

# PRIMARY CARE NETWORK



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## Second wave Primary Care Trusts launched

**Another 23 Primary Care Trusts are being launched this month. What lessons can be drawn from the first wave of 17 launched in April? Stephen Halpern finds out.**

PCGs achieving trust status will have to deal with greater complexity but will find they have the same management agenda as before.

One of the first wave trusts was North Peterborough PCT. Chris Town, Chief Executive, said that despite all the planning nothing can completely prepare you for the reality of becoming a level four PCT.

'When it really happens there is a lot more in it than there appears to be in the preparation especially taking over responsibility for large numbers of staff. From day one you are suddenly responsible for 270 community health care staff with all the human resource issues involved' he said.

One warning from Chris Town is that the management arrangements are much more complex than in a PCG. He said the existence of an executive and a PCT board means effectively having to work with two boards. This in turn meant setting in place teambuilding and development both separately and collectively for both bodies.

This isn't helped by the amount of time most PCTs will get to put these structures in place. 'It will be almost certain that there won't be a lot of time between the board being appointed and it becoming operational. Our experience is that the boards will have to hit the ground running' he said.

One sobering aspect of PCT trust status for Chris Town was where the buck stops. This was brought into sharp relief when as Accounting Officer he had to sign the Memorandum of Agreement with Health Secretary Alan Milburn.

'The realisation dawns on you that delivering major policies such as the NHS Plan is your responsibility without having the comfort zone of a wider organisation to fall back on' he said.

Despite these additional administrative responsibilities, his biggest worry remains the same – raising the quality of clinical services. To him this is the big issue underpinned with formidable political and public expectation. This means concentrating on setting up monitoring systems for clinical governance.

Chris Town said that one important factor in developing the trust is the increase in funding that now underpins the proposed changes.

'The additional challenges have been matched with increased resources. It has made a considerable difference and been very refreshing to be

given the resources to develop new modern services' he said.

One factor which might cause some PCGs to be tentative about taking the plunge is the danger of sidelining GPs and other clinical staff. The different dynamics of board governance threatens a change in status for doctors who only a year ago were at the vanguard of the new primary care led NHS.

In NE Lincolnshire PCT, they applied for alternative governance arrangements in order to protect the development of GP involvement.

Ros Gower, Head of Service Development said: 'We applied for alternative governance arrangements to put in place steps to maintain the flow of development.'

The PCT now has seven primary healthcare teams, six of which relate to populations of 20,000 and one to 40,000. Each has a GP or clinical representative who sits on the trust executive. Continuity is also maintained by the GP chairman of the former PCG becoming chair of the PCT executive. The PCT has also boosted clinical governance by appointing one GP as a half time Director for Clinical Governance.

Despite making thorough preparations there will always be some areas which will have a

**continued on page 4**



Chris Town

## EDITORIAL COMMENT

Primary Care Trusts take centre stage this month as the second wave are launched, though with much less of a fanfare than the pioneering first waves in April. Looking back over the last six months, first wave chief executives and their staff admit they have had a steep learning curve. While we have gathered a few tips from them for the October tranche, more would be welcomed for the 135 set to take trust status next April. Letters or articles please from board members as well as chief execs.

Care Trusts, as announced in the NHS Plan, are another boardgame. But the NHS Confederation point out they will have 'major advantages in commissioning and providing personal social services.' (See page 3). And according to Jane Austin, they will 'place the patient...firmly in the centre of proceedings.'

This will be good news for the People's Voice for Health campaign, launched last month to ensure the NHS Plan's proposals for patient-centred care become a reality. If PCG/PCTs and health professionals want to sign up to the campaign, see p.4 for their website.

Jenny Sims, Editor

NEWS IN BRIEF

**NICE inhalers**

Guidance on inhaler systems (devices) for children under five with chronic asthma has been issued by NICE. All GPs and health professionals working with asthma in England and Wales should have received it.

It recommends both corticosteroids and bronchodilator therapy should be routinely delivered by pressurised metered dose inhaler (pMDI) and spacer system, with a facemask where necessary.

**NICE events**

*Setting Standards and Spreading Good Practice*, annual conference and exhibition, 29-30 November.

*Health Technology Assessment (HTA) and the Industry: A global challenge and an insider's view of submitting to NICE*, 28 November. Harrogate International Conference Centre. Details from Sterling Events on 0151 709 8979 or [www.sterlingevents.co.uk](http://www.sterlingevents.co.uk)

**On-line recruiting**

The Department of Health has announced plans to launch an internet website to act as a one-stop billboard for all NHS job vacancies from next spring. It will include comprehensive and continuous coverage of all NHS staff vacancies in PCG/Ts, Trusts and HAZ throughout England and Wales for hospital doctors, GPs, nurses, therapists, managers and support and practice staff.

**Prostate cancer**

By the end of the year patients will be able to see a specialist within 14 days of an urgent referral from a GP under new plans for better prostate cancer services announced by Health Secretary Alan Milburn. This includes an extra £4 million funding over the next three years. The Prostate Cancer Charity is campaigning for a national screening programme to detect the disease on the same scale as nationwide screening for breast cancer.

**LMCA event**

The Long-Term Medical Conditions Alliance's conference, *Partnerships for Successful Self Management - Outcomes and implications of the LMCA's Living with Long Term Illness (Lili) Project*, will be held at the Royal College of Physicians, London, 28th February aimed at health care professionals, health care commissioners and providers and others. Further information from: Cathryn Stokes, LMCA Conference Co-ordinator, 22 Park Lane, Coxtie Green Road, Brentwood, Essex, CM14 5PT. Tel and fax: 01277 373797. Email: [cathryn.s@btinternet.com](mailto:cathryn.s@btinternet.com). Or visit our website at [www.lmca.demon.co.uk](http://www.lmca.demon.co.uk).

OPINION

Consultant Nurse role must expand



Lynn Young

Prime Minister Tony Blair announced in November 1998 he wished to see a new breed flourish in the NHS – that of Consultant Nurse. We in the nursing world were taken completely by surprise as there had been no discussion, let

alone formal consultation on the subject, so it felt as if Mr Blair had suddenly had a great idea! Much work has taken place on Consultant Nurse since then, over 100 have taken up their new posts and the second round of appointments is currently taking place. Progress is being achieved and the NHS Plan calls for an expanding number of them to be positioned throughout all sectors of the service, including primary care.

The language may have changed, but well over a century ago Florence Nightingale wrote of the need for both 'extraordinary and ordinary' women to enter the nursing profession (she certainly did not approve of the male nurse!) and that high quality nursing care was provided in the hospital ward run by a 'superior nurse'.

The nursing profession is rapidly increasing its influence over service development and patient care. Consultant Nurse is another initiative which will further accelerate this healthy and essential trend, resulting in benefits to both the public and the profession.

Nursing suffered in the 1960s because of a lack of data and research-based evidence. During the 80s and 90s it experienced large scale disinvestment and political exclusion. Then dramatic change with the current Government as it perceives nursing to be a significant solution to many of the NHS' problems, including poor public health and social exclusion. The good news is that Consultant Nurse must spend at least 50% of her time in clinical practice which is highly symbolic given the overwhelming focus of the NHS Plan on patient care, rather than systems and structures.

Consultant Nurse leads on clinical care, practices at advanced level and must have the wit and ability to address the factors in all sectors which impact on people's health. Assessment, diagnostic, screening and case management skills are essential for Consultant Nurse to be successful.

To be honest, no one can suggest with credibility that Consultant Nurse is the panacea for today's nursing problems, but at least we can now celebrate the political acknowledgement that high level clinical nursing and leadership is crucial to a successful NHS. It is also important for nurses who are passionate about the quality of care to have something worthwhile to aspire to.

It is in the public interest that the role of Consultant Nurse is allowed to flourish and expand, so let's offer our full support and call for many more to be appointed.

Lynn Young, Community Health Adviser, RCN.

Why email will be easier on NHSnet

A national on-line address book for the NHS will be available in December, the NHS Information Authority has announced.

The web-based directory will be available to all users of NHSnet, the NHS's private network, and will hold addresses in both Internet (SMTP) and X.400 messaging formats.

Using the new service, locating an email address for any of the 60,000 plus people currently connected to NHSnet will be easier than finding a phone number.

Steve Walker, head of Project Connect, the programme responsible for connecting Trusts and GP practices to NHSnet is enthusiastic about the new directory:

He said: 'It will certainly make NHS email messaging much easier. The service will be seamless. Users won't need to be aware of the messaging protocol used by the recipient. To send an email, simply look up the name you want in the address book. With the number of NHSnet users set to double, a national up-to-date directory service will be invaluable, particularly for individuals and small NHS organisations, such as GP practices.'

The on-line directory will be kept up to date by a regular exchange of address book data between NHS organisations and The NHS

Messaging Service, supplied and managed by Syntegra. Updates are flexible and can be as simple as a single email from an individual requesting an address change or an upload of the address information for a whole community.

Directory information will be contained in a variety of address books based on geographical location, health authority area and primary care group area; plus one for the Department of Health and one containing the executive teams of all NHS organisations. Address books can also be downloaded by individual organisations for use on their own internal mail systems.

Part of a recently announced package of enhancements to The NHS Messaging Service, the new national directory will be supported by performance guarantees, with a search returning up to 25 address 'hits' normally taking no more than five seconds.

Steve Walker added: 'We have created an infrastructure that allows organisations to use either X.400 or Internet email. It is only right that we support both mail protocols and fully integrate email messaging and encourage the use of email as part of everyday NHS business.'

Address books, supporting X.400 addresses only, have been available to NHSnet users for three years. These have had most relevance to trusts or health authorities that have their own internal mail systems and manage their local address book. All NHS organisations will be required to submit addresses to the national service and ensure that those addresses are kept up to date.

# CARE TRUSTS: *Key issues explored*

Many NHS organisations have long histories of close and effective partnership working with social services, enhanced recently by Health Act flexibilities.



Jane Austin

Where partnership is already working well, establishing the newly announced Care Trusts seems a natural extension of the arrangements – the next step along the PCG to PCT continuum that adds further value and freedoms in existing health and social care partnerships.

What Care Trusts offer is a mechanism for avoiding the difficulties of inter-agency working when there is dual accountability and duplication of processes. There will be major advantages in Care Trusts being able to commission and even provide personal social services. For the patient or service user their local Care Trust will reduce the frustration of boundaries between agencies and promote a far more holistic approach to planning and tailoring total care packages.

In the spirit of the NHS Plan, the principles behind establishing Care Trusts place the patient or service user firmly in the centre of proceedings. However as the detail of Care Trusts is fleshed out over the coming weeks – and primary legislation drafted where needed – it is vital that some key issues are addressed to make these new organisations achieve their full potential. These are:

■ **Funding:** A real challenge of the current system between health and social care is the requirement for two streams of assessment and two streams of resource allocation – which can be major

obstacles to achieving a seamless service from the patient or service user perspective. There needs to be joint strategic direction from health authorities and local authorities, and surety of funding from both streams so that sensible business plans can be made. Optimally there would be a move to a nationally agreed common resource allocation, alignment of annual financial planning cycles and eventually three year settlements.

■ **Charging:** The two sources of income for a Care Trust create the potential for postcode variation in social care provision as a result of differences in local government allocation approaches. At its worst this could manifest itself in scenarios like A&E trolley waits and bed blocking, with the bad publicity that accompanies such things. The government has expressed an aspiration to create a national charging structure for social care to circumvent lack of co-terminosity between NHS and local authority boundaries. This is vitally important for Care Trust success.

■ **Voluntarism:** And lastly all organisations should be able to determine their own pace of change, just as PCGs have freedom to choose the timing and level of their development. Care Trust proposals should be determined locally on the basis of a broad local consensus. In the same way establishment and governance can build on the best elements of the governance of PCTs and NHS Trusts with health and social care professionals in the driving seat. It is important that early wave Care Trusts should not be seen as punitive as the NHS Plan suggests may happen if local partnership fails.

Care Trusts can and will revolutionise health and social care locally for patients and service users, and are a positive development on from Primary Care Trusts in a modernised NHS.

Jane Austin Policy Adviser, NHS Confederation

## OLDER PEOPLE *PCGs show promising signs of improving services says King's Fund report*

Referring to relationships between health and social services the NHS Plan says, 'A key test of these closer working arrangements will be how well they provide older people with improved services.' How well will PCGs stand up to the Government's test? PCGs and PCTs were given a central role in commissioning/providing services on the assumption that they know about local needs and can work with local organisations. A study by the King's Fund shows what progress can be made by PCGs in improving services for older people\*.



Margaret Edwards

We looked in detail at five PCGs over their first year of operation. All had identified older people's needs as a priority. Although the pace of progress varied, four had chosen to work with partners in health and local government rather than take the safer option of looking only at primary care. They had also invited older people and carers into discussions about how services should change. The emerging plans, to which the

PCGs signed up, reflect this joint approach. They include proposals about community services, joint assessment and rehabilitation.

The study also shows that being local is not enough. Although primary care staff may gain impressions about what is going on in their patch and where there are problems, they need more consistent information. Information gained through patient contact is rarely translated into a broader picture and implementation of over 75's assessments is too patchy to be helpful. As PCGs get more involved in joint planning they start to agree with other organisations where the information gaps are. They also find out about other services and how they work, essential information for deciding what needs to change in the future.

Three of the PCGs in the study decided to appoint project officers to develop services for older people, reflecting the complexity of work and pressures on permanent staff. A year is little time to set up a new organisation and build partnerships, but the signs are promising that PCGs can be catalysts for change.

Margaret Edwards

King's Fund Project Manager, PCGs and Older People  
(\*Full findings of the report, *PCGs and Older People, Signs of Progress*, will be published at the end of October. For more information contact Margaret Edwards on 020 7307 2685, fax: 020 7307 2810 or email: M.Edwards@kingsfund.org.uk)

## October 2000 PCTs

\*Information from the regional offices.

### ERO

Hertsmere  
West Norfolk

### LRO

Bexley

### NWRO

Blackburn with Darwen  
Central Manchester  
North Manchester  
Trafford South

### NYRO

Airedale  
Bradford City  
Bradford South and West  
North Bradford

### SERO

Dartford  
Milton Keynes

### SWRO

Bournemouth  
Carrick  
North Dorset  
South Hams and West Devon  
Torbay (level 3)

### TRO

Doncaster

### WMRO

Birmingham North East  
Birmingham Yardley  
Herefordshire  
North Stoke

## April 2001 PCTs – early indications are approximately 135+ PCTs

Already announced:

Harlow (ERO)  
Lowestoft (ERO)  
Morecambe Bay (NWRO)  
Sunderland West - level 3 (NYRO)  
North Hampshire (SERO)

continued from page 1

steep learning curve.

Ros Gower said: 'We underestimated the time and the infrastructure involved in setting up partnership arrangements with the other local trusts and the health authority. These are factors which people shouldn't underestimate.'

Steve Gillam, head of primary care at the King's Fund health charity, says that the major organisational issues remain the same despite the change of status.

'In many ways the major headache for PCTs is the same as for PCGs coming up behind them. There is a policy overload and they will all struggle in the face of the number of items in the agenda' he said.

Steve Gillam referred to the first evidence from the National Tracker Survey about PCTs not delivering major policy items any better than PCGs although he said they are better placed to carry out initiatives such as intermediate care.

'The effort involved in setting themselves up as trusts might have sapped PCTs of the energy for carrying out the major policy initiatives – for instance many of them are struggling to define their HImP objectives,' he said.

He feels that many current PCGs are avoiding the next wave because they do not want to be distracted from the next round of reforms. One aspect which is of concern is that many of the lessons from the first wave of PCTs will not get passed on to successive waves.

'In the NHS we are traditionally not good in linking the leaders to a more systematic approach to develop the second or third waves. How much of this learning is percolating throughout the region?' he asked.

Indications are that about another 135 PCTs will be set up next April.

See page three for October 2000 and April 2001 PCT lists.



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## Patient involvement

# The proof of the pudding....

**The People's Voice for Health (PV4H), the campaigning arm of the Long-term Medical Conditions Alliance (LMCA), has launched a challenge to health care providers and professionals to demonstrate their commitment to patient-centred care.**

While welcoming the NHS Plan's proposals for patient involvement at all levels of the health service, the charity wants to ensure the rhetoric becomes reality soon. They are inviting PCG/PCT, HA chairs, and others to demonstrate their commitment by carrying out a patient-centred initiative within a year. Individual health professionals and patients are also invited to 'sign up' pledging their support.

Cliff Prior, chair of PV4H said: 'Extra resources for the NHS are welcome of course, but money alone will not achieve real changes in services. We need a culture change of attitude among health professionals to involve patients more in their care, especially those with long term conditions who are expert patients.'

'We want GPs, nurses and other health professionals to think about what practical things they could do to make a difference for patients

in their practice, such as making it easier to book an appointment or providing more information about support groups locally.'



Cliff Prior

Professor Sir George Alberti, president of the Royal College of Physicians, was among the first health leaders to sign up. Other royal colleges and health unions are also taking part.

The campaign should gather momentum through lobbying at political party conferences, research projects, and monitoring and publishing results of promised initiatives.

PV4H members include Arthritis Care, Breakthrough Breast Cancer, National Asthma Campaign, National Schizophrenia Fellowship, Parkinson's Disease Society, Stroke Association, Terrence Higgins Trust and the Alzheimer's Society.

To sign up or for more details contact People's Voice for Health, Long-term Medical Conditions Alliance, Unit 212, 16 Baldwins Gardens, London EC1N 7RJ  
Tel 020 7813 3645, email pv4h@lmca.demon.co.uk  
Website: www.pv4h.org.uk

## PCG TIPS: Books and reports

### *The Electronic Red Book (CD Rom)*

This allows you to move between relevant sections in *The Red Book*, *Making Sense of the Red Book*, *The Red Book Expert* and *NHS Regulations* at the touch of a button. You can also add your own notes, print any sections of text or incorporate them into your own notes. It includes:

- The full text of *The Red Book*
- *Making Sense of The Red Book* (ISBN 1 85775 291 0)
- *The Red Book Expert*
- NHS Regulations, and amendments to the Statutory Instruments
- Terms of Service
- Pharmaceutical Regulations
- Health Service Circulars
- The White Paper: *The New NHS, modern, dependable.*

Licensed by the DoH, updates are produced whenever required and are offered automatically to purchasers of the CD ROM.

Produced by The Computer Room, published by Radcliffe Medical Press 01235 528820 £99 inc Vat

### *Improving the Health of Black and Minority Ethnic Groups A guide for PCGs*

By Shona Arora, Naaz Coker, Steve Gillam & Hanif Ismail

Aimed at PCG/T boards attempting to address the core Government objectives of reducing inequalities and tackling racism, this 71 page report should particularly benefit those with small minority ethnic populations who may have little experience

of tackling the issues.

Published by the King's Fund, £8.99 ISBN 1 85717 423 2 Available from the King's Fund bookshop on 020 7307 2591

### *Clinical Governance in Primary Care A review of baseline assessments*

By Lesley Wye, Rebecca Rosen & Steve Dewar

This 24 page report has been produced to disseminate research findings and promote good practice. It summarises a review of the clinical governance baseline assessments of 36 London PCGs. These provide insights into the range of approaches being taken to implement clinical governance, though much has happened since their completion. About a third of PCGs explicitly aimed to use the exercise to start building open, consultative relationships between the practices and the PCG.

Available from the Primary Care Department, King's Fund on 020 7307 2694

### *Making Clinical Governance Work for You*

By Ruth Chambers and Gill Wakely

The authors show what individuals and workplace teams can do to identify their own learning needs, and draw up and prioritise their own action plans. It bridges the gap between theory and practice, and 'thinking and doing'.

Radcliffe Medical Press 01235 528820 £19. 95

### *Quality in General Practice*

By Katherine Birch, Steve Field and Ellie Scrivens

The Secretary of State says in the foreword: 'This book outlines the key issues of quality review and performance assessment. It draws on a comprehensive national survey of all HA in England and Wales and provides practical examples on the breadth of quality and performance management programmes currently in use in primary care'.

Radcliffe Medical Press 01235 528820 £19.95