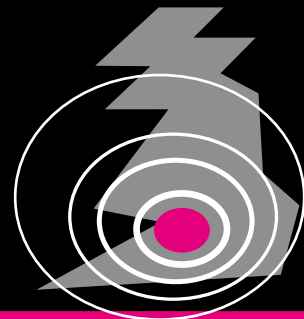


# PRIMARY CARE NETWORK



Making YOUR PCG & PCT work

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## Lay members challenge government on their role in PCTs

**The newly formed National Association of Lay People in Primary Care (NALPPC) has challenged the Government on the role of lay people in public life and particularly in relation to their involvement in PCTs.**

Its founder, Nicholas Reeves has said that the current guidance for setting up PCTs could risk jettisoning the experience built up by lay people in PCGs. PCG lay members will have to come through another selection process to continue into PCTs. In addition the DoH guidance for PCTs includes lay representation only on PCT boards and makes no provision for lay input at PCT executive level. This model can be varied only by having ministerial approval for an alternative exception

Mr Reeves is calling for the recruitment of two lay members to each PCT board with appropriate remuneration. He said unless this happened only a very small minority of people would be eligible to take on these roles.

'That would have been acceptable in Victorian England but it makes no sense in the very different world of the 21st century' he said.

Sheena Bowen, a West Wiltshire PCG member said: 'People do not realise the possibility of alternative governance. Its almost as if the bog standard guidance is being generally accepted as the only option. People are not being sufficiently imaginative.'

Mrs Bowen said that the presence of lay people on the executive was crucial. 'The lay contribution makes a considerable difference. All professionals tend to get into a comfort zone. The lay person can be a catalyst for new thinking'

Micheline Smith of Hillingdon PCT condemned PCT structures which excluded a lay presence on the executive.

'We are in grave danger of losing the lay contribution and all the good work achieved since PCGs were formed. It would be a great shame and a great loss'. She said that the executive had been described as the 'engine room' of the PCT and where they were excluded non-executives would be 'one removed from where the activity is taking place,' she said.

It was perfectly possible to create PCT models without losing lay involvement she

argued. For example, Hillingdon PCT was based on the merger of three PCGs each of which has an executive board (called locality directorates) which includes two lay members. In addition there are eight lay members on the overall PCT board making a total of 14 lay members overall.



Ann Covell

On the wider issue of pay and conditions for lay members, Mrs Smith supported the NALPPC view that PCT chairs and non-executives are relatively poorly rewarded for their contribution.

'When you compare trust board payments with their health authority equivalents, it isn't right especially as PCTs are taking over so much of the work that was done by health authorities.'

Jane Austin of the NHS Confederation made it clear that non-executive membership of Primary Care Trusts involved entirely different roles and responsibilities than are involved in PCGs.

'PCTs are statutory bodies and lay appointments are made on the basis of Nolan principles to attract people of the highest calibre and character' she said.

PCGs are sub-committees of health authorities. Its members have not necessarily been appointed on the same basis as PCTs and therefore might not have been subjected to the same rigorous criteria. It was not therefore possible to expect that PCG lay members could automatically translate their membership to the boards of PCTs.

A Department of Health spokesperson said  
**Continued on the back page**

## EDITORIAL COMMENT

Health minister John Denham, speaking at the NHS Alliance's annual conference in Birmingham last month, announced the Government is to carry out a review of the primary care workforce (see page two). Noticeably absent in the wide-ranging speech was any mention of lay members in primary care.

However, lay members make their voices heard loudly and clearly in this issue of PCN. Unhappy at being excluded from Trust 'engine rooms,' the PCT Executive Committees, they are campaigning for changes to Government guidance to allow them on.

Leading the campaign, Dr Nicholas Reeves, Chair of the National Association of Lay People in Primary Care, argues their case in an Opinion piece on page four. Though they have the support of the NHS Alliance, it will be no easy task. Meanwhile, we would like to hear from any lay members who fear they may be out in the cold when their PCGs become Trusts.

Dr Mike Dixon, Chair of the NHS Alliance, in his conference speech, criticised the appointments system to Trust Boards and warned that PCTs risk becoming re-organised Health Authorities or Community Trusts. For conference coverage see pages two & three.

**Jenny Sims, Editor**

NEWS IN BRIEF

**Diabetes Workshops**

Medical Management Services (MMS) are pleased to announce the launch of a series of 10 FREE UK wide workshops entitled *Integrating Diabetes Services - Time to Respond* in association with the NHS Alliance, NHS Confederation, BMM & the RCN with help from Diabetes UK & PCDUK and sponsored by Novo Nordisk. The aims of the workshops are to help you assess your local diabetes services, identify best practice and what services are needed to prepare for the Diabetes NSF. The workshops will culminate in a National Feedback Report to be launched at a National Conference in the Spring 2001.

Anyone wishing to attend should call Sarah White at MMS on 01225 333711 for a registration form or register via our website [www.medman.co.uk](http://www.medman.co.uk)

Region	Date	Location
London	6th Dec. 2000	Westminster
South West	13th Dec. 2000	Exeter
West Midlands	January 2001	Edgbaston
Northern & Yorkshire	January 2001	Bradford
North West	January 2001	Newton Le Willows
Wales	January 2001	Cardiff

**Computerised medical records**

The DoH has agreed new terms of service with the BMA which allow GPs to maintain all their records on computers. The Good Practice Guide on Electronic Patient Records can be found at [www.doh.gov.uk/gpepr](http://www.doh.gov.uk/gpepr)

**Read before signing**

A new core contract for GPs in Personal Medical Services pilots starting next year will reward practices for the quality of the services they provide to patients. It will require GPs and their practices to provide patient access to a primary care professional within 24 hours and a GP within 48 hours by 2004. But the BMA warns GPs to read its latest guidance before signing.

**Zero tolerance on violence**

DoH guidance on safeguarding staff at risk in community and primary care settings, mental health and ambulance service has been published as part of the Government's drive to make the NHS a zero tolerance zone for violence.

**6 December**

Sharing Good Practice in Health Improvement, half-day of seminars led by NHS Beacon winners. For more details contact Alison Abbott at Healthstart on 0151 236 1737 or email [alison@health-start.com](mailto:alison@health-start.com)

**7 December**

Implementing the National Service Framework for Older People, one-day seminar in central London. For details call Capita, on 020 7222 5110.

# NHS Alliance third annual

## Shake-up of primary care workforce announced by health minister

**The government is to carry out a review of the primary care workforce because a new model was needed, health minister John Denham announced at the NHS Alliance's annual conference.**

'The review will go well beyond the historical counting of GPs as independent contractors and look at the needs of primary care in the 21st century. This will encompass the medical and non-medical workforce and go well beyond the practice base,' he said.

'It will look at what needs to be done so that the workforce for primary care is fully planned at a local and a national level' he added.

An external reference group is to be set up to carry out the review and NHS Alliance chair Dr Mike Dixon was invited by Mr Denham to be a member. He said he welcomed the contribution the Alliance had already made in its report on new career structures for GPs, *A GP Workforce for all the Talents*.

He pointed out health service funding will grow by half in real terms over the next five years, but on its own funding was not enough to bring about real change and modernisation.

### SETTING PRIORITIES AND MANAGING DEMAND

**Looking at the experience of PC commissioning groups, there is a limit to what can be achieved by focusing on drugs alone as a demand management technique in primary care, said Shirley McIver, one of the authors of a report\* launched at the conference.**

The report says: 'In order to maintain control over their spending in the longer term, GPs will need information on the new and existing strategies that may be used to help control their pharmaceutical costs.'

It draws out lessons for PCGs and Trusts from the experience of HAs, fundholders and GP commissioners in setting priorities and managing demand.

The authors also set out to examine whether HAs had moved on in decision making about priorities and 'in particular, whether disinvestment had been made from what were considered to be low priority areas.'

It selected three case studies, West Hertfordshire HA, Oxford HA and Lambeth, Southwark and Lewisham HA.

All had policies on restricting treatments in low priority areas and were attempting to withdraw funds from these areas. However they went about this in different ways.



John Denham, health minister

The NHS Plan aimed to achieve both by 'doing things differently' not changing structures. But it couldn't be delivered without the full involvement of everyone working in Primary Care – GPs, nurses, other health professionals and health care staff.

He added: 'We should extend the role of practice and community nurses with more nurse prescribing and Patient Group Directions. And we should encourage properly trained health care assistants to take on more responsible roles.'

He promised primary care could expect its 'fair share of support from the new Modernisation Agency' and additional support from the centre on commissioning.

He reported that the first group of Primary Care Trusts was 'developing well' and said there was still an effective role for HAs to play in supporting PCGs and PCTs.

After two years in the job, Mr Denham said he was impressed by the vision many people in primary care had, and he could recognise the frustrations they had in their daily work.

He added: 'I believe the NHS Plan offers the chance to overcome the frustrations and provides the opportunity to make the vision a reality.'

*\* Despite the minister's assurances there had been no pressure put on PCGs to become PCTs, nearly 80% of delegates disagreed in a poll carried out at the conference. Only 15% agreed and 5% didn't know.*

Success in savings were achieved. But Prof. Chris Ham, another author of the report, said: 'Releasing resources has proved very difficult indeed.'

He suggested instead of focusing on savings, managers and health professionals should look at 'the envelope of resources, and see how we could get more benefit.'

The report also looked at economic techniques such as Quality Adjusted Life Years (QALYs) and programme budgeting and marginal analysis (PBMA), and managing demand in primary care. Key conclusions included:

- There is scope for achieving prescribing savings and using diagnostic tests more efficiently, both to control costs and to improve quality.
- PCGs and PCTs can help to manage demand in the NHS by developing intermediate care services to reduce emergency admissions and by working with HAs and NHS Trusts to control access to elective surgery
- There are opportunities for more services, like anti-coagulation clinics to be delivered in primary care.
- Setting priorities and managing demand in the NHS

*\* Lessons for primary care groups and trusts and their equivalent organisations in Scotland and Wales. By Shirley McIver, Darrin Baines, Chris Ham and Hugh Mcleod  
Published with an educational grant from Merck Sharp & Dohme Limited by Health Services Management Centre, University of Birmingham, tel: 0121 414 7050, fax 0121 414 7051, [www.bham.ac.uk/hsmc/](http://www.bham.ac.uk/hsmc/)*

# conference *Implementing the Vision*

## Primary Care Trusts risk role crisis

**Primary Care Trusts are at risk of becoming no more than re-engineered health authorities or community trusts, warned Dr Mike Dixon, chair of the NHS Alliance.**



Dr Mike Dixon

'In many regions the NHS is using a system developed in the 19th century for appointing PCT Board members and chairs' he said.

However, he pledged the NHS Alliance would support PCT health professionals, managers and lay members in their efforts to be 'new and different.'

It planned to publish a Primary Care Development Pack within three months written by people at the leading edge of the first wave of PCTs.

Other initiatives would include producing a joint report with the British Association of Medical Managers on appraisal in primary care, called 'What is a good Primary Care Group or Trust?' with an accompanying self assessment system. And, what could be its most ambitious project to date, a follow on to its report, *Implementing the Vision*.

'It will embody the spirit of the NHS Plan but allow primary care to take the initiative and to ensure that there is proper ownership and enthusiasm at grass roots level. It will be a proposal for a "people's health service in primary care" because it will have been written by the people, the local primary care professionals and the managers who know about it. We will be looking for consensus and our intention is that it will include a wide range of organisations representing the professionals, the managers and the people,' he said.

Dr Dixon questioned why there were no primary care organisations on the Modernisation Action Teams or on the Modernisation Board to oversee the implementation of the NHS Plan, or why a Task Force for primary care had not been set up when the ten Task Forces for health were announced.

'The government needs to take advantage of the new multi-professional, holistic ways of working we are developing. It needs to change the balance between primary and secondary care – between healthcare outside and inside hospitals. It needs to listen to the new voices in primary care. If you lose sight of the people who have the vision, you lose the vision itself.'

He pointed out primary care received only 5% of funding compared with 10% 50 years ago. 'If that doesn't change, the systems can't change either' he warned.

'We risk the new NHS delivering little except more of the same, just tinkering at the edges. That isn't what the government wants, it's not what we want, and it certainly isn't what our patients want,' he added.

## Conference workshop: PCGs becoming PCTs – if when and how?

PCGs must have a vision if they want to become PCTs, said Geraint Davies, locality director, Hillingdon PCT, a first wave Trust. Theirs had been simple: 'To improve the health of our population.'

'Not rocket science, is it? said Mr Davies, warning PCGs they should really question why they wanted to become a Trust. Was it, because they could? Because of policy? Or, because the clock was ticking?

When Hillingdon became a PCT they had a £3million deficit, but they were working with the acute trust to reduce it over three years.

Seven months on, they were:

- Bedding in organisational structure
  - developing HR policies
  - creating communication processes
  - developing links with providers
  - seeing transfer of services i.e. NHS Direct & PAMs
- They had:
- Developed financial control systems, two ledgers (provider & commissioner)
  - Established corporate governance arrangements, SFIs/SOs, Audit and Remuneration Committees
  - Established PCT budget
- And they were:

- Managing SLAs
- Delivering the NSFs
- Developing Integrated Pathways of Care (diabetes should be up and running soon)
- Developing relationships with SSD
- Developing Intermediate Care
- Reviewing skill/case mix, and
- Keeping the show on the road.

From strategy to action, PCTs should include all the stakeholders. Hillingdon has consulted hundreds of organisations from pensioners to the Campaign for Real Ale. 'Be inclusive, include everybody,' Mr Davies advised.

And they needed to be confident and competent to take on the services currently run by community trusts.

Cynthia Bower, Chief Executive, Birmingham Specialist Community NHS Trust (which was set up in April), is working closely with the 12 Birmingham PCGs – two of which became trusts in October, and offering them help and support.

The Trust has 4,500 staff and a £140 million annual turnover (£22million of which is spent on community nursing). On 1st October she signed over 100 community nursing and primary care support staff to work for the PCTs.

They have also opened a whole range of support services to PCTs from its seven clinical directorates, including learning disabilities, sexual health, family planning, and elderly services.

Ms Bower said: 'We have a head start

in some areas where you are going to need our expertise, including long term relationships with the community and strong links with the voluntary sector.'

She added: 'We welcome the formation of Primary Care Trusts. Everything we do as a community trust should support the development of primary care. We have tried to manage our community nursing teams as if they were already in PCTs. This involves some nursing managers working to the chief executives and chief officers of primary care. There is no point giving our nursing staff mixed messages or making the transition harder than it is. And nurse managers want to work in primary care, they understand that's where their future lies.'

David Hunter, Professor of Health Policy Management, University of Durham, told delegates the key factor to consider was what 'added value' would be gained by becoming a PCT.

Over the next few months he will be developing a 'Tool Kit for PCTs' which will be published by the NHS Alliance. Areas covered will include prescribing and management.

Prof. Hunter said: 'We want to avoid a textbook of practice telling you what you should be doing and to produce something useful based on the experiences of the first and second wave trusts, grounded in evidence and practice.'

A helpline is also to be set up and workshops offered.

Continued from Page 1

that the guidance for PCTs meant that lay members formed a majority on the board as well as providing the chair. They were in the majority when it came to setting priorities and strategy. She added that PCG lay members have been very closely involved in the applications for PCT status.

'Their knowledge and experience have been invaluable in that process and we wish, wherever possible, to see that expertise remaining in the NHS whether in the emerging PCT or in another local NHS organisation' she said.

In some cases the transition from PCG to PCT appears to have been handled smoothly. Torbay became a level 3 PCT in October and according to its newly elected vice-chair, Ann Covell, the benefit of lay people was recognised at the PCG stage.

There does appear to be a much more developed culture of collaboration than in many other parts of the country. As evidence of the extent of continuity, the former PCG lay member, Roger Ward, has now been co-opted onto the Torbay PCT executive committee. In addition, the chair of the PCT executive has invited all lay members of the PCT board to attend (and participate in) executive meetings.

Mrs Covell said that this kind of collaboration was happening across most of South and West Devon and that much of this was down to the support and lead from the chief executive and others in the local health authority.

'I can see us going from strength to strength, its a pity this level of lay involvement isn't happening everywhere else' she said.

Although progress being made in places such as Torbay will go some way to assuage the fears of Nicholas Reeves and others, it is clear they will not be satisfied with anything less than a fundamental re-appraisal of the role of lay people in the NHS.

**Stephen Halpern**



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**OPINION**



## Guidance needs changing on lay members of Primary Care Trusts

**Dr Nicholas Reeves**

*Chair, National Association of Lay People In Primary Care*

**The decision to appoint one lay person to each PCG Board might have represented the very worst form of tokenism but, in reality, PCG lay members have made a significant impact on the boards on which they serve. Primary care has its own very particular culture and traditions, yet lay members look at this with fresh eyes, questioning and challenging long-established practices and conventions.**

This might simply have been a recipe for conflict and confrontation, but in reality it has proved very different. Entering into their new role with energy and enthusiasm, lay members worked hard to master the ever-changing agenda of primary care, winning at the same time the trust and the confidence of the clinicians with whom they worked so closely. The end result is something quite new in the NHS: a small group working together co-operatively and collaboratively, making effective use of the skills and competencies of all its members.

But now there is a real danger that this could

all be lost. Current guidance for the governance of PCTs proposes a structure in which lay people are relegated to the Trust Board, with no lay people at all on the Executive Committee, the body that many regard as the true 'engine room' of the Trust. Moreover, the lay people on Trust Boards will serve as Non-Executive Directors, recruited to regional lists like their counterparts on other NHS Boards and Trusts. With generic recruitment to ill-defined, poorly paid roles, PCT Trust Boards are in danger of falling back on the 'great and the good', curious surrogates for the local people they are supposed to represent.

Already, some PCTs have disregarded the guidance, insisting that there is a lay presence on the Executive Committee and that strenuous efforts are made to recruit people with real roots in the local community to their Boards. But as long as the guidance itself is unchanged, they will remain in a minority. The guidance needs to be changed now so we can ensure that PCTs truly engage with the communities they are designed to serve.

## PCG TIPS: Books and reports

### **Culture, Religion and Patient Care in a Multi-Ethnic Society** **A Handbook for Professionals**

Meeting cultural and religious needs is an essential part of providing care in a multi ethnic society. This book describes ways of identifying individual needs and offers sensitive and practical approaches to adapting care to meet them. Coverage includes:

- how to improve communication across cultural and language barriers
- sample quality standards for care that meet cultural and religious needs
- detailed information on seven religious groups and five traditional cultures.

**Published by Age Concern England £19.99**  
**ISBN 0 86242 231 Tel: 0870 442 2044.**

### **Contested Decisions** **Priority Setting in the NHS**

**By Chris Ham and Shirley McIver**

This is a study of five contested treatment decisions and is a sequel to the King's Fund Publication *Tragic Choices in Health Care: The case of child B*. A highly topical and controversial NHS issue it is aimed at GPs, nurses, practice managers, PCGs, HAs, patient organisations and others.

**Published by the King's Fund, £10.99 ISBN 1 85717 4186 Available from the King's Fund Bookshop on 020 7307 2591**

### **Prevention is better than cure** **How vaccines contribute to health** **An ABPI Medicines for Health booklet**

Highly infectious diseases that used to severely harm or kill thousands of children and adults in Britain could return if vigilance is relaxed and vaccines stopped, warns this 42 page report. It looks at issues including the development of vaccines, the impact on public health, safety, and the future of vaccination.

**Available free from the ABPI publications department on 020 7930 3477 ext. 1446 or email [m Fleming@abpi.org.uk](mailto:m Fleming@abpi.org.uk)**

### **Poverty and Child Health, second edition**

**By Nick Spencer**  
**Radcliffe Medical Press £19.95**  
**Tel: 01235 528820**

Updated and expanded, this edition challenges many widely held views on the links between poverty and child health. It brings together new evidence, both historical and current, and considers the practical implications for health and social policy, outlining innovative approaches to future development.

### **Successful Supervision in Health Care Practice** **Promoting Professional Development**

**Edited by Jenny Spouse and Liz Redfern**

The authors provide answers about how to implement supervision successfully and how to survive as a supervisor. It also provides guidance about the relationship between supervision and clinical governance, and outlines strategies to improve health care provision through supervision.

**Blackwell Science £16.99 ISBN 0 632 05159 0**  
**Tel: 020 7404 4101**