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HOW PCGs ARE IMPLEMENTING CLINICAL GOVERNANCE

Clinical governance arrangements have come to the top of the agenda in recent months as health ministers have emphasised its importance and PCG members have campaigned for more resources.

In its recent discussion paper, *Implementing the Vision*, the NHS Alliance pointed out that the workload of both PCGs and practice clinical governance leads has been underestimated, which has resulted in numerous resignations.

It said: 'The apparent expectation that the primary healthcare team can continually expand its remit and responsibilities without adequate resourcing is unrealistic and threatens successful implementation of clinical governance at practice level.'

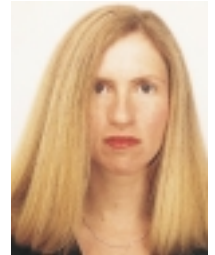
Most problems which clinical governance leads are experiencing stem from the fact that they need to take time away from the practice to carry out their work.

Under the current legislation, the HA is able to decide whether the cost of clinical governance leads can be met for work undertaken outside normal NHS clinical time. Therefore, most clinical governance leads are obliged to stay in full-time practice in order to remain fully paid.

The NHS Alliance believes that the cost of their work should be met from PCG or PCT funds, whether this is within or outside NHS

clinical time.

Lesley Wye, an associate research fellow at the King's Fund, the health charity, in London, has just completed a study of how the 66 PCGs in London are coping with clinical governance.



Lesley Wye

She asked PCGs for copies of their baseline assessments for the first year and received replies from 35. The findings give a fascinating insight into how PCGs are faring.

'One of the main findings was that only 65 per cent of PCGs have collected data from practices through questionnaires, but the other 35 per cent do not have anything they can go back and re-audit,' says Ms Wye.

'Around 25 per cent of PCGs had carried out practice visits. One of the most popular questions to ask was whether the practice had a coronary heart disease register.'

Another theme which emerged was that PCGs were struggling to find the right relationship with their member practices.

'There seems to be a tension between creating a collaborative structure and telling practices what they should be doing. PCGs are keen to be democratic organisations but there is a tendency just to use practices as a resource for data, rather than as full participants,' says Ms Wye.

Other problems which came up included the difficulty of integrating clinical governance work into the rest of the PCG's activities, with some PCGs seeing it in isolation; a lack of clarity of purpose, with many PCGs collecting huge amounts of data but being unsure what to do with it; and a focus on 'non-clinical' data in some PCGs, such as practice equipment, facilities and staff contracts.

'There is a wide variation in what PCGs are doing but this reflects the diversity of healthcare services, and the fact that they are still grappling with their role,' says Ms Wye.

Dr Jonathan Stead, clinical governance lead for Mid-Devon PCG, says that although there is firm support for CG, resources are the key.

'Clinical governance is well-embedded in health improvement programmes and baseline assessments for governance had to be submitted to the HA and then to the region, so most PCGs are aware of their responsibilities and their limitations,' says Dr Stead.

'All PCGs have had to compile an annual

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EDITORIAL COMMENT

Clinical governance is our focus this issue in which we carry a message from Professor Liam Donaldson, the government's Chief Medical Officer who has written a piece exclusively for us (see back page).

In addition, in response to readers' suggestions, we have tried to find out how PCGs are implementing CG. Resources are still a big issue. Lack of time is another, but King's Fund research shows there is wide diversity in what PCGs are actually doing.

For an update on consultation about the future of primary care, see NHS Alliance conference coverage on page three.

Thank you to all the PCG lay board members who responded to our appeal for members of a PCN readers' panel. This has now been set up and we will use their feedback on each issue to ensure our newsletter provides you with the information you want and need. However, every reader's view on any issue is always welcomed.

Jenny Sims, Editor

NEWS IN BRIEF

28-30 June

Fresh Thinking, NHS Confederation's annual conference and exhibition, Scottish Exhibition and Conference Centre, Glasgow. Details for the events department on 0121 414 1536, fax 0121 472 7783 or at www.nhsconfed.net

PCGs or PCTs? Facing the Challenge Together Report

After a series of eight U.K wide workshops the above national feedback report written by Professor David Hunter, University of Durham and Linda Marks, Visiting Research Fellow, University of Durham will be launched by NHS Alliance on 13th July at the Palace of Westminster. Details from Clive Johnstone at MMS tel: 01225 333711.

£21 million for ambulance services

The government is to give an extra £21million to speed up ambulance response times so that 75% of category A (urgent) calls are answered in eight minutes by April 2001. The funding could save 1,800 lives a year in people under 75 suffering acute heart attacks. It followed the announcement of £10million to 22 communities who had demonstrated the most progress in implementing their HImPs and produced the best plans to tackle CHD. Both initiatives are designed to help implement the National Service Framework for CHD. The government's target is to reduce deaths from heart disease, stroke and related illness by two fifths by 2010.

Male suicide strategies ineffective

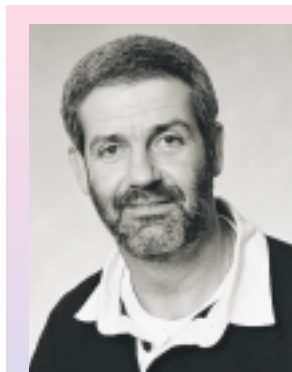
Most young men at risk of suicide are unlikely to visit their GP says *Young Men and Suicide*, a report by the Men's Health Forum. Strategies by local health and community services as well as government policies, are not properly evaluated, it says. And it calls for prevention work to involve a broad range of settings and disciplines. Available at www.menshealthforum.org.uk/suicide

PMS Third Wave Pilots

A third wave of Personal Medical (PMS) Services Pilots will go live on 1 April, 2001 and three more PCTs (Trafford South, Blackburn with Darwen and Herefordshire) will come into effect on 1 October 2000, health minister Lord Hunt announced.

'The third round will focus on tackling social exclusion problems, meeting the needs of deprived communities and supporting general practice and primary care clinicians' he said.

COLLABORATION NEEDED TO 'DISINVEST' IN SECONDARY CARE



Dr Jonathan Shapiro
Senior fellow
Health Services
Management
Centre
University of
Birmingham

As primary care trusts (PCTs) appear, and attention focuses on the transition from primary care groups (PCGs) to PCTs, it may be time to consider the place of commissioning in the new order. The main distinction between PCGs and PCTs is the fact that the latter hold the cash to procure services from other organisations. PCGs may have a notional responsibility in this respect, but only PCTs hold real funds that are theoretically theirs to dispose of in the most appropriate way for their population's benefit.

Yet many of the new primary care organisations (PCOs) seem to be more concerned about the provision of primary and community services than the services offered by their local acute care providers. Sorting out their internal relationships and tidying up the mode and style of their own care delivery seem to be preoccupying them largely to the exclusion of the interface with the trusts that form the 'technical provider' arm of the NHS. Maybe such exclusion is appropriate, given the enormous agenda for change that exists inside the new PCOs. Other issues do need to be resolved before the embryo PCOs can really fulfil their potential as the main drivers for change within the NHS.

One of the obstacles to progress has been the frustration felt by many in the NHS about its seeming inability to effect change in the acute sector. The purchaser/provider split of the 1990s was intended to allow purchasers (whether they were HAs, commissioning GPs or fundholders) to question the quantity and quality of the services that were being delivered by NHS Trusts, and to encourage these to improve, if necessary moving contracts from one provider to another. In reality, such contestability rarely occurred to any significant extent. Partly, hospital trusts were able to play off their minor purchasers against each other so that a contract lost here was regained there, and the net effect on total services was minimal.

Partly too, the political and media pressures surrounding high technology, 'sexy' services such

as coronary surgery, cancer services, and paediatric intensive care (to say nothing of the pressure to deliver waiting list targets), have meant that attempts truly to change the paradigm of care have effectively been doomed from their outset.

The demise of the 'internal market' was intended to mark a move away from this adversarial model of contestability towards more inclusive working, but this did not address the external pressures that continue to make the promotion of change so difficult. Moreover, the end of the internal market has highlighted two more issues concerning the commissioning of services from the technical sector: the concept of collaborative commissioning and the difficulties of 'disinvesting' from secondary care.

Even with the economies of scale (compared to fundholding) that have been gained by the move to PCOs, no single PCG or PCT is likely to have the clout necessary to change the way local trusts provide their services in any but a marginal way. Modern acute trusts need catchment populations of 500,000 or more, so significant changes need to be planned at this level. Modifying existing services to increase local sensitivity can only be done incrementally: discharge letters can be written differently, or admissions procedures varied, but large scale changes can only be carried out if there is real collaboration.

For issues that involve anything other than straightforward acute care, all the local PCOs, acute providers, and local authorities will need to work together, as even the simplest planning decisions will have implications throughout the care environment.

Any system-wide change must involve all the stakeholders to ensure that services are maintained and to promote 'ownership', particularly for those clinicians in the acute sector who may perceive any change in services as a threat to their status, job satisfaction and even employment. To achieve this, all the vested interests must see a benefit in their collaboration, a common cause that gives them a shared identity, rather than perpetuating the belief of to believe in 'my own organisation above all'.

Disinvestment from the acute sector has always been the holy grail, and like the grail itself, is probably unattainable; as long as demand continues to outstrip supply, and technology continues to improve, any treatment that is moved outside hospital will be replaced by a new one inside. Perhaps we should put less time into chasing this chimera and more effort into the new PCOs. If we invest differentially, and give preference to the development of the PCOs, we might be able to develop the new paradigm without overtly destroying the old one. The day of the traditional hospital is done, but we may not need the triumphal march to celebrate it.

NHS ALLIANCE 2000 CONFERENCE

Who's listening?

Most people working in primary care who have been 'consulted' during recent DoH visits to practices around the country do not feel their views will be acted on, according to a show of hands at the NHS' Alliance's summer conference in Manchester.

The response confirmed the Alliance's concerns that the government's 'listening exercise' over the pace of consultation and the lack of time for a proper debate at either local or national level before the Modernisation Action Teams' report by 15 June.

Mike Dixon, Alliance chair said: 'Many PCGs and PCTs were under the impression that they would get a personal ministerial visit. In fact consultation has been orchestrated through regional NHSE and Health Authorities in the usual way.'

Many Alliance members had said the consultation was proving 'tokenistic' and some had expressed concerns that the centre was still demonstrating 'top down cronyism rather than bottom up pluralism and representation.'

While approving the appointment of experts to the Modernisation Action Teams, Dr Dixon complained: 'An inclusive process should include the representative organisations within primary care – and this has not been the case.'

However, he said he was not cynical and believed the

government did want genuine consultation. He pointed out: 'The Prime Minister says he wants us to have ownership of the four year National Plan.'

To ensure that, the Alliance was launching its own consultation exercise to 'complement and support that of the government.'

'The NHS Alliance has always backed the principles behind the New NHS. That is why it is so important that we help government make sure this is a proper listening exercise that does provide primary care with proper ownership of the National Plan.'

'We will be e-mailing all our members with a preliminary survey this week, which will allow us to provide a preliminary report for government, as requested by 12 June' said Dr Dixon.

This would be followed by a fuller and more comprehensive national survey of all Primary Care Groups and Trusts that would provide a more complete picture of what primary care thought.

There would also be open debates at the end of each of the Alliance's regional meetings which would be written up and presented to government by the first week of July. However, the process would continue throughout summer.



Dr Michael Dixon

DELIVERING THE VISION

Money should no longer be the issue in delivering a better quality NHS said Lord Hunt, Under Secretary of State for Health, in his keynote speech.

Funding was now in place and over the next five years the NHS would grow by one half in cash terms and one third in real terms

'The first £600 million gives you the opportunity to begin to go forward to deliver the vision. This is the first instalment. More will follow, but not unconditionally. The debate now has to move forward. We need to focus on how best to use the money to modernise' he told Alliance members.

Modernisation would only be achieved if the government, those who worked in the NHS and the Local Authorities and other partner organisations worked together. But there was much common ground.

However, effective management of change had to be at the heart of the five key modernisation challenges set by Prime Minister Tony Blair. GPs would have a pivotal role but would no longer be the gatekeeper, instead they would be the patient's navigator, 'providing care where appropriate, guiding care where necessary.'

The move to PCT status had to be locally-driven and based on local views. 'It can only happen where there is broad social support. No one group will be allowed to have a veto.'

Good working relationships were critical to the performance of a successful PCT, as well as being important to delivering successful clinical governance.

'The relationship between the PCT Lay Board and its professionally led executive committee is key. Similarly the relationship between the PCT Chief Executive and Professional Chair will be paramount to the whole performance of the PCT.'

He added: 'The relationship between the PCT Executive Committee and the constituent practices is vital to the PCT's delivery of its financial and clinical objectives. It is at practice level that the key clinical decisions (on referral or prescribing) take place. It is those decisions which determine the quality of services received by patients. And which commit the PCT's financial resources.'

'Working together in partnership we will address the new challenges and deliver the vision. We will make the performance of the new modern NHS truly dependable' he said.

Guidance on PMS pilots

Government guidance will be issued shortly on applying for the third wave of Personal Medical Service (PMS) pilots which will go live in 2001, said Michael Farrar, Head of Primary Care, NHS Executive.

The question was whether to continue with further sets of waves of pilots before allowing them to be permanent or to decide if enough was known to allow for fast tracking for switching permanently.

'I would hope we know enough to allow everyone who wants to go PMS not to have to do a three year pilot first,' he said.

In response to a question on whether there was a role for Primary Care Trusts in PMS pilots, he suggested in future PCTs could act as commissioning agents for PMS pilots.

On NHS Direct, he said: 'What confuses me is when I hear GPs complaining about workload, that they have a bigger role and more pressure, yet they oppose an initiative that is trying to help people care for themselves, sooner, quicker, faster.'

He admitted: 'The way we developed NHS Direct hasn't really got alongside the way GPs would have liked.'

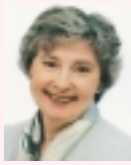
However, a review of out of hours services would aim to link services better to NHS Direct in future to make them more 'efficient and effective.'

■ A newly published paper, *NHS Alliance Response to the Prime Minister's Five Challenges for the NHS*, says national standards have an important place in achieving and measuring improvement, but they must be interpreted locally, taking into account existing service provision, local health problems and cultural factors. Available at www.nhsalliance.org

■ The government must, with the profession, agree mechanisms of professional accountability to the public says Dr Graham Archard, National Clinical Governance Lead for the NHS Alliance, in his paper, *Supporting Doctors, Protecting Patients A Discussion on Implementation*. Available at www.nhsalliance.org

DoH backs Patient Participation Groups

The Department of Health is funding a three year project to help PCGs and PCTs form Patient Participation Groups (PPGs).



Edith Todd

The project is being carried out by the National Association for Patient Participation (N.A.P.P.), an apolitical organisation and registered charity. N.A.P.P., which is partly funded by the DoH, has been promoting the cause of patients' active involvement in their own healthcare for 23 years.

With over 200 affiliated PPGs representing over one million patients and staff, and dealings with many more groups, we have regular contact with both voluntary and statutory health bodies.

Traditionally, N.A.P.P. has responded to enquiries from individual practices and health centres about starting patients' groups. Our view is that there is no blueprint for patient participation. PPGs meet the needs of their own communities. The key element for success is commitment from doctors so that patients and healthcare professionals can build and maintain informal but effective links.

With the establishment of PCGs and the emphasis on public involvement throughout the NHS, we are now tackling large groups of practices. We still advocate having separate patient groups for each practice to take account of differing needs.

The more challenging aspect of the project involves the establishment of structures whereby patients and Lay PCG members can communicate. We have been involved in Wiltshire HA's Patient Advisory Groups. We intend to investigate existing models and would like to hear from anyone involved in this field.

To find your N.A.P.P. Regional Officer or for further information, visit our website at napp.org.uk or tel/fax Edith Todd on 01932 242350.

Edith Todd

N.A.P.P. South East Regional Officer



Medical Management Services

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Telephone: 01225 333711

Facsimile: 01225 422533

Email: med.man.serv@dial.pipex.com

IMPLEMENTING CLINICAL GOVERNANCE IN PRIMARY CARE

Exclusive for PCN readers from

Professor Liam Donaldson, Government Chief Medical Officer



Clinical governance is a means of introducing the culture change necessary to underpin continuous quality improvement.

Viewing clinical governance as a starting point liberates an organisation from the bounds of its existing structures and systems. It provides a mechanism for challenging the traditional models and organisational constraints. An understanding of 'systems awareness' informs the culture change which is necessary to design and support the delivery of patient-centred, best quality health care.

Successful clinical governance is founded on teamwork, effective communication, ownership and strong leadership. It enables a culture which supports professionals as they work together to develop the organisational capability which will deliver best quality care. An organisation with such a culture is no longer simply a collection of disparate parts but is reflective and receptive, responsive, focused and flexible – a 'learning organisation'.

The National Clinical Governance Support Team (NCGST) is currently working with delegates from a range of organisations across

the NHS to support delivery of the culture change and the organisational capability which will embed continuous quality improvement into NHS organisations. One set of Primary Care delegates on the Clinical Governance Development Programme has said:

'It feels at present as if the NHS, and Primary Care, is being buffeted by a series of tidal waves... rather than yet another wave, we see clinical governance as a boat which, if manned with commitment (and enough people), might offer a way through the storm to those of us trapped on the beach.'

'To us, clinical governance is a means by which we can collectively preserve our core values, seize the initiative, and ride the waves.'

'Clinical governance reinforces the position of primary care professionals at the heart of healthcare in this country. It offers a real opportunity to make primary care part of a 'joined up', high quality service.'

PCG TIPS: Books and reports

Improving Services for Older People: What are the issues for PCGs? By Emilie Roberts

PCGs are well placed to improve services for older people and carers says a King's Fund report. A valuable reference tool for PCGs, it presents a comprehensive and accessible overview of recent national policy initiatives and evidence that current services are systematically failing to meet the needs of many older people and carers. It also outlines key issues for PCGs aiming to develop these services. Available from: King's Fund Bookshop tel 020 7307 2591.

Funding Long-Term Care: Reshaping the debate By Lorna Easterbrook

Vulnerable older people are being driven into residential care unnecessarily says this interim working paper on the King's Fund's long-term care funding project. It calls on the government to set out what people can expect from the state and what they should provide for themselves when they need long-term care. Available on the King's Fund web site at www.kingsfund.org.uk

Facilitating Groups in Primary Care: A manual for team members By Marion Duffy & Elaine Griffin Radcliffe Medical Press £25 Tel: 01235 528820

This workbook shows how practices can become team based, facilitate their own group in-house and acquire the necessary skills to be effective. It draws on practical research and development experiences, uses case studies and tools to guide the reader through the text, and contains tips and techniques to highlight communication skills.

Continued from page 1

report on clinical governance and these have been submitted recently. But they need to have resources set aside to meet the costs of the work.'

In Dr Stead's area, the first year has been taken up developing systems of accountability, undertaking a baseline assessment and producing a development plan for the next three years.

One of the themes that has emerged from practice visits by PCG leads has been the need for protected time to reflect on quality issues, and so the PCG board has decided to fund one session of protected time each month for each PCG lead in mid-Devon.

On a quarterly basis, the leads will meet to discuss and share data, based on the national minimum dataset. The PCG's priorities for the first year will be the national service framework for CHD and a long-term service agreement on diabetes.

Dr Graham Archard, CG lead for Christchurch PCG in Dorset, agrees that the problem is finding the protected time. 'There is a problem in some areas, where some colleagues are getting cheesed off with partners taking time outside the practice although some practices are happier than others,' says Dr Archard.

'A lot of clinical governance is depending on the goodwill of doctors. I don't have a problem with that but at some point the goodwill is going to run out. The government knows that CG is underfunded and it will have to address it at some stage.'

Paul Dinsdale