

# Primary Care Partnerships

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## Primary care providing more and better services

Huge improvements have been made in primary care over the last four years but more needs to be done, says Dr David Colin-Thomé, Primary Care National Director and author of a DoH progress report\*.



David Colin-Thomé

Primary care has improved patient access to care and expanded its range to provide many specialist services previously only available in hospitals. With PCTs backed by new investment and commissioning powers, it says 'primary care is now well placed to move forward.'

Dr Colin-Thomé said: 'With 90 per cent of NHS contracts taking place in primary care, it's important that the extra investment going into these services is delivering the right results.'

In particular, he said he wanted to see more improvement of services for people with chronic conditions. 'The ultimate aim is to cut the number of premature deaths and to improve people's quality of life.'

He also wanted to see an expanding role for community pharmacists and hinted that the Department will shortly be issuing a consultation document on pharmacists' roles including their access to patient records and patient confidentiality.

He added: 'There is no doubt the report is good news for PCTs and healthcare professionals but there is more to do. I hope it will help sell primary care because a lot of negative stories have put off recruitment.'

In his foreword to the report, Dr Colin-Thomé says: 'There have been big advances in the quality of care patients receive. For example, thanks to better prescribing, more than double the number of people with heart disease now take life-saving statins compared to 1999/2000.'

Key improvements include:

- Increases in specialist services in family practices - 700,000 procedures were carried out last year that until recently were only available in hospital, an increase of 100,000 on the previous year

- NHS Plan target met of recruiting 2,000 more GPs by April 2004
- Nearly 2,000 surgeries improved or replaced and 268 one-stop primary care centres established
- More than 25,000 community nurses trained to prescribe medicines, with some 1,900 qualified to prescribe independently.

Health Secretary John Reid said: 'All of the staff that work in primary care should be congratulated for helping to deliver the improvements in services we have seen over the last four years. It has been a period of tremendous change for primary care but as this report highlights, the extra investment and organisational reforms are bringing about real improvements in the quality of care and access to services.'

He added: 'The next few years will see an increased focus on delivering more primary care services. This will be backed by a 33 per cent increase in funding for primary care.'

Dr Gill Morgan, NHS Confederation Chief Executive said the report provided 'a firm basis on which to continue the trend towards integrated services across primary and secondary care.'

Dr John Chisholm, Chair of the BMA's General Practitioners Committee said the report paid tribute to what had been achieved in primary care and general practice 'through the hard work and commitment of GPs and primary care teams' and heralded what was to come as a result of the GP contract - improvements in health outcomes and reductions in premature deaths.

**\*A responsive and high-quality local NHS: The primary care progress report 2004 available at: [www.dh.gov.uk](http://www.dh.gov.uk)**

## Editorial

There is no doubt the DoH's progress report is a morale-booster for PCTs and primary care teams and it may well help staff recruitment as Dr David Colin-Thomé hopes. In addition it may encourage more GPs and nurses to develop special interests - a hope expressed by several NHS Tsars recently - particularly in elderly care services and Stroke (see page 3 article).

However, some services are lagging behind, management of many chronic diseases is making slower progress than others and failing to achieve the attention they deserve. Within this category Epilepsy is 'not being given the same commitment as other chronic diseases' according to Chief Medical Officer, Sir Liam Donaldson, following a report two years ago. Fortunately, this situation is changing because of a number of new initiatives affecting primary care. Annette Russell explains how Epilepsy is now firmly on the agenda, page 3.

Jenny Sims, Editor

**Expanding nurse prescribing**

New proposals for nurse prescribing will add over 60 medicines to their extended formulary of more than 180 products for over 80 conditions. The new list covers ten areas: central nervous system, circulatory, eye, infections, musculoskeletal, oral, poisoning, respiratory, skin and substance abuse. The expansion is hoped to improve emergency care services. The consultation document is available at: [www.mhra.gov.uk](http://www.mhra.gov.uk)

**Online recruitment goes national**

Following a successful trial of the website [www.nhs.uk/jobs](http://www.nhs.uk/jobs) which attracted hundreds of thousands of visits in three months, it has been rolled out nationally to allow the public to search and apply for NHS jobs on one website. It is one of a number of DoH initiatives aimed at improving recruitment and retention of NHS staff.

**Abuse of older people**

The Healthcare Commission has pledged to do all it can to make abuse of older people within health services a thing of the past, following a report published by the Parliamentary Health Select Committee. Health Commission Chair, Professor Sir Ian Kennedy, said it will be ensuring its inspection team is alert to potential abuse of older people while conducting remaining clinical governance reviews of mental health trusts and will investigate any allegations of abuse brought to its attention.

**Patient choice**

Patients want more involvement in decisions about their condition and treatment as well as more information and support to enable them to make choices, according to a major survey carried out by MORI for the DoH. It found improvements in communication with healthcare professionals are key and patients want not only detailed information about their conditions but more information about lifestyles and how to prevent illness.

Research carried out for the DoH by Dr Foster, an independent authority on healthcare quality, into pilot areas where patients have been offered a choice of hospital at the point of GP referral, found: patients value the offer of a choice – even if they choose to stay at their local hospital; offering choice does not significantly increase GP consultation times; patients and GPs need accurate, clear information on the different options available.

Primary Care Partnerships Editor, Jenny Sims, has been shortlisted for a freelance writing award by the Medical Journalists' Association. Award winners will be announced at the MJA's annual general meeting and followed by a reception at the Royal College of General Practitioners on 7th July.

**IT Watch**

# Working smarter not harder with a Wizard

Mary Smith, Clinical Director, Milton Keynes Speech & Language Therapy Service, describes an IT project which has cut waiting lists and brought many benefits to service providers and users.



Mary Smith

Faced with rising waiting lists and recruitment difficulties which hindered the quality and accessibility of our service to adults and children with all types of communication and swallowing disorders, we decided to utilise IT to make improvements.

Our service is delivered in homes, clinics, hospital wards and schools. The introduction in October 2002 of the Speech & Language Therapy Wizard, which links Microsoft Access, Word and Outlook, has successfully cut waiting lists and within the existing staffing resource has:

*Provided a single point of patient access;* so that patients have a single number to call to request/change/cancel an appointment. Improved information sharing means that potentially any member of the Speech & Language Therapy team can make the changes required, even if they are at remote sites.

*Improved waiting list management;* because paper-based lists have now been replaced by electronic lists, which are shared service wide. People who have waited longest, with information about their preferred appointment location, whether they have already been offered an appointment and by whom, can be instantly accessed from any site.

*Improved information quality;* by linking Therapists' diaries, waiting lists and letters to a standard patient master index. This gives a single point from which to manage patient demographics. Updates are real-time and service wide.

*Allowed shared diary management;* the software supports the use of shared diaries and allows an integrated approach to organising patient, professional and private appointments. It also supports the use of hand-helds, laptops and PDAs for mobile working.

*Introduced automated letter/report generation;* as templates are now managed centrally, this allowed the introduction of standard letters & reports across the service, which can also be tailored as circumstances dictate. This has saved large amounts of clinical time and improved information flows to patients and outside agencies and professionals.

*Initiated patient journals;* providing historical records, which together with the use of task

lists, notes and reminders improve patient-to-professional and professional-to-professional communications.

*Utilised standard Microsoft products;* albeit customised, have meant minimal staff training requirements and maximum co-ordination with existing systems.

The facility for network-based updates has meant that installs are typically a one-off operation and new software updates can be completely automated with no user intervention required.

Overall, our initial expectations have been greatly exceeded and benefits for service and system users have been significant. For example:

- Waiting times have been significantly reduced even in the face of staffing shortages and service cuts. Initial wait times cut from averages of six months to zero (as we now use drop-ins) and waiting times for treatment have not exceeded six weeks since the changes were introduced
- Non-attendance has fallen from 4.5 per cent to 1.9 per cent and is expected to fall further
- Complaints were reduced by 85 per cent in the second quarter of 2003 in comparison with the period preceding the changes
- All members of the team have been empowered in a variety of ways resulting in more work satisfaction
- A greater number of administrative tasks undertaken by the centrally based administrative team has meant more efficient use of all staff
- Communication has been markedly improved with patients and staff
- Access has been improved for the most disadvantaged members of the community because they can drop in or phone to make appointments
- There is greater service flexibility to meet patient needs
- Capacity to cope with increased workload without stress has been increased, as work is more widely shared.

**For further details email:**  
[mary.smith@mkpct.nhs.uk](mailto:mary.smith@mkpct.nhs.uk)

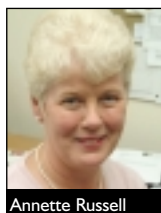
Medical Management Services is organising a one day workshop 'Implementing the Renal Services NSF' on 6th July 2004 in London.

Key presentations from Dr Steve Smith, President of the British Renal Society and Dr Donal O'Donoghue, Co-Chair of the Renal NSF External Reference Group.

**Please see [www.medman.co.uk](http://www.medman.co.uk) for full details.**

# In the spotlight

Annette Russell, Assistant Director in Clinical Specialism at the National Society for Epilepsy, looks at new initiatives affecting primary care.



Annette Russell

Epilepsy affects one in 200 adults in the UK. The National Society for Epilepsy (NSE), along with others, has been campaigning for an improvement in Epilepsy services, particularly since the publication of the National Sentinel Audit of Epilepsy-related death in 2002 which found that many of the 1,000 such deaths a year were 'potentially and probably avoidable'.

Several new initiatives are now in progress indicating that Epilepsy is now firmly on the nation's health agenda.

These include:

- The National Service Framework for Long Term Conditions – now in its final stages and looking to address needs such as a creative approach to diagnostic services; a co-ordinated approach between primary, secondary, tertiary and social care services and the importance of having face-to-face communication with somebody who can deliver information effectively

- A new government initiative for people with long term chronic diseases – a programme establishing case management demonstrator sites within 28 Strategic Health Authorities to provide patient-centred care. NSE has joined with 15 other organisations involved with long term conditions to ensure that under the new initiative, patients will have a personal care plan (if wanted), access to an advisor and that there will be investment in rapid, expert and accurate diagnosis to ensure people receive the right care and support at the right time
- NatPaCT – Epilepsy is included in the GP Competencies issued by NatPaCT
- GP contracts – quality markers for Epilepsy are included
- NICE technology appraisals of Epilepsy drugs and clinical guidelines for the management of Epilepsy.

The recent NICE recommendations on the use of anti-epileptic drugs (AEDs) are good news for people with Epilepsy and clinicians alike. NICE recommends that the newer AEDs should continue to be prescribed in the management of epileptic seizures in adults – although in most cases the older AEDs such as sodium valproate and carbamazepine should be tried first; that adults with Epilepsy should be treated with just one AED if possible and that a person who has a seizure for the first time should be seen by an Epilepsy specialist as soon as possible – with treatment reviewed at regular intervals i.e. at least once a year.

The importance of regular reviews has been acknowledged in the new GP contracts. Practices can earn up to 16 quality points for Epilepsy care. The workload of undertaking an annual review could be made easier by an initial audit of patients.

To meet the anticipated demand from healthcare professionals looking to broaden their knowledge of caring for people with Epilepsy, a unique range of courses and GP study days have been developed by NSE.

**Details on 01494 601371 or [www.e-epilepsy.org.uk](http://www.e-epilepsy.org.uk).**

# Boost for Stroke services

Stroke services in primary and secondary care will get a boost next month (June) with the publication of two separate sets of guidance.



Dr Tony Rudd

First, the RCP has revised its Stroke guidelines for secondary care and will also be producing a separate version for GPs. Second, NICE will be publishing its technology appraisal on anti-platelet treatments for the prevention of occlusive vascular events.

Leaders in the field say the government's Expert Patients Programme could play a role in helping implement both more effectively by raising awareness of Stroke prevention and improving poor patient compliance.

Prof Tony Rudd, President of the British Association of Stroke Physicians, (BASP) said: 'We have to educate the general public more about preventing Stroke. For example, knowing about their cholesterol levels and ensuring they get it checked.'

Dr David Colin-Thomé, National Primary Care Director, said: 'Basically, the management of chronic illnesses needs partnerships between doctors and patients. Patients need more say in the continuity of their care.'

Whether the Older People's National Service Framework targets for Stroke were met by 1 April, with all Trusts having a specialised Stroke service, will not be known until at least the end of August when the RCP's Effectiveness & Evaluation Unit's National Sentinel Audit for Stroke services has been completed.

Meanwhile, Professor Ian Philp, National Director for Older People's Services, has said he believes most Trusts will meet the April target. There have been some accusations that the DoH had 'moved the goalposts' to do so. Some specialists thought Trusts had to set up their own geographical unit but Prof Philp has recently said this was a misinterpretation and the target included 'roving' services.

Dr Rudd said evidence showed that specialist Stroke units were more effective than roving Stroke services but added: 'There may be certain circumstances where roving Stroke teams are useful, eg, palliative care and rural areas.'

Overall Dr Rudd felt quite positive about Stroke services in the UK. 'There have been huge and rapid changes over the last ten years in treatment and rehabilitation. We now have a greater percentage of hospital Stroke specialists than anywhere in the world except Scandinavia but there is still a long way to go.'

He said the new guidelines and the GP Contract would be positive influences and he hoped that the government's development of GPs with a Special Interest (GPwSIs) would encourage more GPs to choose Stroke as a speciality.

Dr Colin-Thomé said he didn't know how many of the 1,700 GPwSIs were Stroke

specialists but he hoped other members of the primary care team would also make Stroke an area of special interest. 'It doesn't have to be GPs, it could be nurses or therapists but primary care teams have to redesign their services to make them more effective.'

Prof Ian Philp, National Director for Older Peoples' Services speaking at a recent RCP meeting on emergency care for older people, said he wanted to boost the number of GPwSIs in elderly care. At the same meeting, Dr Roger Boyle, National Director for Heart Disease said increasing clinical audit would be the biggest driver for change in ways of working and improving outcomes – including Stroke services.

As Chronic Disease Management is a new priority for the NHS and new guidelines and targets need to be met for Stroke, PCP is planning to launch an "Action on Stroke" campaign next month with the Stroke Association and BASP.

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**NSF for Diabetes: One year on DoH report**

Commenting on the report, Sue Roberts, National Clinical Director for Diabetes, said she was encouraged by the progress that has already been made. 'This report describes that progress. We are not there yet – it is after all a ten-year programme – but with the support of healthcare professionals...we will see the transformation in Diabetes services envisioned by the NSF become a reality.'  
**Available at: [www.dh.gov.uk](http://www.dh.gov.uk)**

**Multiple Sclerosis: National clinical guideline for diagnosis and management in primary and secondary care RCP report**

Funded by NICE, this new guideline report on the diagnosis and management of Multiple Sclerosis has been produced by a multi-disciplinary group for the National Collaborating Centre for Chronic Conditions based at the Royal College of Physicians. It stresses the importance of communication and says healthcare professionals sometimes treat people with MS insensitively. Available at: [www.rcplondon.ac.uk/pubs/books/MS/index.asp](http://www.rcplondon.ac.uk/pubs/books/MS/index.asp)

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Comment

**Wanless II: Building partnerships**

Julia Ross, Director of Social Services, Barking & Dagenham, comments on the report from a local authority viewpoint.



Julia Ross

Wanless II\* makes over 20 recommendations, many of them focusing on what PCTs and Strategic Health Authorities should do in future. David Hunter's article in last month's Primary Care Partnerships concentrated quite properly on PCTs and the key role identified for them in the report as well as concerns about their capacity to deliver a wider public health agenda. However, the welcome objective of turning a 'national sickness service' into a health service will only be achieved by much closer working between PCTs and local authorities.

Local authorities have long had a real interest and skill in overcoming social exclusion and inequality and would happily become real champions in taking this forward with health colleagues. I also hope that the quiet revolution, which has been going on nationally on integrating health and social care to create front line seamless services, could be a major factor in forming more powerful alliances. Although central government certainly needs to give us a steer and framework for taking this forward, the real challenge lies in what we do locally and I for one would much prefer to work that out for ourselves!

This raises the interesting question, not really addressed in Wanless II, apart from the call for a national strategy, about how to develop the public health workforce and what is the nature of that workforce. There are fundamental questions about skills and professional backgrounds, which need to be studied as part of that capacity building. Perhaps though, we are missing a trick if we see the public health workforce as separate from the Primary Care Team. According to Wanless, 'The step change needed will require strong leadership and organisation in public health delivery as well as access to high quality, personalised information, advice and increased support to help individuals take vital health and lifestyle decisions.'

Well, yes but not necessarily on top of what we have already. Where will that leadership come from? Presumably a strong Director of Public Health is a key figure. Wanless says there should be a National Framework of objectives for all key risk factors with – and this is a crucial new element – PCTs and local authorities agreeing joint local targets.

One way of ensuring that real joined up partnerships and outcomes are achieved is to create joint public health appointments with local authorities. We have done that in Barking and Dagenham, modelled on the successful example in Wolverhampton but struggled initially with the complexity of the process to achieve it. As Dr Harry Burns, Director of Public Health in Greater Glasgow, said recently, it's not enough either to change the environment or to help people to help themselves, we need to do both.

We will miss a trick, however, if we focus too much on the leadership from the top or confine ourselves too much to thinking about public health workforce as a separate entity. A true 'primary care' team would involve GPs, community nurses, therapists, social workers and even pharmacists. I was initially taken aback when our local Pharmacy Committee challenged us that they should be seen as part of the Primary Care Team, as indeed they said, so should social workers. Different communities will have different opportunities and solutions with the development of extended schools and will want to think seriously about how to bring together education and health services to serve the local population. We are using a combination of education PFI and the LIFT programme to build primary health care into one of our new secondary schools.

One body singled out for special mention is the Commission for Healthcare Audit and Inspection (CHAI) which, 'should develop a robust mechanism for the performance assessment of the public health role of PCTs and Strategic Health Authorities'. Let's hope that they also take account of the recommendation that there should be local joint targets agreed between PCTs and local authorities. The wise and the worried would do well to get going on this now and what about using the current consultation on Choosing health?\* to ask real questions and stimulate debate, as urged by John Reid, instead of gathering in comments as some SHAs seem to be doing.

**\*Securing Our Future Health: Taking a Long-Term View and Choosing Health? A consultation on improving people's health are available at [www.dh.gov.uk](http://www.dh.gov.uk)**

**Putting Stroke Policy in Practice feedback reports**

Earlier this year Medical Management Services ran a series of workshops in association with the Stroke Association, British Association of Stroke Physicians, the NHS Alliance and Boehringer Ingelheim. We still have a few workshop feedback reports summarising the speakers presentations (including Prof Ian Philp and David Colin-Thomé). Please contact Medical Management Services on [enquiries@medman.co.uk](mailto:enquiries@medman.co.uk) indicating which of the three reports you would like:

- Feedback reports covering
- 1) Newmarket, Watford and London
  - 2) Derby/Nottingham, Darlington and Warrington
  - 2) Bristol, Bournemouth and Birmingham