of Health Policy and Management, School for Health, University of Durham and Chair, UK Public Health Association, comments on the recently published Wanless report*



David J Hunter

The eagerly awaited report from Derek Wanless, former banker and adviser to the Chancellor, should give a welcome boost to public health. The report has received a mixed response and has been criticised for not charting a clear way forward in terms of what needs to be done to improve health and for sidestepping the vexed issue of finding the optimum balance between government intervention and individual freedom. However it does contain several important recommendations, especially in respect of primary care.

Public health's importance is rising rapidly up the political agenda, with a White Paper promised for the summer following a four-month extensive public consultation exercise, now underway. As Mr Wanless says: 'The growing public concern about issues such as obesity, children's diet and smoking in public places seems to signal a change in the current climate for public health'.

Only time will tell how far this is the case or whether the White Paper is merely a tactical device to defuse Wanless' critique of catastrophic failure on the part of successive governments, stretching over 30 years, to put health before healthcare. He notes that the production of worthy policy statements has not been matched by 'rigorous implementation of identified solutions'. Meeting the challenge requires 'a step change in effort and achievement' and 'a massive shift away from seeing the NHS primarily as a "sickness service" '.

Wanless singles out PCTs as having a crucial role in rebalancing the policy agenda in favour of health but he identifies particular problems relating to the size of PCTs and their variable capacity to deliver appropriate public health. While not recommending structural change as the answer to these weaknesses - 'repeated restructuring has tended to weaken the NHS over decades' - where it seems locally that combining PCTs' forces to tackle public health is the best way forward, then this should not be discouraged.

Perhaps more importantly, Wanless is critical of the 'target culture' and performance management regime pervading the NHS which has marginalised public health and focused effort on what can be measured rather than on what is important. Smoking cessation targets - and the distortions they give rise to - come in for trenchant criticism as 'far from ideal'.

A survey cited by Wanless of the experience of DsPH in PCTs reports that 76 per cent of DsPH felt that national work programmes displaced local priorities, with waiting lists being the most commonly identified factor. Pressures to achieve financial balance were also perceived as hampering the adoption of public health priorities.

Wanless recommends that PCTs, local authorities and other partners 'should determine shared local objectives' based on national objectives and local needs. These objectives should then be included in the planning and performance management of both PCTs and local government - through the priorities and planning framework and the comprehensive performance assessment.

Among his other 21 recommendations, Wanless wants the Secretary of State for Health to be given the role of ensuring that the cabinet assesses the impact on population health of any major policy development. This would provide leadership in central government for public health and ensure that a joined-up approach across departments is achieved.

Wanless laments the lack of investment in public health research and evaluation, particularly in the area of economic appraisal and cost-effectiveness analysis and looks to the White Paper to tackle the deficit.

To achieve the full engagement of the population with their health, Wanless recommends strengthening health literacy in the form of new ways of giving advice to people. New skills will be needed in the public health workforce to deliver on this agenda, especially in the fields of communication and social marketing.

What happens now depends largely on how serious the government is in turning its attention from the NHS and downstream healthcare concerns to an upstream agenda genuinely centred on prevention and health promotion. The forthcoming White Paper will count for little unless the incentive structures are in place to ensure that public health priorities are not sidelined as they have been repeatedly. Only political will can avoid such an outcome - and on whether that exists in sufficient abundance, the jury is out. The hope must be that there is not a Wanless III in a few years' time documenting the lost opportunity to put health first.

***Securing Our Future Health: Taking a Long-Term View is available at www.dh.gov.uk and www.hm-treasury.gov.uk**

Hear keynote presentations from Derek Wanless & Prof David Hunter and have your chance to influence the forthcoming White Paper at Medical Management Services' workshop, **Acting on Wanless II - Putting Public Health First in PCOs** on 26th May in London. For more details please email enquiries@medman.co.uk