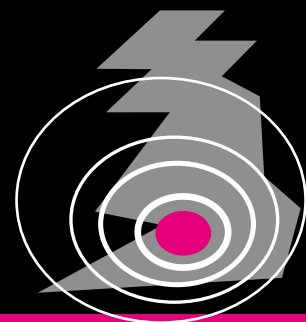


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Long Term Care: A huge step forward or dishonest spin?

The Government has turned down the fundamental recommendations of the Royal Commission on Long Term Care. But, shadowed by the National Plan published the same day, the long-awaited response has received little media coverage.



Professor Dame June Clark

Long term care experts and health organisations, however, have expressed a range of opinions.

Disappointed members of the Royal Commission have described it as 'dishonest spin,' while the RCN proclaimed it as 'a huge step forward.'

'At last, everyone who needs nursing care, as defined by nurses working with them – including those in nursing homes – can get that free under the NHS,' the RCN said.

Not so, say critics. The commissioners are 'furious' at the timing of publication as well as the document's 'dishonest spin.'

You have to piece together the response (no costings) with chapter 15 of the National Plan, to find that although the Government has funds enough to carry out all the Royal Commission's proposals – they refuse to, a member of the commission told PCN.

'Free nursing care' is only for those in nursing homes, and will only be funded at £100 a week – one hour a day, Professor Dame June Clark of the School of Health Sciences at the University of Wales, Swansea, pointed out.

Dame June said: 'The beauty of the Commission's recommendation was its simplicity. We said everybody recognises the difference between board and lodging, and the so-called indirect care like housework and gardening that everyone needs in old age, but the 'personal care' that only some people need should be provided free. That would have cut through the bureaucracy, and wouldn't have needed detailed assessment. I don't believe it would have cost more. Figures that never appear in the costing are transaction costs. This will cost a bomb!'

She said there is nothing in the National Plan to solve the problems of those who need long term care. And it creates confusion, proposing that nursing care should be free, but 'personal care' should be paid for. 'What part of someone's bill is nursing and what part is non nursing

care?' asked Dame June

Sally Roberts, chief executive, Blanchworth Care, the largest provider of nursing homes in Gloucestershire, said overall she was dismayed and disappointed at the government's proposals.

'They are so lightly defined that clients will still end up paying for the majority of their care, for example dressings, catheter care, chiropody, continence care and products.'

As to administration and implementation, she foresees a nightmare. 'You can't just say, OK it takes five minutes to do a dressing, therefore if it's done by a registered nurse it will be paid for and the home and client will eventually be reimbursed. If we are heading down this route it's going to be extremely complicated.'

She is also angry that people with dementia will be discriminated against. 'I think it is shocking they will still be expected to pay for their own care,' she said. However, she was pleased about the extra funding for intermediate care.

Dr Clive Bowman, Department of Clinical Gerontology, Western General Hospital has just completed a survey of nearly 1000 people in nursing home care. He and colleagues found the proportion who were admitted for social care reasons was less than 5%.

'Most of them have got a discreet diagnosis that has led to their disability, most of that group have got dementia, and of the ones who don't, mental impairment is the most clear reason for on-going nursing care. This turns everything upon its head, because all the government policy is based on the fact that people are old and frail, rather than ill and sick. And we've got quite good evidence now that these people are clinically unstable, sick, and their disability is a consequence of that, rather than age. It is true disability is more likely, their illnesses more likely, because they're older, but to say "it's age what done it," is unfair.'

The response did not give the nitty gritty of how government proposals will work in practice, but this month (September) will bring revelations of radical change. Dr Bowman is co-author of a report to be published jointly by the RCP, RCN, and the British Geriatrics Society, saying care of the sick elderly should be by teams comprising nurses, GPs and hospital doctors, but the lead clinician should be the nurse.

'This is radical. And this is a report coming out from the Royal College of Physicians,' he says.

continued on page 4

NEWS IN BRIEF

Implementing the Vision

The NHS Alliance will hold its third annual conference on October 19 & 20 in Birmingham. Speakers will include: health minister John Denham; Sir Michael Rawlins, chair, N.I.C.E.; Christine Hancock, general secretary, Royal College of Nursing and Dame Deirdre Hine, chair, The Commission for Health Improvement. Details from Health Links on 0121 444 3399.

B.A.M.M. expands

The British Association of Medical Managers has set up a sub group, Medical Managers in Primary Care (MMPC) to 'provide a support network and focus for the continued development of those with a medical management role in primary care.'

Members include PCG chairs, clinical governance leads, chairs of executive councils in PCTs, and PCT medical directors of out-of-hours providers. For further information contact BMM on 0161 474 1141.

Masters course

A Masters Course in Primary Care Studies has been launched by the University of Derby, available in classroom taught format and distance learning. Other short courses for primary care professionals are also available. Details from: www-hcs.derby.ac.uk or on 01332 593164.

Fast tracking

Ten fast track teams for heart disease start next month (October) to provide rapid response for heart attack patients and follow-up care planning. They will work across NHS management boundaries, between hospitals and PCGs/PCTs to provide integrated heart disease care.

The teams are:

North Essex Cardiac Partnership; North West London CHD Partnership Programme; East London and the City CHD Programme; Manchester, Salford and Trafford Network for Cardiac Care; East Riding and Hull CHD Partnership; Southampton & South West Hampshire HA & Winchester CHD Partnership Programme; South West Peninsula Cardiac Consortium; Dorset & Southampton Whole Systems CHD Partnership Programme; North Trent CHD Partnership Programme; The Black Country CHD Collaborative

£63m stepdown care

Health and social services are to get a £63million cash boost for step down care this winter to bridge the gap between hospital and home.

It will be put into pooled budgets. Uses will include providing step-down care in hospitals, private nursing homes and support at home.

INFORMATION TECHNOLOGY

How to use the Primary Care National electronic Library for Health

The creation of the NeLH (National electronic Library for Health) was one of the key objectives of the NHS Information Strategy – Information for Health. The Primary Care library is being developed ahead of the main library project – to meet a commitment that there would be some primary care resources on-line by the autumn of 1999. This primary care portal has been available since then, the full site is on NHSnet: <http://nwww.nelh-pc.nhs.uk> with an Internet presence available as well at <http://www.nelh-pc.nhs.uk>



Simon de Lusignan

Site layout:

The site is organised to reflect a 'use-spec' (user requirement) developed over the first three months of the project. It can be approached via different views. The library or 'home' page has information organised by categories as found in a library – books, journals, reference section etc. A people view has information organised by primary care professional groups – including midwives, CPNs and Primary Care Pharmacists – as well as a comprehensive database of every PCO (Primary Care Organisation) and their health improvement plans. Lastly a Health Improvement view links to key information to enable those leading on Clinical Governance and Health Improvement.

Every link to the site has an electronic index card, including a site rating score and feedback form. User feedback is taken account of in the rating of sites.

Getting started:

Users navigate between the views using the drop-down menu at the bottom left of the screen. The 'home' link always take you back to the library view. The left hand column of each view is the list of category headings. These take you to the second level of the site. In front of every link is an 'i' that links to the index-card about the site in question. Every link is indexed and rated. If you can't find what you want via the category headings - either browse the index from A to Z – or search the index card via the 'search this site' search-box.

The meta-evidence search engine is accessible from all views. This is designed to provide rapid access to distillates of evidence from a number of accredited sources. It aims to produce the right volume of review information for busy primary care professionals. Just type in your search term and press 'go'.

Other features of the site include links to a database of NHS libraries, feedback forms and the option, via the feedback section to submit new material to the library. Users can also go directly to a category on any of the views via the site map. The site can also be personalised. Users can group together their twelve favourite resources within 'my-NeLH-PC.'

Summary:

The NeLH-PC aims to support those addressing the clinical governance agenda through the provision of links to key information. New users are encouraged to give as much feedback as possible – in order to help shape the development of this project.

Contact: ikpobie@drs.desk.sthames.nhs.uk
Tel 020 8725 5661 Fax 020 8767 7697

Simon de Lusignan
Director, NeLH-PC Project Team, St George's Hospital Medical School, London

LETTER

Dear Editor,

I am IM&T Lead for my PCG (Chiltern Vale, Beds) but not on the Board. Your report on the National Tracker Survey (July issue) suggests problems with IM&T in the majority of PCGs: could I highlight some of the difficulties?

1. Lack of resources. Unlike Clinical Governance (CG), there is no separate funding for GPs undertaking this role, and certainly no locum cover. In my PCG, the hourly rate for non-Board members is less than the BMA recommended locum fees.
2. Breadth of the agenda. The information required by PCGs includes information generated in secondary care as well as in primary care. There are issues of data quality and uniformity in entering data – which is partly the remit of the CG group – as well as the educational issues of persuading busy clinicians to put anything on computer!
3. Lack of timely support and tools. For example:
 - the change from IMG to NHSIA meant that, at a time when support was needed, it was not

available. I required use of MIQUEST from late 1999. PRIMIS has only just succeeded CHDGP, and I do not know when the services it offers will be available.

- electronic communication and web browsing prevented by the failures of the NHSNet installation programme. Because we expected to be connected by November 1999, we were prevented from using other forms of connection. The few sites that are connected have unexpected breakdowns.
 - the amount of time spent on NHSNet is large – and detracts from other areas of IM&T.
 - NSFs are published without adequate Data and Read Code tables. This means that, all over the country, PCGs are having to develop their own lists of Codes to enable easy audit of CHD and Mental Health. This is a waste of precious time and resources, and leads to the risk of different data sets being audited in different PCG/Ts.
4. Lack of vision on the part of PCG Boards. I could expand on all of these – and add more – but you get the message!

Mary Hawking

Human Resources

More scope in County Durham

Am I my brother's keeper? Or, to put the question into contemporary health service terms, who cares for the (professional) carer? Traditionally, you were meant to cope – either by denying that the job was stressful, and just getting on with it, or by seeking the support of artificial stimulants or relaxants. And any pattern of personal and professional development was up to the individual concerned. No one really took formal responsibility for anyone else.

This failure of support mechanisms within primary care is not, however, universal. Psychologists, counsellors, social workers and Community Practice Nurses, for example, frequently adopt proper systems of mentoring and appraisal. Nurses, particularly those employed by trusts, utilise programmes of clinical supervision. But GPs, practice nurses, and managers and receptionists are often left to their own devices – sink or swim. Beginning in 1996, and as a response to this important agenda, County Durham and Darlington Health Authority developed a raft of primary care support initiatives called *More scope in County Durham*. This is now an NHS Beacon Service within the human resource category, with the following three strands to the initiative:

GP Career Start and Practice Match

The first is aimed at younger GPs and those looking to find GP work in the county – GP Career Start and GP Practice Match. GP Career Start is a two-year salaried scheme for vocationally trained doctors. On leaving their training, new GPs increasingly feel the need to develop further skills and gain more experience before settling into a more permanent work pattern. The Career Start scheme offers a supportive, structured environment for both personal and professional development, not least through protected time for study and peer support, and by working in a variety of practices.



Dr Jamie Harrison

GP Practice Match seeks to connect doctors to job opportunities in County Durham, both as principals and in salaried posts.

GP Choices

GP Choices is an innovative response to the needs of practitioners under pressure. Initially reserved for doctors, this programme of support mechanisms is now being rolled out to all in primary care, whether GPs, nurses, managers or other practice staff. It is a significant attempt to build an occupational health scheme for general practice. Designed to respond to problems early (prevention is better than cure), GP Choices can offer mentoring, a confidential counselling service, out-of-area treatment options and practical interventions to practices, and practitioners, under strain. Confidentiality is the key to its success, allied to the backing of the health authority and the quality of the leadership of the programme.

GP Fellowships and Sabbaticals

The third strand offers developmental opportunities to established GPs, either by being funded to undertake research at Durham University, having a six-week sabbatical to pursue a clinical or managerial topic, or receiving educational grants towards the cost of diplomas and courses. Many GPs in mid-career feel the need to widen their horizons or take stock of where they are going.

This educational strand allows space for reflection and the chance to develop new skills. GP Career Start doctors are often used to provide clinical cover for practice absences and the GP Tutors liaise with the health authority in encouraging uptake of these options.

Conclusion

The *More scope in County Durham* programme highlights the possibilities available to all in primary care, assuming health authority support and a willingness to take the initiative. It is very much a team effort, each strand depending on the others for its success. Do come and visit us in Durham to find out more.

Jamie Harrison is a GP and runs the GP Career Start scheme. He can be contacted by telephone on 0191 333 2807 or by e-mail: cdha.gpcareerst@dial.pipex.com

The role of practice managers in the successful development of PCGs and PCTs

Practice managers' skills are underused in the development of PCGs and PCTs according to a study carried out for 3 PCGs in the south of England. Nicci Iacovou, principal consultant with PCA Consulting which carried out the survey, writes about its findings.

The work was commissioned within the context of recent government policies and:

- the drive to make best use of practice managers' skills within PCG/PCT processes;
- develop the role and skills of practice managers to match the development of PCGs and PCTs;
- acknowledgement of the wide variation in skills and responsibilities of practice managers.

The study was conducted by confidential one to one interview using a standard questionnaire. Completed questionnaires were collated and analysed. They showed that practice managers work at a variety of different levels for wide ranging salaries and terms and conditions of employment.

The evaluation provided these 3 PCGs with useful information including:

- A baseline picture of the current tasks, roles and responsibilities of practice managers;
- A distribution of practice managers with an appropriate qualification;
- An overview of training and development needs

of practice managers;

- A comparison of practices showing 3 different levels at which practice managers are; functioning linked to size of practice and salary range;
- The number of practice managers who receive formal appraisals;
- The number of practice managers due to retire within 10 years.

The findings also highlighted some important issues and concerns for the new Primary Care Organisations (PCO) nationally: -

- The stress and frustration for many practice managers comes from being unable to use their managerial skills to their full potential, in addition to the stress from the workload itself;
- Many are keen to take a more active role in PCG/PCT activities;
- Many practice managers are well equipped to take on wider roles and responsibilities within practice localities and the new PCOs as a whole;
- The variation in GPs' level of understanding and appreciation of the important and beneficial role that practice managers can take on within their own practice, the practice locality and the wider context of the PCOs;
- The wide variation in the level of understanding among GPs of appraisal systems, their benefits to both the practice (and consequently the PCO) as well as the individual.

Exploiting the skills of practice managers in PCO development would have a number of benefits: -

- Reduction of pressure on PCO board members by implementing at local level the PCO's plans and strategies
- Taking an important liaison role between board members, particularly lay members and social services representatives
- Positively contribute to practice managers' individual development. This links in with CPD programmes as part of wider clinical (and indeed corporate) governance initiatives
- Facilitation of stronger links within core practice teams, extended primary health care teams and cross-team working in PCO localities
- Help maintain an appropriate balance between practice teams as individual entities and as integral effective parts of the new PCOs;
- Make better use of existing resources.

The success of the new PCOs is dependent on appropriate, effective, efficient links across practice teams, in an organic grid-like structure based on best use of individual skills and expertise. With appropriate processes, support and recognition, many practice managers are ideally placed to take all parts of the PCO, not just the board, in the right direction.

For more information contact Nicci Iacovou on 01788 336887.

Editorial board comments on government's response to Royal Commission's report on long term care

Lynn Young, RCN community health adviser, said: 'The RCN welcomes the range of initiatives aimed at improving care for older people. The decision by Government to remove nursing care charges, including the cost of nursing care while the older person is living in a nursing home is especially welcome. However we anticipate problems on account of older people having to be means tested for personal care.'

'Making a distinction between nursing care and personal care is fraught with difficulties and this decision by Government could result in endless futile discussions and inevitable disagreement which will do nothing to enhance the care of older people.'

Janice Miles, Policy Manager, NHS Confederation, said: 'We support the provision of free nursing care in all care settings as we have long argued that it is illogical to have nursing care free in some settings and not in others.'

We are pleased it is accepted that making personal care free for everyone would consume a significant amount of additional resources without improving overall service quality, and we welcome the ending of the residential allowance, particularly as by transferring the resource to local authorities it could in future be spent on maintaining people in their own homes.

Most importantly clarity is essential on a national definition of nursing care. Without this there will still be the possibility of different interpretations at local level. The proportion of the total cost of residential care to be met by the NHS, local authorities and the individual could continue to be a source of discontent.'

Readers' views are welcome.

Jenny Sims, Editor



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Medical Management Services (UK) Ltd
24 Gay Street, Bath BA1 2PD
Telephone: 01225 333711
Facsimile: 01225 422533
Email: enquiries@medman.co.uk

OPINION

PALS should not take over responsibility for patients' complaints

By Donna Covey, Director, Association of Community Health Councils for England and Wales



One of the most positive ways in which Community Health Councils (CHCs) have extended beyond their statutory remit in

recent years is in the work they have done around primary care. In particular, the advent of PCGs has seen CHCs across the country supporting lay members and developing public involvement. Our association put forward proposals to the National Plan process that would have extended and formalised that work*.

The proposals in the National Plan for patient empowerment could make a real difference to many patients. However, the proposal to abolish Community Health Councils is wrong, and does not follow from the initiatives outlined in the plan.

For example, the plan proposes that the role played by CHCs with regards to patient

complaints be taken on by the Patient Advocates and Liaison Services (PALS). This type of trust-based advocate can play a valuable role in resolving problems for patients, and in places where they already exist they complement the independent support and advice given by CHCs. PALS will not replace the full range of the support a CHC can give. And nowhere is this more obvious than in relation to primary care. A trust-based advocate in primary care will not be 'on the spot' in the local surgery. They will not be on the spot if there is a problem with the out-of-hours service, or with a home visit.

Community Health Councils have worked hard, together with local primary care providers, to make a real difference to local communities. It would be a tragedy if, in implementing the National Plan, that work was lost in the headlong dash for reform.

**Old watchdog, new tricks,* ACHCEW submission to the National Plan.

PCG TIPS: Books and reports

Beacons Learning Handbook 2000/20001 Spreading good practice across the NHS

The Beacon programme is proving effective in sharing good practice throughout the NHS, according to the NHS Executive, publishers of the handbook. It contains details of 287 Beacons and seven national Learning Centres as well as useful information on the National Patient's Access Team. It lists interactive learning events, workshops, conferences and secondment opportunities. It also gives details about people willing to act as mentors and others able to help PCGs/PCTs think through changes.

Free from the NHS Executive on 01730 235018 or visit the Beacons national web site at www.nhs.uk/beacons which also showcases other sources of good practice.

Acupuncture: efficacy, safety and practice

Health authorities, PCGs and PCTs should consider including acupuncture services in their HImPs in light of the effectiveness of treatments for some conditions, says this report carried out by the BMA. It calls for more research into the effectiveness of treatments but also calls on the government to consider making acupuncture available on the NHS. Harwood Academic Publishers On 0118 9520314, £12.99 ISBN 90-5823-164-X

Cancer Research – a fresh look
House of Commons Science and Technology Committee' Sixth Report

Welcoming the new cancer referral guidelines for the primary care sector, the committee said the government must monitor the implementation and effectiveness of the guidelines in supporting diagnosis of cancer and referral to cancer specialists. They also recommend the government reviews arrangements for the provision of anti-cancer drugs to NHS patients 'to ensure the best drugs are available, to all those patients who may benefit, as quickly as possible.'

Published by The Stationery Office on 0870 6005522, £12.50 ISBN 0 10 253900 6

The Team Guide to Communication

By John Middleman

This is a practical and comprehensive guide to communication in family medicine for doctors, nurses and staff in the primary healthcare team. It brings together all facets of communication in healthcare, including involvement of patients, staff and external workers. It shows how to address all aspects of communication in relation to one-to-one situations, teaching and groups, and encourages the reader to reflect on their own clinical and work experience.

Radcliffe Medical Press on 01235 528820 £19.95

continued from page 1

No wonder then, the RCN did not complain about the total confusion that critics warn is going to come about because of the Government's rejection of much of the Royal Commission's report on Long Term Care.

Whether these plans will work at all may well create a political storm this autumn.

The NHS Plan The Government's response to the Royal Commission on Long Term Care, published by The Stationery Office, £7. Also available at www.nhs.uk/nhsplan

Di Latham