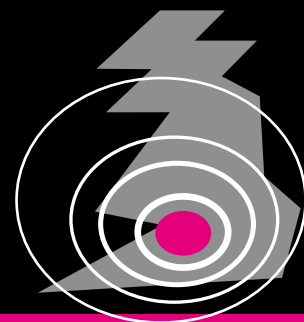


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Jane Austin

Joint working 'a long way off' says Audit Commission

The government is to end the huge variation in how much councils charge elderly and disabled people for home care services, following the publication of a damning Audit Commission report into local authorities' charging regimes.

The study, *Charging With Care*, found that charging policies in a third of councils had left elderly and disabled people with less money to live on than the appropriate income support levels for people of their age.

The report also identified perverse financial incentives that led councils to steer people towards residential or nursing care rather than foot the bill for keeping them in their own homes. Ministers have promised national guidance to ensure charges are more consistent and fair.

Charging With Care, has been greeted by NHS managers as further evidence that the

social service care which clients receive depends largely on where they live and on local funding priorities. They argue that such variations in council services have a negative impact on health services and that clients are too often at the mercy of two different regimes.

Elderly and disabled people who are frequent users of both health and social services are among those most likely to suffer when joint working fails. And the report has prompted renewed calls for a more seamless health and social care system where clients get the support they need regardless of where they live.

Over 500,000 people receive home care in England and Wales and 94% of councils charge for services. *Charging with Care*, found charges ranged from nothing to well over £100 per week for the same level of support.

The NHS Confederation said variations in charging policies had an impact on people's ability to look after themselves at home and consequently on how quickly they can be discharged from hospital.

The Audit Commission's evidence suggests that a needs-led co-ordinated health and social care service is still a long way off.

Changes introduced by the Health Act 1999 made co-operation between the NHS and local authorities mandatory and introduced new 'flexibilities' including pooled budgets, and opportunities for one side or the other to take over the commissioning or provision of particular services.

But there are fears that these changes don't go far enough. Last month, the NHS Confederation re-ignited the debate over who should provide care services by calling for the commissioning of social care for elderly and disabled people to be passed to PCTs.

The Local Government Association firmly rejected the proposals citing the NHS's lack of experience in the field as a reason for maintaining the status quo.

John Ransford, head of social affairs for the Local Government Association says health and local authorities should avoid getting side-tracked by a debate over organisational change which would divert energies away from planning and working together.

He says joint working has improved since the creation of Primary Care Groups, all of which must have a social services representative on the board. The new scope for pooled budgets and working in partnership will bring about further

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EDITORIAL COMMENT

Joint working is the theme of this issue. Traditional barriers are coming down, as our report from the National Tracker Survey of 72 PCGs in England reveals, particularly with the help of social services members on PCG boards. But there is 'a long way to go' as the Audit Commission points out in its report on councils charging for home care.

The NHS Confederation has stirred up a hornet's nest with its proposal that PCGs/PCTs take over responsibility for social services currently provided by local authorities and for a single budget for elderly and physically disabled people.

Not surprisingly, it has met with strong opposition in some quarters. Sir Jeremy Beecham, chair of the Local Government Association, has said such a move would be a disaster. And Jo Williams, Cheshire social services director and president of the Association of Directors of Social Services also wants social services kept in local government.

'The biggest shortcoming is the investment in community based nursing services, and I don't see how the NHS Confederation's suggestion would change that' she says.

All sides await the government's National Plan due this month with interest!

Meanwhile at PCN it has been suggested we include more material relevant to lay members and that we start a letters' slot where people can share problems and solutions (anonymously). Contributions to start this slot are urgently needed and all other suggestions for articles will be welcomed.

Jenny Sims, Editor

NEWS IN BRIEF

NICE guidance for patients

NICE, the National Institute for Clinical Excellence, will be producing guidance for patient carer and user groups later this month (July) on submitting views. Anne-Toni Rodgers, executive director of NICE, said: 'NICE really wants to hear the patient and carer voice in its technology appraisals. We hope this guidance will provide the support organisations are looking for.'

'We understand NICE may shortly be asked to look at certain cancer drugs, and the institute expects to receive its third full work programme in the near future.' For details call 0207 849 3455.

Scottish Confederation launched

The Scottish NHS Confederation was formally launched at the NHS Confederation's annual conference in Glasgow last month (June). 'The new organisation will have the scope to develop its own agenda, to develop an understanding of the issues and needs of boards in Scotland and take it's own approach to addressing them,' said acting chair Caroline Thomson before the launch. News on the conference will be covered in our next issue.

Exercise on prescription

The government is shortly to publish new guidelines to help GPs start exercise referral schemes for patients, public health minister, Yvette Cooper told the Royal College of Physicians conference, 'Physical activity for patients: An Exercise Prescription.'

Over 200 practices in England currently offer 'exercise on prescription.' Evidence suggests that one third of all coronary heart disease cases and a quarter of strokes could be prevented with appropriate exercise.

The recommended levels of physical activity are: 30 minutes of moderate exercise (brisk walk, cycling, swimming, dancing etc.), five times a week for adults and one hour of moderate exercise, five times a week for children and young people.

Joint working success

Newham PCG has obtained £121,000 government funding to help reduce waiting times for cancer appointments at Newham General Hospital.

It will pay for five extra healthcare assistants, better data capture and provision of information, and an extra specialist nurse for stomach cancers. Lee Borrett, PCG head of finance and commissioning said: 'This is the result of a joint bid between the PCG and Trust and shows the benefits of improved joint working.'

NATIONAL TRACKER SURVEY

PCGs have taken positive steps to implement the government's modernisation agenda but some areas need further investment and action according to a major survey.

The survey tracking the progress of 72 English PCGs during their first six months of full operation was carried out by the National Primary Care Research and Development Centre (NPCRDC), University of Manchester and the King's Fund.



Professor David Wilkin

Project director, Professor David Wilkin of the NPCRDC said: 'PCGs have made remarkable progress in a very short time. Board members have responded to the challenges with great enthusiasm.'

However, pressure from ministers and the NHSE to produce rapid results may undermine their ability to produce long-term change. Local ownership and initiative should not be squeezed out by central control.'

FINDINGS INCLUDED:

Trusts

Two fifths of PCGs were aiming to become trusts in 2000 or 2001, but there was no evidence they were significantly more advanced in development than those anticipating a slower pace of change.

Professor Wilkin said: 'Whilst PCGs are under great pressure to produce rapid results in the rush to convert to trust status, questions must be raised about their capacity to take on new

roles and responsibilities.'

Health & social care

Tribal boundaries between health and social care were being tackled by PCGs. Board members showed a positive attitude to working with social care and local authority partners. Having a social services representative on the board has begun to break down historical inter-professional difficulties, particularly between social services and GPs. Relationships between social services and community health have also improved.

The development of partnerships between PCGs and local authorities is being held back because of different geographical boundaries. Over a third of PCGs have patients spread across two or more social services departments.

Nearly half of PCGs are in areas with two-tier local government and have no automatic links with other local authority services such as housing or community development, but two thirds of PCGs had begun making wider links with liaison over urban regeneration programmes such as Health Action Zones, Healthy Living Centres and Surestart programmes.

Caroline Glendinning, reader in social policy at the NPCRDC, said: 'In planning mergers and moves to PCT status, PCGs have an opportunity to look again at boundaries and the advantages of closer alignment with local authority boundaries. It is important that the real progress which PCGs have made in developing partnerships with local authorities are not overlooked in their desire for greater autonomy as trusts.'

Prescribing

PCGs placed more emphasis on reducing the costs of prescribing than on improving the quality

Continued from page 1

improvements. 'Our view is that we need people to work together at the front line,' he says.

'The cultures of organisations are very different. The more you work together the more those differences are made explicit. In my experience you can't work together properly unless those tensions are ironed out.'

Everyone agrees that the traditional barriers that exist between health and social services have stood in the way of effective service delivery.

'The difficulty is there hasn't been a common framework in which joint-working can occur. It has often grown up in areas where there have been local champions pushing the joint-working agenda,' says Jane Austin, policy manager for the NHS Confederation.

The best inter-agency working has often come about with the aid of funding for a specific initiative such as in a Health Action Zone. In these cases staff from all disciplines have established new infrastructures with the help of pump-priming money to deliver a completely integrated service.

A Social Services Inspectorate report on social services links with primary health services, published last year, came to similar conclusions.

Inspectors found examples of successful small-scale partnerships covering one area of work or geographical location. These took the form of links between GPs' surgeries and social services, teamwork with community nurses, links between the care programme approach and care management systems for people with mental health problems and collaboration over home, residential and nursing care.

The inspectors also found signs that the creation of the PCGs had a positive impact and raised primary care further up the social services agenda.

Examples of good practice included links forged between social services fieldworkers and GP practices. In North Yorkshire three care managers liaised with a total purchasing project of four GP practices to improve services.

However, these pockets of success have not yet been rolled out into any 'wider partnership between social and primary health services across the area covered by any of the SSDs', said the report.

For the future, Ms Austin predicts more effective joint working, 'once the flexibilities of the 1999 Health Act have been fully implemented in a few years time'.

By Kendra Inman

OF PRIMARY CARE GROUPS AND TRUSTS



Caroline Glendinning

of prescribing. This was largely due to pressures on prescribing budgets exacerbated by a shortage of generic drugs earlier in the year.

The report said: 'Although most PCGs focused on the role of GPs in prescribing, it will be important for them to look to other health professionals including nurses and pharmacists if they are to improve quality prescribing and contain costs.'

Clinical governance

There was a wide range in the resources allocated to CG – from £3,000 to £150,000 per PCG, with an average of £15,000. The survey found that 74% of PCGs had made good progress in assessing their current capability, 50% had already identified CG leads and 20% identified budgets for CG.

PCGs made a good start in establishing a framework for clinical governance, emphasising collaboration with local GPs, community and practice nurses and conducting assessments of their existing capabilities. However, lack of time and resources are major problems likely to hold up the development of CG. Some practice staff remain ambivalent or suspicious of it. Considerable work needs to be undertaken to achieve the cultural change needed if CG is to achieve its full potential. The most common clinical priority area was coronary heart disease.

Commissioning

Most PCGs had begun to prepare themselves for taking on greater responsibility for commissioning in their second year.

'Many PCGs are already commissioning community services jointly with their neighbouring

PCGs. Such collaboration will enable them to make the best use of resources,' said Steve Gillam, King's Fund director of primary care.

However, there was no evidence of early involvement of all key stakeholders. Most PCGs were not meeting regularly with providers of community services and few had consulted with patients, carers or the public.

IM&T

Unrealistic targets, lack of resources and inadequate existing systems were seriously impeding the generation of appropriate, reliable and timely information needed by PCGs. In the first six months most PCGs had hardly begun to address the huge development agenda in IM&T. Of the 72 PCGs taking part in the survey almost one fifth were unable to identify an IM&T lead. Of the 38 leads who responded, more than half spent less than five hours per week on IM&T work for their PCG. The report warns that PCG/Ts must secure financial resources to fund IM&T development and adequate levels of appropriately skilled staff if they are to contribute to the achievement of the long-term goals set out in *Information for Health*.

Managing budgets

Some PCGs were getting to grips with their responsibilities for managing budgets, including developing incentive schemes, but many lacked the necessary information and financial management capacity.

Health authorities' role

HAs have worked hard to support PCG development but are often unclear about their role in providing strategic leadership. Although many recognised that their PCGs needed more support they often did not have the resources to provide it.

KEY ISSUES RAISED BY THE RESEARCH

Development takes time – PCGs are under great pressure to produce rapid results. Short term political agendas may undermine their ability to learn from experience and implement long term change.

Getting the right balance between national policy and local ownership – PCGs are struggling to keep up with demands of national policy and guidance. There is a danger local initiatives will be squeezed out.

Information – the information needs of PCG/Ts must be given higher priority.

Collaboration and partnership – has yet to be translated into real changes in working practices.

Changing the culture – organisational changes need to be accompanied by changes in the culture of primary care.

* *The National Tracker Survey of PCGs/Ts Progress and Challenges 1999/2000*. A full copy of the report is available at <http://www.npcrdc.man.ac.uk/pages/research/PCG.htm>

Care of disabled people inadequate and badly organised

Services for people with disabilities are inadequate and not properly targeted says a new report from the Royal College of Physicians.

Disabled people themselves feel current services are remote, inadequate, fragmented and designed more for the convenience of health service providers than patients, it found.

Dr Linda Marks, chair of the Joint Specialty Committee in Rehabilitation Medicine said: 'Disabled people often feel that services provided for them come at the bottom of the NHS priority list. More resources coupled with better targeting of facilities could do much more to supply disabled people with the framework and support necessary to allow them to fulfil their potential.'

'People with disabilities often have so much to give back to society but are unable to do so because of current barriers in accessing appropriate health care and over-coming social attitudes.'

The authors conclude there is a need for more information and advice, greater autonomy in making choices and greater involvement in the planning and implementation of individual treatments and services generally.

Recommendations include: a population of 250,000 should have an in-patient unit of 15-20 beds to cope with people who have suddenly become disabled or whose level of disability has suddenly increased.

Welcoming the report, the British Society of Rehabilitation Medicine said it had

been concerned for some time about inequities of provision of rehabilitation in the NHS and had recently carried out its own survey of services (excluding spinal injuries) throughout the UK. This showed:

- No region of the UK meets the RCP's minimum recommended levels of provision. Scotland comes closest with a mean of 2.9 consultants in rehabilitation medicine per 1 million population. The least well provided regions are Wales (0.8) and North East Thames (0.9). The mean for all UK regions is 1.8.
- No region is able to offer the minimum number of beds.
- Fifteen-fold differences were found in the availability of specialist rehabilitation medicine clinics (excluding amputees) which range for 0.3 per week for each million population in Anglia to 5.3 in the West Midlands (mean for the UK 3.7).

The society said: 'Ten-fold or greater differences in the access that disabled people have to NHS consultants in rehabilitation medicine in different parts of the UK cannot be explained on any rational basis.'

* *Medical rehabilitation for people with physical and complex disabilities* by L Marks, DL McLellan, R Langton-Hewer and C Ward. A summary and recommendations are available at www.rcplondon.ac.uk

FUTURE REGULATIONS OF HEALTH PROFESSIONALS DEBATED

'The current, fragmented systems for regulating the work of doctors, nurses and other health professionals have lost public confidence and need radical change,' Celia Davies, Professor of Health Care at the Open University, told a breakfast discussion at the King's Fund.

Opening the discussion, she said: 'The government has become impatient for reform. And the professions are feeling uncomfortable in the spotlight of intense media scrutiny. Only a fundamental change in the framework of professional regulation will improve this situation.'

'We need a new framework to unify and simplify regulation, covering all those who give hands-on health care. It should involve service users and ensure its work is open to the public.'

Presenting the opposing view, Bob Nicholls, a lay member of the General Medical Council, said: 'Professional self-regulation is the best way to protect the public from poor medical practice. Control by contract and inspection is no substitute for a system that works through the conscience of the professional. The vast majority of health professionals continue to enjoy public trust.'

'Professional regulation is not just about dealing with bad doctors. It is about raising standards of care, encouraging good practice and preventing poor performance. It must involve and be informed by the public, but should be led by the professions themselves.'



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ACHIEVING CORPORATE GOVERNANCE

Advice from a legal expert

A sense of corporacy is often difficult to achieve because of limitations imposed by managerial costs, other priorities and sheer overwork.

The following questions could facilitate your transition from a PCG (and as such a Committee of the Health Authority with no corporate identity and limited accountability) to a PCT.

PCTs have a public corporate identity and full accountability, from the 'accountable officer' status of the Chief Executive to the exercise of, what might be described as, 'career limiting' decisions of officers and non-executive members of the PCT Board.

■ You will have Standing Orders and Standing Financial Instructions in place. However, have you considered implementing 'key guides' for those who may, by example, be making decisions on your behalf? Can they make those decisions, have they, and do you, the Board, know about them or need to know about them? Do you have a decision-making framework in which the accountability of the decision-makers is self-evident?

■ Are you sharing information about partnership arrangements concerning the development of community care and social services? If so, how, who has access, does the sharing and access preserve patient or client confidentiality



and does it comply with the data protection principles of the Data Protection Act 1998?

■ Have you in place strategies and systems for improving 'clinical governance' and monitoring arrangements so that you can meet your statutory duty of 'Quality'? What systems are in place to enable your clinical governance leads to fast track decisions to the Board?

■ As there are major cost pressures on prescribing, what arrangements do you have in place for co-ordination between your prescribing leads and the clinical objectives of the PCG? What is the balance of that subcommittee or working group? Does it offer another perspective so that cost pressures do not dominate the agenda? Have you considered all relevant information and discounted irrelevant information? Would a member of the public know what decision you had made and how it was reached?

■ Is the decision-making of the Board sufficiently open and transparent? Is it self-evident from the agenda, reports, discussion at meetings, and minutes as to what decision was reached, how and why? An audit trail of agenda, reports and minutes should be established as a matter of good practice.

Melanie Print

Partner, Beachcroft Wansbroughs, Sheffield office, on 0114 209 5096, specialises in all aspects of GMS, PCGs/PCTs and the interface between healthcare and community care as delivered under partnership arrangements.

PCG TIPS: Books and reports

Elderly People and the Boundary between Health and Social Care 1946 – 91

By Paul Bridgen & Jane Lewis

The Nuffield Trust ISBN: 1 902089 39 1 £8.50

This 124 page study presents a thorough investigation of central government's policy, based on archival sources. It shows health and local authorities have sought to avoid responsibility for people in need of nursing and/or medical attention.

PCTs – a radical change in primary health care
Royal College of Nursing

This eight-page RCN Information for Nurses pamphlet answers the question What are PCTs? and explains simply and clearly their functions and differences. It also covers governance and lists

relevant NHSE publications.

Available from RCN Direct on 0345 726 100, publication code 001 170.

Developing a national plan for the new NHS: Nursing's views on NHS modernisation in England
Royal College of Nursing

This 47-page document responds to the six challenges to the NHS made by the Prime Minister which are providing the structure for the DoH's National Plan for the NHS in England.

Published June 2000, available from RCN Direct on 0345 726 100

Implementing evidence-based changes in healthcare
Edited by David Evans & Andrew Haines
Radcliffe Medical Press
ISBN 1-85775-382-8 £27.50

Jenny Simpson, British Association of Medical Managers Chief Executive, says in the foreword: 'I believe this is an important book. For too long the NHS has relied on dedicated and committed individuals to drive forward clinical change, with little or no support from their organisations.'