

# Primary Care Partnerships

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## PCP launches Action on Stroke Campaign with new awards

The cost of stroke to the NHS is more than £2.3 billion a year and at any one time stroke patients occupy 20% of all hospital beds. The aim of this campaign is to keep stroke high on the agenda of PCOs.



Graham Archard

The Stroke Association is backing our campaign and the Stroke Care Awards of Excellence which will reward examples of best practice among PCTs and GP practices.

The awards will therefore be split into two categories. The first will celebrate the success of a PCT that can demonstrate it has developed shared care protocols with secondary colleagues, as demanded by the National Service Framework. The second category, for GPs, will reward the best example of how a practice has managed its nGMS stroke targets.

The campaign will include a series of workshops on stroke which will include implementing the new RCP guidelines, the new British Hypertension Society guidelines for hypertension management, meeting targets and examples of good practice.

The workshops are also likely to explore what is happening in stroke generally, look at the Healthcare Commission report due out soon and suggest action plans for a stroke shared care protocol and transfer of care. Further details will be announced in our July/August issue.

Dr Graham Archard, Clinical Governance Lead for the NHS Alliance, said: 'The Quality and Outcomes Framework gives us an opportunity we have never had before to focus our attention on the prevention of stroke and the support of people who have had stroke.'

'The PCP Awards and courses will further improve the understanding and management of stroke victims and make a significant

contribution to work at the primary and secondary care interface.'

The Stroke Association wants to see specialist stroke units in all general hospitals in England and Wales. It says: 'At present only 36 per cent of admitted stroke patients spend any time on a stroke unit. Thirty people each day die or are left seriously disabled because of this lack of specialised treatment.'

Sue Wayne, Stroke Association Regional Manager, said: 'stroke is a burden on the whole family, not just the victim. We must make people more aware of the risk factors, especially high blood pressure and what they can do to prevent stroke – such as quitting smoking and eating healthily.'

Stroke facts (from The Stroke Association):

- There are 130,000 new strokes in England and Wales every year
- One third die within the first four weeks
- Stroke is the third biggest cause of death in this country
- At any one time in the community there are over 300,000 people disabled by stroke
- Stroke is the largest cause of disability
- At any one time stroke beds occupy 20 per cent of all hospital beds.
- The cost to the NHS is estimated to be more than £2.3 billion annually.

**\*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

PCP's 'Action on Stroke' is well timed for several reasons, not least the long-awaited publication of the Health Committee's report on obesity – a major risk factor for heart disease and stroke (see p 4).

The report is highly critical of the food industry's relentless targeting of children through intense advertising and promotional campaigns. It calls for a sustained health education campaign to target obesity by raising individual awareness of its consequences. The report says: 'It is clear people are now overeating in relation to their energy needs. Solutions need to address both sides of the equation: nutrition and physical activity.'

These recommendations tie in well with what The Stroke Association has been advocating for a long time in its prevention awareness campaign, raising the profile of smoking, diet and salt as risk factors people can do something about themselves to cut their chances of having a stroke.

The Stroke Association supports the Government's commitment to reduce the death rate by 40 per cent for people under the age of 75 from strokes and believes that more action is needed to raise awareness of stroke – so does PCP!

Jenny Sims, Editor

### Expert patients website

Contributions, stories and comments from patients with long term conditions are requested from the National Primary and Care Trust Development Programme which is expanding its new website for expert patients over the next few months.

[www.expertpatients.nhs.uk](http://www.expertpatients.nhs.uk)

### New National Director for Social Care

Kathryn Hudson, Director of Social Services at Newham Council, has been appointed National Director for Social Care. The new position has been created to strengthen relationships between the DoH and social care stakeholders across Central and Local Government, national social care bodies and the private and voluntary sectors.

### GP charges for overseas visitors

GPs will be given new powers to charge overseas visitors for their services under new proposals announced by Health Minister, John Hutton. In a consultation paper the DoH sets out proposals to establish new criteria for determining who will be eligible to receive free NHS primary medical services. The proposals include an option that would allow GPs to charge overseas visitors as private patients.

Consultation ends on 13 August. See [www.dh.gov.uk/PublicationsAndStatistics](http://www.dh.gov.uk/PublicationsAndStatistics)

### NHS Alliance Conference

Bookings are now being taken for Choice and Consequence, the NHS Alliance's 7th annual conference, 20-21 October, Bournemouth International Centre. Speakers include Health Secretary, John Reid and Sir Nigel Crisp, Permanent Secretary, DoH. Details from [yhunter@health-links.fsnet.co.uk](mailto:yhunter@health-links.fsnet.co.uk) or 0121 248 3399.

### LIFT problems

Health centres, GP surgeries and other primary care premises, currently being built through the LIFT (Local Improvement Finance Trust) initiative, may fail to meet sustainable development objectives, a review of LIFT projects in three areas has found.

Jonathan Porrit, Chair of the Sustainable Development Commission, told a recent joint conference with the NHS Alliance: 'LIFT projects may not be as big as PFI schemes but health centres and GP practices are at the heart of our communities. They should be enhancing communities and supporting local economies as well.' [www.nhs.alliance.org](http://www.nhs.alliance.org)

## IT Watch

# Benefits for all

Dr John Parry, GP and IT Lead, Airedale Primary Care Trust, discusses the implementation of shared records in Airedale PCT utilising SystemOne from the Phoenix Partnership.



Dr John Parry

At a recent lunch presentation in Westminster, MPs expressed their concern that the National Health Service was not yet joined up by its Information Technology. There was fear that the wider NHS did not understand enough about the future systems being promised by the National Programme for Information Technology and that clinicians were not being trained to use the systems for the future, now.

At our Strategic Health Authority meeting of the NPfIT Board at the end of May a very different story emerged. Planning for the implementation of new Patient Administration Systems in several Acute Trusts is well under way. Plans are being drawn up to ensure proper communication across the local NHS and the challenge of staff engagement is being addressed.

The MPs are correct in one area. There is not yet very much experience within the NHS of shared electronic records. Electronic records are often for collecting extensive data sets that are seldom useful as clinical communication tools.

In Airedale PCT the Primary Care Electronic Patient Record developed over four years ago permits the sharing of the GP electronic record (subject to the patient's consent) with the local Consultant Diabetes Centre at Airedale NHS Trust. This process goes much further than the patient held record of the maternity patient. The GP record - acknowledged as the richest data source within the NHS - is available to the diabetes consultant, permitting a more holistic approach to the care of the patient.

Recent, as well as past, consultations, medication, allergies, blood test results are available for scrutiny. As a result the electronic record becomes a true communication channel - so much so that it can be used for e-consultations and e-referrals. Rather than referring a patient to a clinic, a specific question can be asked of the specialist and the record shared with the diabetes unit. The consultant reviews the entire record and enters his or her opinion directly into the patient record, instantly available to the GP.

This process alone is extraordinarily useful and should serve as a model for future developments.

The shared record enhances the doctor-patient relationship. Patients feel that those involved in their care know what is going on - there are no communication black holes as the different members of both the primary and secondary care teams contribute to the patient record.

The shared record has other effects. As a general practitioner opening your records up to a consultant's scrutiny is like having your homework marked by the head teacher - it concentrates the mind. The consultation tends to contain more narrative information as a part of good communication.

The system used for this record sharing runs from a single wide-area enabled database. The records of the population are available for PCT-wide audit. This allows rapid and simple access to complex reports combining disease coding, numeric data entry and pathology results. This model permits targeting of care where need is highest, similar to the way the NPfIT envisages the data in the Data Spine being used once populated from the feeder systems over the next five years or so.

Shared records are now routinely in use in other areas. The GP Out-of-Hours Co-operative uses the same system to provide access to the GP record at all times and to ensure that the Out-of-Hours consultation notes are available to the local practices. Access to GP records in the local A&E departments is permitted (again subject to patient consent) and the five local palliative care teams use the same system.

Experience to date shows that virtually all patients welcome record sharing between clinicians at the point of care. Whenever an encounter is recorded in the shared record there are immediate benefits to all - speed of communication, auditable access control and better-informed decision-making.

**For further details email [john.parry@bradford.nhs.uk](mailto:john.parry@bradford.nhs.uk)**

## More room at the top for PCTs

The NHS Alliance is calling for more primary care representation at the DoH top table of tsars. It says Government policy to devolve power from the centre to frontline staff is not happening as it should and some PCTs are being coerced and bullied by their Strategic Health Authorities.

The Alliance said clinician representation within SHAs was often tokenistic and it was aware of resignations by clinicians and non-executive directors because they felt unable to carry out their roles effectively.

NHS Alliance Chair, Dr Michael Dixon, said: 'SHAs - and even the "top table" - appear to misunderstand the difference between performance management, which is the proper

role of an SHA and instructing how services should be commissioned and provided, which is not.'

He said it was not happening the way it should because there was inadequate understanding of the issues around frontline services, which was 'inevitable' without proper representation of primary care.

'Government should insist that the bureaucracy actively supports its policies for local decision making by clinicians and patients. The top levels of the NHS should open their doors to primary care and demonstrate the same commitment to radical change that PCTs and frontline clinicians already have', he added.

# Why are PCTs employing so few healthcare assistants?



Yvonne Sawbridge, NHS Alliance Nurse Lead and Director of Nursing, Burntwood, Lichfield and Tamworth PCT, examines the issues.

How many practices are employing healthcare assistants to help deliver their services? In our PCT there are six compared to 66 practice nurses. Contrast this with our community nursing workforce and you find a different picture. If this is representative of the national approach then there is obviously room for debate and action. Is the field of practice nursing so different from other nursing fields that this type of skill mix would be inappropriate for patient care? I can see no evidence to support this.

Primary care is facing many challenges currently, one of which is capacity. The new GMS Contract is a practice-based contract, utilising the skills of the team appropriately to meet diverse needs of patients. The focus on the Quality & Outcomes Framework and management of long-term illness plays to the strengths of nurses. A great deal of debate around workforce issues concentrates upon the medical workforce.

The increase in GPs, as required in the NHS Plan, may have been met with less ease than the national target for nurses but let's not breathe a sigh of relief just yet. A recent Audit Commission report (1) highlighted the demographics of the primary care nursing workforce - we are getting old! One in three was aged 50 or over and recruitment measures will find it difficult to keep pace.

Workforce figures for general practice staff may be notoriously difficult to collect and validate but Department of Health (2) figures

indicate a rise in whole time equivalent practice nurses from 9,821 in 1996 to 12,967 in 2003. The new GMS Contract indicates the need for continued expansion of this workforce. While the additional commissions for nurse training should eventually catch up with this growth, the service still needs to be delivered today.

International recruitment appears less likely to offer the solutions in primary care than for acute partners. Appropriate skill mix seems to be the obvious answer. One of the barriers to this development may be the hesitancy of a registered nurse (and/or their employer) to be clear about appropriate delegation of tasks to these new recruits. The registered nurse remains responsible after all.

Lynn Young, RCN Primary Care Adviser, wrote in a recent article that appropriate training and development of healthcare assistants would ensure that accountability issues for the registered nurses responsible for delegation of roles could be managed effectively. To encourage untrained receptionists to provide unsupervised consultations with patients may be a higher risk. Issues such as patient rights, choices, cultural issues and health and safety demand a degree of understanding that is unlikely to be assimilated by chance - training will be necessary.

A framework that provides a currency to assess competency is the NVQ route. This is a well-established model in healthcare and

as most PCTs are set targets to achieve numbers of personnel attaining NVQs - they may well welcome an additional pool in which to fish. In addition Nursing Times (3) reporting on Unison's annual healthcare conference in April found that 73% of HCAs would like to train as registered nurses - that takes the headache out of pre-registration recruitment plans, surely!

In summary, this unqualified workforce is readily available, keen to train and offers a range of life experiences and diversity of background. If supported and developed appropriately, they will enable us to deliver the quality aspects of new GMS with an immediacy that would be unimaginable if dependent upon an increase in registered and experienced practice nurses. PCTs are well placed to provide the support and guidance, not to mention encouragement to practices to utilise their staff budget to employ and develop this valuable human resource. So what's stopping us?

## References

1. *Audit Commission, Transforming Primary Care. Audit Commission 2004*
2. *Department of Health. March 2004 Statistical bulletin NHS Hospital and Community Health Services Non-Medical Staff in England 1993-2003. Department of Health.*
3. *Nursing Times. HCAs need more opportunity to train May 4-10th 2004 p5.*

## Incontinence: Breaking the taboo

**Urinary incontinence is 'under-reported' and 'under-treated' according to the charity, the Continance Foundation, which is launching an awareness week, 13-19 September, publicising help available in the NHS.\***

Incontinence affects more than six million men and women of all ages in the UK but many are too embarrassed or ashamed to seek help. Many people are unaware their condition can be treated or in most improved if not cured, says Judith Wardle, the Foundation's Director.

'Continance problems are one of the last taboos. If only they knew how common they are, how easy it is to get help and how many treatments are available, most women and men would find their lives transformed,' said Ms Wardle, presenting results from a UK survey of Stress Urinary Incontinence (SUI) at a recent briefing at the Royal Society of Medicine.

Speakers at the RSM meeting pointed out that PCTs spend a large proportion of their budgets on continence pads and perhaps some of this would be better spent by commissioning secondary care procedures to reduce SUI.

Mr Dudley Robinson, Consultant Gynaecologist at Kings College Hospital, London, discussed a new treatment for SUI being carried out in several NHS Trusts.

The Q-Med, Zuidex system - a gel injected using an IMPLACER device - can be used for all women when pelvic floor exercises have failed to help. In women considered for surgery, it can be tried first as it is minimally invasive and doesn't rule out the possibility of surgery later on.

Studies indicate that more than 75 per cent of the women treated with ZUIDEX remain either cured or markedly improved 12 months after treatment.'

Survey results: How UK women view incontinence

- Over a quarter of UK women are incontinent on exertion
- 2 in 5 avoid exerting themselves
- 1 in 3 have sought or received information about urinary incontinence
- 4 out of 5 who seek medical help consult a GP
- 4 out of 5 who consult a GP are satisfied with how their condition is handled
- 1 in 2 who seek medical help have an operation
- 1 in 10 who do not seek medical help believe that none is available
- 1 in 2 use continence pads.

[\\*www.continence-foundation.org.uk/directory](http://www.continence-foundation.org.uk/directory)

## Our sponsor



**Practice-led Commissioning: Harnessing the power of the primary-care frontline**  
By Richard Lewis

This King's Fund report examines the return of GP fundholding in the form of practice-led commissioning. It argues this is a positive development that has so far failed to receive the attention of other crucial health reforms.

Available at: [www.kingsfund.org.uk/pdf/practiceledcommissioning.pdf](http://www.kingsfund.org.uk/pdf/practiceledcommissioning.pdf)

**Making a difference – engaging clinicians with PCTs**  
**NHS Alliance and National Clinical Governance Support Team report**

This report provides the most thorough examination yet of how the unique structure of PCTs is operating in practice. It considers what needs to be done to maintain and nurture the critical three-way partnership between the Board, the Executive Management and the Professional Executive Committee.

Available at: [www.nhsalliance.org](http://www.nhsalliance.org) (members only)

**Medical Records Use and Abuse**  
By Heidi Tranberg and Jem Rashbass

Written by a lawyer and a clinical informatician, this book offers clear guidance on legal and practical issues. It explains the current legal framework set in the context of real-world applications. The background to 'consent' and the impact that implied as well as explicit consent can have on the way records are collected and used is particularly well covered.

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**Care of Drug Users in General Practice, Second Edition Edited by Berry Beaumont**

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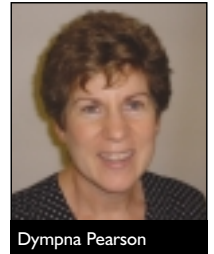
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**Obesity Report**

# A wake-up call for Government

Obesity poses a devastating threat to the nation's health says the Health Committee report which calls for action at the highest level.



Dympna Pearson

The report paints a bleak picture of the problem showing that obesity has grown by almost 400 per cent in the last 25 years, with three-quarters of the adult population now overweight or obese (22 per cent).

It warns: 'Should the gloomier scenarios relating to obesity turn out to be true, the sight of amputees will become much more familiar in the streets of Britain, there will be many more blind people and a huge demand for kidney dialysis.'

It says the positive trends of recent decades in combating heart disease will be reversed and this will be the first generation where children die before their parents as a consequence of childhood obesity.

Committee Chair, David Hinchliffe, said the enquiry was a 'wake-up call' for Government to show that the causes of ill health needed to be tackled by many departments not just health. He said the Committee had found a 'total lack of joined up solutions at present' and called for 'wholesale cultural and societal changes.'

Many health organisations have welcomed the Health Committee's call for a 'comprehensive raft of measures to combat obesity' including the establishment of a Cabinet-level Public Health Committee to oversee the development of targets across all relevant Government departments.

Dympna Pearson, Vice-Chair of the National Obesity Forum and Chair, Dietitians working in Obesity Management (UK), said she was pleased with the recommendations but disappointed they did not go far enough.

'The key omission is that there is no firm plan to help PCTs develop structures to actively manage prevention and treatment of obesity. PCTs are going to need a lot of support in developing a strategic approach to this' she said.

Primary care should utilise the skills of dietitians more, who are highly qualified in all aspects of obesity management, from prevention to treatment. The recently published Counterweight\* study is an excellent example of a dietetic-led nurse intervention, which achieved impressive results.

King's Fund Chief Executive, Niall Dickson, said the report was extremely important and

timely. 'It demonstrates that the extra funding for the NHS will go to waste if we do not get to grips with the devastating rise in obesity. There is now an overwhelming case for reorienting our health system to ensure it not only treats people when they are ill but helps them to stay as healthy and independent as possible.'

'We need Government to be brave and intervene to improve the health of the nation while considering the vital role that individuals, industry, communities and employers have to play.'

King's Fund Director of Health Policy, Anna Coote, added: 'We're still in the middle of the Government's wide-ranging public health consultation. Much will depend on the outcome of this and the proposals ministers put forward in the White Paper later this year. One thing's for sure, the time has come to stop talking and start acting.'

Professor Peter Kopelman, Chair of the RCP Nutrition Committee, also welcomed the report. He said: 'It very much supports the recommendations that we made earlier this year in 'Storing Up Problems: The medical case for a slimmer nation' joint report with the Faculty of Public Health and the Royal College of Paediatrics and Child Health.'

The RCP particularly supports the recommendation to set up a Cabinet-level Public Health Committee. 'The societal problem far outstrips the role of any one Government department but we agree that the Health Department should play a leading role in developing the cross-Government action plans needed to tackle it,' Prof Kopelman added.

**Reference: The Counterweight Project Team (2004). Current approaches to Obesity management in UK Primary Care: the Counterweight Programme. J. Hum. Nutr. Diet 17, (3) 183-189, and The Counterweight Project Team (2000). A new evidence-based model for weight management in primary care: the Counterweight Programme. J. Hum. Nutr. Diet. 17, (3) 191-208.**

**Obesity Report available at: [www.parliament.uk/parliamentary\\_committees/health\\_committee](http://www.parliament.uk/parliamentary_committees/health_committee)**

## Chronic disease management

Joint clinical directorates are the way forward for chronic disease management according to a new joint report from the NHS Alliance, the Royal College of Physicians and the Royal College of General Practitioners.

The report, *Clinicians, services and commissioning in chronic disease management in the NHS*, argues that organisational boundaries in the NHS, particularly those between hospitals and

primary care, make little sense to patients, are often seen as anachronistic by doctors and other clinicians and can lead to unnecessary costs.

It says: 'The systematic application of pragmatic solutions, led by clinicians, can cut through the limitations imposed by organisational barriers and can preserve the uniquely holistic nature of NHS provision.'